Guidance: Standard Operating Procedures for Addressing Partner Relationships and Gender-Based Violence in Pre-Exposure Prophylaxis (PrEP) Services

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CHARISMA Agency in Relationships & Safer Microbicide Adherence

MOSAIC Maximizing Options to Advance Informed Choice for HIV Prevention

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Abbreviations and Acronyms

CAB PrEP/CAB LA	Cabotegravir long-acting injectable for prevention
GBV	Gender-based violence
HIV	Human immunodeficiency virus
IPSV	Intimate partner sexual violence
IPV	Intimate partner violence
NPSV	Non-partner sexual violence
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SOP	Standard operating procedure
STI	Sexually transmitted infection
WHO	World Health Organization

Definitions

Burnout – defined by the WHO as a syndrome resulting from chronic workplace stress that has not been successfully managed and results in feelings of energy depletion or exhaustion, increased mental distance or negative feelings about one's job, and reduced professional efficacy.[1]

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

Clinical inquiry — an approach to identifying intimate partner violence (IPV) by staying attentive to possible clinical cues and other signs of violence and asking about violence if you note these cues. Clinical cues include ongoing stress, anxiety, or depression; substance misuse; thoughts, plans, or acts of self-harm or (attempted) suicide; injuries that are repeated or not well explained; repeated sexually transmitted infections (STIs) and unwanted pregnancies.[2]

Compassion fatigue — feelings of emotional and physical exhaustion resulting from supporting others and exposure to their pain or trauma. Unaddressed compassion fatigue may evolve into vicarious trauma over time.

First-line support — the minimum level of (primarily psychological) support and validation that should be received by all clients who disclose violence to a health care (or other) provider. First-line support involves five tasks, which are summarized by the World Health Organization (WHO) using the acronym "LIVES" (Listen, Inquire about needs and concerns, Validate, Enhance safety, and Support).

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

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

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[1] World Health Organization (WHO). Burn-out an "occupational phenomenon": International Classification of Diseases. Geneva: WHO; 2019. Available at: link.

[2] World Health Organization (WHO). Violence against women prevalence estimates [Internet]. Geneva: WHO; 2018. Available at: link.

Gender-based violence (GBV) — any harmful threat or act that directed at an individual or group based on actual or perceived sex, gender, gender identity or expression, sex characteristics, sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity.[3] Throughout this standard operating procedure (SOP), and in accordance with USAID and PEPFAR guidance, we will hereafter use the broad term "GBV" to refer primarily to IPV and NPSV unless otherwise specified.

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

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

IPV also includes violence committed by former partners and individuals in dating relationships. IPV also encompasses harmful practices such as female genital mutilation/cutting; child, early, and formed marriage; and dowry-related murders if perpetrated by an intimate partner. IPV occurs in all settings and among all socioeconomic, religious, and cultural groups. The vast majority of known victims of IPV are cisgender women and girls; however, IPV also occurs against transgender women and cisgender and transgender men, and nonbinary people.[4] Lesbian, gay, bisexual, and transgender people are at particularly high risk of IPV.

Non-partner sexual violence (NPSV) — a form of gender-based violence that refers to sexual violence committed by someone who is not a former or current partner of the survivor.

Pre-Exposure Prophylaxis (PrEP) — the use of antiretroviral medications by people without human immunodeficiency virus (HIV) to prevent acquisition of the virus. PrEP methods include oral tablets or pills, known as oral PrEP; a vaginal ring, known as the PrEP ring; and an injectable, known as CAB LA or CAB PrEP.

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[3] United States Agency for International Development (USAID). United States Strategy to Prevent and Respond to Gender-Based Violence Globally 2022. United States: USAID; 2022. Available at: link.

[4] Peitzmeier SM, Mannat M, Kattari SK, Marrow E, Stephenson R, Agénor M, et al. Intimate Partner Violence in Transgender Populations: Systematic Review and Meta-analysis of Prevalence and Correlates. Am J Pub Health. 2020; 110: e1-e14.

Routine inquiry — an approach to identifying cases of GBV among all clients who present for specific services, without resorting to the public health criteria of a complete screening program.[5] It is recommended for populations that may be at a higher risk of experiencing violence, including those accessing antenatal care, HIV care and treatment, HIV testing services, and PrEP services. Routine inquiry is used in settings where clinical inquiry cannot be conducted but where violence is a known risk factor for HIV.[6]

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

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

Vicarious trauma — trauma that results from being exposed and listening to stories of trauma, suffering and violence. Vicarious trauma may worsen with repeated exposure to traumatic material.

[5] WHO. Responding to intimate partner violence and sexual violence against women: Clinical and policy guidelines. Geneva: WHO; 2013. Available at: link.

[6] Peltz A. Gender equality and gender-based violence priorities for USAID's PEPFAR programs. Slide set; 2019; Washington DC.

Background

This guidance is intended to be utilized by programs providing PrEP so that support staff can identify clients who are experiencing IPV and provide appropriate violence response services. It also provides procedures and counseling messages to help clients decide whether to talk to their partner(s) about their PrEP use and strategies for using PrEP with or without their partner's knowledge. The PrEP Job Aid for Discussing Partner Relationships was developed to support the implementation of this SOP guidance. It can be found at https://www.prepwatch.org/.

Important Note:
The SOP and job aid **must** be adapted by each PrEP program to reflect local laws, policies, resources, and procedures. The bracketed sections of this SOP should be completed based on local circumstances and standards. The SOP should be formatted using the program's standard template, including dating and assigning a version number at the time of adaptation. The SOP should be reviewed and signed off on by the relevant staff and updated as needed after implementation.

Evidence has shown that IPV may act as a barrier to accessing HIV services, including PrEP services. IPV is associated with lower PrEP uptake[7] and adherence[8] and increased PrEP interruption[9] among cisgender women. Although cisgender women have made up the majority of participants in research on PrEP and IPV to date, it is likely that IPV has similar impacts among other populations as well. Likewise, while other forms of GBV may have similar effects on PrEP use, less is currently known about their impact. PEPFAR requires that PrEP service providers conduct routine inquiry with all clients to improve effective use of PrEP, especially among adolescent girls, young women, and members of key populations affected by HIV – including men who have sex with men, sex workers, people who use drugs, and transgender people. In the context of PrEP services, routine inquiry for GBV focuses on prevention of and response to physical and sexual IPV and NPSV because of their clear link to HIV acquisition.

- *Note: Throughout this guidance document, and in accordance with USAID and PEPFAR guidance, we will hereafter use the broad term "GBV" to refer primarily to the GBV sub-components of IPV and NPSV, unless otherwise specified.*

After conducting routine inquiry for GBV, staff must offer appropriate support and referrals to GBV response services, per WHO clinical guidelines.

WHO clinical guidelines[2] state that the following minimum requirements must be in place before providers can ask clients about GBV:

- A protocol/SOP for asking about violence
- A standard set of questions to which providers can document responses[10]

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[7] Lanham M, Hartmann M, Palanee-Phillips T, Mathebula F, Wilson E, Wagner D, et al. The CHARISMA intervention to promote PrEP use, improve relationship dynamics and reduce IPV: intervention and methodological adaptations for an RCT and considerations for future scale up. Sexual Violence Research Initiative Forum. Oct 2019.

[8] Roberts ST, Nair G, Baeten JM, Palanee-Philips T, Schwartz K, Reddy K, et al. Impact of male partner involvement on women's adherence to the dapivirine vaginal ring during a phase III trial: Disclosure to male partners, partner engagement with the study, and partner support of ring use. J Acquir Immune Defic Syndr. 2016; 73(3): 313-322.

[9] Cabral A, M Baeten J, Ngure K, et al. Intimate partner violence and self-reported pre-exposure prophylaxis interruptions among HIV-negative partners in HIV serodiscordant couples in Kenya and Uganda. J Acquir Immune Defic Syndr. 2018;77(2):154-159.

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

- Providers who are trained on how to ask about GBV
- Providers who are trained to offer first-line support when violence is disclosed. Per the WHO clinical guidelines, first-line support "refers to the minimum level of (primarily psychological) support and validation of survivors' experience that should be received" by those who disclose violence to a health care or other provider. It shares many elements with "psychological first aid" in the context of emergency situations. The WHO uses the acronym LIVES[11] to help providers deliver first-line support:
    - Listening with empathy
    - Inquiring about the client's immediate needs and concerns
    - Validating the client's experience
    - Assessing and helping Enhance the person's safety
    - Linking the client to other Support
- A private setting with confidentiality ensured where providers ask about GBV
- A process for offering referrals or links to other services

When adapted to the local context, this guidance document helps PrEP programs meet the requirement for having an SOP in place for conducting routine inquiry for GBV. The guidance also outlines how programs can ensure compliance with the other minimum requirements.

Purpose

This SOP guidance defines procedures for using routine inquiry to identify current or potential PrEP clients who have experienced GBV and for providing clients who disclose violence with adequate first-line support, referral, and follow-up, including referral for post-exposure prophylaxis (PEP) services when applicable. It provides staff with basic counseling tips for clients who are using PrEP or considering using PrEP in the context of emotional, psychological, physical, and/or sexual abuse. Given greater evidence on the intersections of IPV and PrEP use, some sections may focus more on IPV.

Scope

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

This SOP guidance does not cover provision of comprehensive clinical services that should be available within the clinic or via referral (e.g., treatment of injuries, emergency contraception, PEP for HIV and STIs, mental health screening and treatment for depression and post-traumatic stress disorder, and forensic examination). It also does not cover the provision of nonclinical services to which a client may be referred. For more information on clinical services, please see *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*[5] and *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook*.[12] For more information on nonclinical services, please see Section 8.2: Establish Coordination and Referrals between Health Services and Services of Other Sectors in *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.[13]

Responsibilities

- All staff who interact with PrEP clients are responsible for understanding and following any SOP developed based on this guidance.
- The referral liaison or other designated party is responsible for establishing and maintaining the referral network.
- Programs must delegate staff to be responsible for training relevant program staff to work with clients in accordance with this SOP guidance and for day-to-day oversight and support of relevant staff.
- Program staff who provide PrEP counseling should be trained to conduct GBV routine inquiry and provide first-line support.
- All program staff who directly interact with clients, including counselors, clinicians, clinic support staff, and community workers, should be trained to provide first-line support to clients who spontaneously disclose violence.[14]
- Programs must delegate staff to be responsible for monitoring and assessing the effectiveness and efficiency of routine inquiry; GBV identification; provision of first-line support, referral, and support activities; and for working with program staff to improve strategies, including through supportive supervision as needed to provide the best possible violence-related support to clients, as outlined in this SOP guidance.

Programs must delegate staff to assume the ultimate responsibility for ensuring that all applicable program staff follow any SOP developed based on this guidance.

Procedures

1.0 SOP development and preparation

1.1 Review local laws to determine the obligations of the health system to care for survivors, including female, male, transgender, and nonbinary survivors, and to understand any situations in which mandatory reporting of violence is required. A checklist of local laws is

[12] WHO. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. Geneva: WHO; 2013. Available at: link.
[13] WHO. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: WHO; 2017. Available at: link.
[14] WHO. Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: WHO; 2019. Available at: link.

available in Job Aid 6.1 of *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*.[13]

1.2 Develop and maintain a referral network. An accurate and current referral network of local organizations that provide survivor-centered, stigma-free services to people who have experienced violence should be developed and maintained. Relevant services are listed in Appendix D: Referral Network Template. See Appendix B: Steps for Establishing and Maintaining a Referral Network.

1.2.1 Staff awareness of referral network. Program staff should be generally familiar with referral organizations and aware of referral processes. [Clinic to specify responsible people] will ensure that team members obtain relevant updates on this information by [insert process and timeline for information sharing within the team].

1.2.2 Supplemental information. Make informational materials from relevant organizations available in clinic rooms and waiting areas [Clinics to add applicable locations that are accessible and/or potentially more private for clients, such as restrooms or the pharmacy].

1.3 Create private spaces within the facility where no other clients or staff can hear the conversation.

1.4 Train staff who are conducting routine inquiry on the provision of first-line support (such as LIVES) according to WHO standards.[2]

1.4.1 It is recommended that all program staff, including peers and other community workers, who directly interact with clients be trained on LIVES using the relevant portions of *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*[12] to ensure that all PEPFAR-funded programs are able to respond to disclosures of violence correctly, consistently, and compassionately. While this approach was designed to address the needs of cisgender women, the general steps for routine inquiry and the provision of first-line support are relevant beyond this population. Where there is a need for adaptation to address the unique experiences of men or transgender people, this is noted. For training materials that include examples tailored to key populations, see the health care worker training in the *LINKAGES Violence Prevention and Response* series of resources.[15]

1.5 Tailor routine inquiry questions. Questions may need to be adapted based on the local language or terminology to describe forms of GBV. In addition, if you are working with key populations or translating questions into a local language, work with staff and beneficiaries to adapt the questions in Appendix A as needed to ensure they are clear and relevant to the experiences of the target populations. This can be accomplished through conducting focus groups or more informal discussions with members of the target populations.

1.6 Ensure all forms required by the program and by local policies, such as police referral and forensic forms as relevant, are available, and safe information storage procedures are in place. See Annex 11: Privacy and Confidentiality in Documentation in *Strengthening Health*

[15] Dayton R, Morales GJ, Dixon KS. LINKAGES health care worker training: preventing and responding to violence against key populations. Durham (NC): FHI 360, 2019. Available at: link.

Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.[13]

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

1.8 Put systems in place that make returning for PrEP visits easy in cases where a partner throws away a client's PrEP products (e.g., pills, rings), forces a client out of the house without their belongings, or controls a client's ability to return to the clinic.

1.8.1 Sensitize program staff to the possibility of clients coming in or calling to return to the clinic before the specified date for refills or replacement products, as applicable.

1.8.2 Establish community-based locations for receipt of PrEP refills or replacement products, as applicable.

1.8.3 When supported by program and national policy and per available supply, allow multi-month dispensing so that clients can have access to additional product when necessary.

1.9 Once the SOP has been developed, convene all staff to review and discuss the SOP and ensure they understand their roles and responsibilities and have the appropriate coordination mechanisms in place to implement the SOP.

2.0 GBV Routine Inquiry

2.1 Mandatory reporting. Based on the legal review conducted as part of SOP preparation, program staff must communicate any limits to confidentiality, such as mandatory reporting requirements, to each client **before** inquiring about violence. Staff should tell the client what situations require them to report what is shared with them and to whom the report would be made.

2.1.1 If the client shares an experience that requires mandatory reporting, the provider should follow all local procedures for reporting and let the client know what will be done.

2.2 Routine GBV inquiry process.

2.2.1 Designated staff member(s) will conduct routine inquiry with all clients who are considering PrEP or currently using PrEP. This can occur only if the client is alone or accompanied by a child under the age of two.

- It is important that clients engaged in PrEP services be asked about violence each time they visit the clinic for PrEP-related services. A client may have experienced violence in an existing relationship since their last visit, or they may have experienced violence from a new partner or a non-partner. In addition, the client may be seeing a different staff person than the last clinic visit.

- Screening for and responding to GBV during telehealth (phone or video) PrEP visits may introduce risk. Safe communication (see section 7.3.1) should be used. In addition, it may be possible to enhance client safety if staff refer telehealth clients in non-confidential settings to online resources (e.g. www.bwisehealth.com) and external agencies and hotlines that can provide information and assistance regarding relationships, health, and safety.

2.2.2 When bringing up the issue of violence, the staff person should explain why questions about violence are being asked—i.e., concern for the well-being of the client, as well as impacts of violence on HIV-related outcomes and PrEP use. Staff should also share that these questions are asked of everyone and that many people experience problems at home. Explain the limits of confidentiality **before** asking the questions.

- To ensure that clients who have been asked about violence previously do not feel that their answers were disregarded, when violence is being addressed in follow-up visits, the provider should preface questions about violence by adding: "Partner relationships, and especially experiences of violence, can affect PrEP use and your overall well-being. It is also possible that PrEP use, the type of PrEP method you choose, or a change in your PrEP method could affect your relationship. There may have been changes in your relationships since last time you came to the clinic or you may have faced other violence, so we ask about any abuse in partner relationships and sexual violence each time you come to the clinic for PrEP, regardless of previous responses."

2.2.3 Use a standard set of questions to ask about violence, such as those below, adapted from PEPFAR guidance:[16]

- Has your partner ever (or since your last visit, for returning clients) made you feel afraid, bullied or insulted you, threatened to hurt you, or tried to control you (for example, not letting you go out of the house)?
- Has your partner ever hit, kicked, slapped, or otherwise physically hurt you?
- Has your partner, or someone else, ever forced you into sex or forced you to have any sexual contact you did not want?

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

2.2.5 Do not pressure someone to disclose violence even if you believe it is occurring. Instead, remind those who do not disclose violence that you and the clinic are there to provide support in the future if violence occurs.

2.2.6 No service should ever be denied to a client because they did or did not disclose violence.

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

2.2.7 Any client who reports sexual violence should be linked as soon as possible to critical clinical and counseling services in-clinic or via referral, including PEP (if within 72 hours), emergency contraception (if within 120 hours or 5 days) and first-line support.

- When indicated, PEP should be offered following the guidance found in Section 2.4 of *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence*.[11] Clients who choose to use PEP should be provided with a follow-up appointment to initiate PrEP. PEP use is considered a potential gateway for PrEP initiation.[17, 18]
- Ensure SOPs regarding PEP provision, referral, and follow-up are easily accessible to providers who are screening for GBV.
- If a client discloses sexual violence that includes a potential exposure to HIV outside of the 72-hour window, they should be offered HIV testing and linkages to care and treatment, as appropriate.

2.2.8 Regardless of whether a client discloses violence, they should still be offered PrEP, unless PEP would be more appropriate.

2.2.9 Additional counseling on the safe and effective use of PrEP should be provided. See Section 4 of this guidance document for more information. This is mandatory for clients who have disclosed violence but can be helpful for all clients.

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

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

LISTEN	Listen to the client closely, with empathy, and without judgment.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to the client's various needs and concerns—emotional, physical, social, and practical (e.g., childcare).
VALIDATE	Show the client that you understand and believe them. Assure the client that they are not to blame for the violence they have experienced.
ENHANCE SAFETY	Discuss a plan to protect the client from further harm if violence occurs again.
SUPPORT	Support the client by helping them connect to information, services, and social support.

See *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook,*[12] Part 2: First-Line Support for Sexual Assault and Intimate Partner Violence for detailed information about implementing first-line support using LIVES. If the client will be using

[17] Baggaley, R. et al. (2015) The Strategic Use of Antiretrovirals to Prevent HIV Infection: A Converging Agenda. Clin Infect Dis 2015 Jun 01;60 Suppl 3:S159-60. Available at: link.

[18] Hatcher AM, Eakle R, Peltz A. Partner violence as conversation opener for preexposure prophylaxis use among younger women. *AIDS* 2022; 36: 1195–1196.

PrEP or PEP, during safety planning (step "E"), include PrEP or PEP as an item to pack if the client must leave their home.

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

3.2.1 Accompaniment. When possible, designated staff should accompany clients for walk-ins or other in-person referral processes. Provide the referral organization a referral letter (see Appendix E), including a detailed reason for referral (only if the client gives permission for this information to be included in the referral letter). This is an important option to offer the client because it can help the referral organization know the client's general situation and needs without the client having to recount their experiences of violence.

3.2.2 Other active/warm referrals. In the absence of accompaniment, other active referrals must be offered. This can include offering to help the client make an appointment by calling the referral organization for them (ask the client in advance what information about their experience or needs should be shared), making a call with them, or offering a private place where the client can make a call. Offer the client a completed referral letter (see Appendix E) to take to the referral organization. In this situation, the reason for referral should be more general, such as "the client is being referred for additional counseling" or "the client is being referred for health services" to reduce the risk of harm if someone else finds the letter.

3.2.3 Offering printed copies of referral list. Program staff can offer printed copies of the referral list to clients, if safe and appropriate.

3.2.4 Note that sometimes having a referral letter or a referral list may put a client in danger if their partner, or another perpetrator of violence, finds it. Alternatively, you could offer to send it to the client by WhatsApp or email, if possible and deemed safe. Be sure to assess the client's comfort and safety to accept a referral letter, list, or mobile-based referral.

3.2.5 Referral follow-up. Program staff should note client preferences for follow-up (phone or in person); in particular, considering the means of follow-up that the client thinks is safest. Those clients who agree to be contacted should be contacted by the agreed-upon staff member(s) to determine whether the client received the services for which they were referred and what their experience was like at the referral organization. This will be documented according to program referral documentation procedures and forms. Clients who do not take up referrals or do not agree to be contacted about the issue again will be reassured that resources are available for them in the future should they change their minds. No service should ever be denied to a client because they did not compete a referral.

3.3 Spontaneous disclosures of violence. It is expected that some clients may disclose experiences or fears of violence, even non-partner violence, without being asked about violence, to program staff, including community workers.

3.3.1 All program staff involved in PrEP services (including health care workers, clinic support staff, and outreach workers who collaborate with the clinic) as well as staff who are involved in the support, referral, or follow-up of clients who report GBV (including social workers, support group leaders, and counselors) should be trained in first-line support.

3.3.2 If a staff person who has not been trained in first-line support receives a spontaneous disclosure outside of the clinic setting, they should be prepared to thank the client for sharing their experience, provide information on the services available to survivors, and offer to go with the client back to the clinic (or provide information to allow for connection via phone) to link them with someone who has been trained in first-line support.

3.3.3 When a spontaneous disclosure is made and the conversation can occur privately, the staff person should listen empathetically, inquire about the client's immediate needs and concerns, and validate the client's experience (L-I-V in LIVES).

- If a staff person who has expertise in counseling clients on GBV (such as a therapist or social worker) is available, the program staff who initially receives the spontaneous disclosure may listen, inquire, and validate, then offer to accompany the client to the more experienced staff person who can complete E (enhancing safety) and S (link to support) in LIVES. This may be appropriate when the person receiving the spontaneous disclosure does not have time to go through all the steps of LIVES. However, the final decision as to whether the client will receive steps E and S from an additional staff person with more expertise must be made by the client. To limit the need for clients to repeat themselves, the person who receives the spontaneous disclosure should offer to summarize what the client disclosed for the staff person with more expertise.
- If the staff person with more expertise is not available or if the client does not want to talk to that staff person, the program staff receiving the spontaneous disclosure should cover all steps of LIVES.

4.0 PrEP Counseling[19,20]

4.1 If multiple PrEP methods are available in your setting, determine if the client has already had an opportunity to learn about these methods and select one that is likely to be a good fit for their circumstance. If the client has not had this opportunity, begin by counseling on available PrEP methods and support them to make a tentative choice based on product attributes, such as mode of use, discretion, effectiveness, side effects, etc. The HIV Prevention User Journey Tool is a useful resource to support clients in learning about PrEP method attributes and making PrEP-

[19] These counseling messages are adapted from The CHARISMA Toolkit: An empowerment counseling intervention to improve women's adherence to oral PrEP; RTI International, FHI 360, Wits RHI; 2020. Available at: link.

[20] Method-specific considerations and youth-friendly visual tools outlining these counseling messages can be found in the HIV Prevention Ambassador Training Package for Adolescent Girls and Young Women, 3rd Edition (pg 135-137, 190-192). Available at: link.

related decisions.[21] Remember that a client may change their choice of method based on the counseling outlined below.

Note: Sections 4.2–4.6 are primarily focused on IPV given the current state of the research on the intersection of GBV and PrEP use.

4.2 Ask all clients, "Are you afraid that your partner would have a negative or violent reaction if they knew you were using PrEP?"

4.3 If a client discloses IPV or indicates that their partner could have a negative or violent reaction to their use of PrEP, discuss with the client how to use PrEP safely in the context of their relationship.

4.3.1 If the client discloses violence or fears violence from their partner, ensure that first-line support is provided (see Section 3 of this guidance document).

4.4 Even if a client has not disclosed violence or fear of a partner, this counseling can help the client think about how to use different types of PrEP in the context of their relationship. If feasible, it is recommended that this counseling be delivered to all clients, regardless of reported exposure to violence, in locations with a high prevalence of GBV or in situations — such as a catastrophic event like the COVID-19 pandemic — when IPV was found to increase in some settings.[22]

4.5 Counseling introduction script:

For clients who have disclosed violence or fear violence from their partner

- Explain to the client: "People in abusive and controlling relationships or who have faced sexual violence, or individuals at a greater risk of violence in general, are often more vulnerable to HIV. It may be difficult or impossible to negotiate condom use and to know your partner's status. This makes HIV prevention tools like PrEP even more important, but using PrEP can be a challenge in these circumstances. Clients experiencing abuse or control in their relationship may find it more difficult to use PrEP as directed and may need extra support. Let us brainstorm specific challenges you may face and together we can come up with ideas for overcoming these challenges."

For clients who have disclosed partner or non-partner sexual violence

- Explain to the client: "People experiencing sexual violence may feel distress, anxiety, or depression for some time after the event or may turn to things like alcohol or drug use to cope. Alcohol and drug use can affect one's ability to attend necessary health appointments and may impact decision-making around sexual health. Alcohol and drug use may also make it difficult to use PrEP as directed. It's important to take care of yourself and access the support that you need both for your general mental health and for your ability to use PrEP." Then review the referral resources for appropriate support for the client.

If discussion of whether to talk to one's partner about PrEP does not come up in the discussion of challenges, ask the following questions of clients who have disclosed violence or fear violence from their partner

[21] MOSAIC. The HIV Prevention User Journey Tool. 2023. Available at: link.

[22] McNeil A, Hicks L, Yalcinoz-Ucan B, Browne DT. Prevalence & Correlates of Intimate Partner Violence during COVID-19: A Rapid Review. J Fam Violence 2023. 38; 241-261.

- Tell the client: “PrEP can help people in abusive and controlling relationships prevent HIV because they can use it without telling their partner. It may be challenging, but many people successfully use PrEP without telling their partners.”
- Explain to the client: “However, if you would like to tell your partner, I can help you brainstorm ways to do so more safely, including having your partner speak to a staff person here.”

If discussion of whether to talk to one’s partner about PrEP does not come up in the discussion of challenges, ask the following questions of the client

- Tell the client: “It’s up to you to decide whether you want to talk with your partner about PrEP. Many PrEP users find it easier to use PrEP if their partner knows they are using it and is supportive. Other PrEP users want to use it without their partner knowing and can do that successfully. I would like to talk with you about whether you want to talk with your partner about PrEP and ways that you could use PrEP successfully. Is that OK?”

4.6 Counseling topic scripts:

For all clients regardless of violence exposure

- Discuss the client’s concerns about using their chosen PrEP method safely.
    - Ask: “What do you think your partner’s response would be if you told them about the type of PrEP you are thinking of using?”
    - Ask: “What do you think your partner’s response would be if they discovered you were using your chosen PrEP method without them knowing?”
    - Give the client an opportunity to reflect on available PrEP methods and consider whether a different method may address any concerns they have mentioned thus far.

- Discuss whether the client will tell their partner they are using PrEP
    - Tell the client: “It is up to you to decide whether to talk to your partner about PrEP. You are the expert in your own relationship.”
    - Ask: “How do you feel about talking to your partner about the PrEP method you have chosen? Do you want to talk to them about it?”
    - Affirm the client’s choice and then share the tips for telling a partner about PrEP use or strategies to use PrEP without their partner knowing listed below.

For clients who want to tell their partner about PrEP

Tips for telling a partner about PrEP use.

How to tell your partner

- Use clear and simple language
- Maintain eye contact, remain confident and calm
- Have prepared answers for anticipated questions
- Listen objectively to your partner’s concerns
- Avoid blaming others for why you decided to use PrEP
- Observe your partner’s body language

- Share informational materials about PrEP or offer to go with your partner to learn more about PrEP at a clinic or community outreach location

Where to tell a partner

- If you are afraid of a violent reaction, choose a location where you can exit safely if need be
- Be near to others so that you can get help if you need it
- Try not to have children present, and consider having a trusted person present

When to tell a partner

- When you will have enough time to say everything you need to say
- When you will have enough time for your partner to respond and ask questions
- When both of you are in a good mood and with a settled mind
- When neither of you is under the influence of drugs or alcohol

Additional tips from clients with experience telling their partners about PrEP:

- Talk about PrEP or your PrEP method generally to see what your partner says before telling them you are using it
- Give a little information at a time
- Only tell your partner what they need to know (e.g., that you will be taking a pill each day/wearing a ring every month/getting an injection every two months to protect your health
- If your partner is resistant at first, continue bringing it up over time until they become more supportive

For clients who do not want to tell their partner about PrEP

Discuss strategies to use different types of PrEP without one's partner knowing. These strategies may also be useful for clients whose partner found out they were using PrEP and were not supportive, but the client wants to continue using PrEP anyway.

- Store pills, rings, or other PrEP-related products in places where the partner will not look, such as a handbag, a keychain with storage, or with pads and tampons.
- Ask a neighbor or a nearby friend to keep the pills or rings, although this can make it challenging to remember to take pills, in particular, as prescribed.
- If multi-month dispensing of oral PrEP or the PrEP ring is available, the client could keep one month of pills or an extra ring in a safe place at their own home and the rest at a friend's house.
- Store extra PrEP supplies, such as additional pill bottles or PrEP rings, in an unmarked container (ensure that this container is stored away from direct sunlight, ideally in a cool and dry place, to avoid damaging the medication).
- If the client's partner monitors them closely, think of a reason to explain the regular clinic visits (e.g., explain that it is for another medical condition or coordinate PrEP visits with other necessary travel or clinic visits).
- Discuss explanations for side effects the client is experiencing or may experience from any of the PrEP methods.
- [For oral PrEP] When their partner leaves the house, the client can take their oral PrEP pill for that day out of the pill bottle or pill box and put it in a tissue in their pocket or handbag to take at the usual time. Taking it from the tissue can be more

discreet if the client's partner is home when it is time to take it. However, if the client still thinks this may put them at too much risk, they can take the pill while their partner is out of the house, even if that means taking it at a slightly different time each day.

- If the client thinks it will be difficult to use PrEP without their partner knowing or fears a violent reaction if their partner discovers their PrEP use, the client could tell their partner they are starting a new medication for another medical condition (e.g., period pains, contraception, headaches, etc.).

For clients who do not want to tell their partner about PrEP

Brainstorm what the client will do if their partner finds their PrEP and becomes angry. The strategies above may also be useful for helping clients who want to keep using PrEP.

- Brainstorm with the client what to do if they need an emergency re-supply because their partner throws their oral PrEP or PrEP ring away, controls their ability to return to the clinic for a re-supply or CAB PrEP injection, or the client must leave home suddenly without their oral PrEP or replacement ring.
- Brainstorming this ahead of time could reduce barriers to getting an emergency re-supply if the client needs it. Ideally, community re-supply would be an option (see preparation).

For all clients

End conversations on PrEP initiation or overcoming challenges to using PrEP by:

- Allowing the client time to reflect on available PrEP methods and confirm the method they have chosen or select a different method.
- Helping the client identify their main reason for wanting to take PrEP and reminding the client of their strength and power.
- Asking the client who else in their life can support their PrEP use. Brainstorm ways this person could help the client, such as providing reminders to take pills or switch to a new ring or providing support to get to the clinic for injection appointments.
- Asking the client what kind of support they need from the clinic to use PrEP safely and effectively.
- Letting the client know that you are available as a resource in the future if they struggle with GBV or with using PrEP as directed.
- Reminding the client that there may be a choice of PrEP methods, and that using an alternative PrEP method might reduce challenges in their relationship.
- If the client is not able to use any of the available PrEP methods as directed, discuss other possible HIV prevention options.

5.0 Staff Experiences of Burnout, Compassion Fatigue, and Vicarious Trauma

5.1 Working with violence survivors can increase the risk of staff experiencing burnout, compassion fatigue, and vicarious trauma. Burnout, compassion fatigue, and vicarious trauma are interrelated challenges that health care providers may experience in situations where they continuously encounter client trauma without sufficient prevention and support mechanisms in place. Staff who experience burnout may begin to feel constantly tired at work, while staff who are experiencing compassion fatigue may feel disconnected from or indifferent to their clients' stories. A health care provider who has vicarious trauma may notice that their inner experiences have transformed as a result of empathetic and/or repeated engagement with violence survivors.[23] Staff experiencing these challenges may notice their beliefs about the world start to change. For example, they may stop being able to believe that any relationship can be healthy. Burnout, compassion fatigue, and vicarious trauma are a particular concern for staff who have themselves witnessed or experienced violence. Clinics where staff may interact with people who have experienced violence may be able to prevent or reduce the impact of burnout, compassion fatigue, and vicarious trauma by providing additional support for staff[24,25] in the following ways:

5.1.1 Educational sessions: The team should take time to engage in sessions or share educational materials on recognizing the signs of and preventing burnout, compassion fatigue, and vicarious trauma.[26],[27] Education should also include tips on self-care and allow staff the opportunity to provide feedback on how programs or clinics can support them.[28]

5.1.2 Debrief sessions: The team should hold group debrief sessions to discuss client experiences, ensuring anonymity and using a survivor-centered approach, and assess general staff and clinic capacity to respond. Sessions should be monitored to identify learnings and potential improvements in response. If sessions are used to discuss challenging situations, they can also include time to discuss the well-being of staff members involved in the case.[29]

5.1.3 Supportive supervision: Those who supervise staff working with survivors should check in with staff about their well-being and their feelings about the work with survivors during regularly scheduled supervisory meetings. Supervisors should also ensure that staff are aware of the services available to them and ask whether the staff members would like support.

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[23] Adapted from Way I, VanDuesen KM, Martin G, Applegate B, Jandle D. Vicarious trauma: a comparison of clinicians who treat survivors of sexual abuse and sexual offenders. J Interpers Violence. 2004 Jan; 19(1):49-71. Available at: link

[24] Sexual Violence Research Institute. Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence. South Africa, 2016. Available at: link.

[25] Garcia M, Roberts ST, Mayo AJ, Scheckter R, Mansoor LE, Palanee-Phillips T, et al. Integrating Gender-Based Violence Screening and Support into the Research Clinic Setting: Experiences from an HIV Prevention Open-Label Extension Trial in Sub-Saharan Africa. AIBE. 2022. Available at: link

[26] EQUIP Health Care. Preventing, Recognizing, and Addressing Vicarious Trauma. Canada, The University of British Columbia; 2019. Available at: link.

[27] Pearlman L. Preventing Burnout. United States, Headington Institute. Available at: link.

[28] The Center for Victims of Torture. Professional Quality of Life Elements, Theory, and Measurement. United States, The Center for Victims of Torture. Available at: link.

[29] Sexual Violence Research Initiative. Guidelines for the prevention and management of vicarious trauma among researchers of sexual and intimate partner violence. South Africa, SVRI: 2015. Available at: link.

5.1.4 Referral for staff: Clinic or program leadership should work with staff members who have been affected about their needs, including referrals to relevant organizations for further support. Leadership should explore any additional support that can be offered to staff, such as one-on-one time with colleagues or individual debriefing sessions, as appropriate.

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

6.0 Documentation

When client privacy and safety is assured, it is recommended that documentation of PrEP and GBV first-line support provision include the client's product choice, related partner concerns, and decision on whether to disclose to their partner(s). At a minimum, programs/clinics should document the reporting of GBV and provision of care and referrals in the following places based on clinic reporting procedures:

- Referral log: Including initial referral and follow-up information.
- The GEND_GBV PEPFAR MER indicator should be used in clinics with GEND_GBV targets to document the number of clients who receive post-violence care as well as the type of violence that was reported (sexual or emotional/physical) and PEP provision and completion, as relevant.

7.0 Adapted Procedures Due to COVID-19

7.1 GBV during COVID-19: During COVID-19, the risk of GBV increased in some settings. At the same time, many violence response services were forced to change their operations, which impacted the services available and how they could be accessed.

7.2 Key messages for clients about GBV during COVID-19: Talk to clients about the increased risk of violence occurring during COVID-19, or other future pandemics/community crises, and remind them they may visit or call the clinic during operating hours — or the clinic's after-hours phone number — to be linked to violence response services.

7.3 Client follow-up: For clients already identified as experiencing violence, arrange for safe follow-up via phone to help them make a plan to stay safe at home in case of future lockdowns or while living in quarantine.[30] This should include tips on how to safely access support.

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

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

7.5 PrEP counseling: Counseling for anyone who discloses violence should include finding ways to discreetly and safely use PrEP during quarantine or lockdown.

[30] UNICEF. Create your safety plan in case of domestic violence. Panama City: UNICEF. Accessed January 2023. Available at: link.

7.6 Resources for staff: Provide additional phone/internet credit to program staff tasked with responding to violence, such as psychologists or clinicians, as they make their services available virtually.

Appendices

Appendix A: GBV Routine Inquiry Questions for Key Populations
Appendix B: Steps for Establishing and Maintaining a Referral Network
Appendix C: Standard Operating Procedure Template
Appendix D: Referral Network Template
Appendix E: Referral Letter Template

Appendix A: GBV Routine Inquiry Questions for Key Populations (to be adapted as needed for your local context)

These adapted GBV Routine Inquiry Questions include additional questions (1a–d) about forms of GBV that members of key populations may experience. However, they may require further adaptation to include other forms of gender-related discrimination, rejection, or violence from others due to actual or perceived gender identity or sexual orientation, which may impact PrEP use and/or require psychosocial support. If you further adapt these questions for your context, ensure that the questions:

- Provide specific examples of violent actions instead of simply asking, "Has a partner been violent?" as people understand "violent" to mean different things, and
- Are specific instead of general; for example, avoid asking questions such as "How is your relationship?", which may be interpreted in different ways.

1. Has your partner ever made you feel afraid, bullied or insulted you, threatened to hurt you, or tried to control you?

a. [For men who have sex with men, transgender or nonbinary clients, sex workers]: Has your partner ever called you names, used slurs against you, or threatened to "out" you?
b. [For men who have sex with men and transgender or nonbinary clients]: Has your partner ever criticized your sexual performance, criticized your clothing, or asked you to act more masculine or feminine?
c. [For transgender or nonbinary clients] Has your partner tried to control your transitioning process?
d. [For transgender or nonbinary clients] Has your partner ever told you that no one else would want to be with someone like you because of your gender identity or gender expression?
e. [For sex workers] Has your partner ever told you that no one else would want to be with someone like you because you are engaged in sex work?
f. [For men who have sex with men, transgender or nonbinary clients, sex workers]: Has your partner ever tried to control your access to money, tried to prevent you from working for money, or taken your money from you against your will?
g. [For men who have sex with men, transgender or nonbinary clients, sex workers]: Has your partner ever tried to control your movement, such as not allowing you to leave your house?

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

3. Has your partner, or someone else [for sex workers, include sex work clients], ever forced you into sex or forced you to have any sexual contact you did not want, including sex without a condom?

Note: *Members of key populations may disclose experiences of violence or harassment that are not related to their intimate partner relationships and do not directly impact their PrEP use. In these instances, appropriate referrals should be made and any relevant resources shared with the client.*

Appendix B: Steps for Establishing and Maintaining a Referral Network

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

Appendix C: Standard Operating Procedure Template

[Facility/Program/Clinic/Site Name]
Standard Operating Procedure

SOP No.: XXX-XXX-XXX, version 1.0
Title: Addressing partner relationships and gender-based violence in PrEP services
Original Effective Date: XX MMM YYYY **Revision Effective Date:** Not Applicable

Purpose

To define procedures for using routine inquiry to identify current or potential pre-exposure prophylaxis (PrEP) clients who have experienced gender-based violence (GBV) and for providing clients who disclose violence with adequate first-line support, referral, and follow-up, including referral for post-exposure prophylaxis (PEP) services when applicable. It provides staff with basic counseling tips for clients who are using PrEP or considering using PrEP in the context of emotional, psychological, physical and/or sexual abuse.

Scope

This procedure applies to all program staff involved in PrEP services (including health care workers, clinic support staff, and outreach workers who collaborate with the clinic) as well as staff who are involved in the support, referral, or follow-up of clients who report GBV (including social workers, support group leaders, and counselors).

Responsibilities

[Staff members who interact with PrEP clients, including those who provide support, referral, and follow-up services for clients who report GBV] are responsible for understanding and following this standard Operating Procedure (SOP).

[Staff members who provide PrEP services] must be trained to conduct GBV routine inquiry and provide first-line response.

[Staff members who directly interact with clients, such as counselors, clinicians, clinic support staff, and community workers] must be trained to provide first-line support to clients who spontaneously disclose violence.

[Clinic coordinator, in-charge, or other individual responsible for training] is responsible for ensuring that the above staff receive appropriate GBV inquiry and response training, as well as training on the procedures outlined within this SOP, and for day-to-day oversight and support of these staff.

[Referral liaison or other designated individual] is responsible for developing and maintaining a referral network and ensuring relevant staff are regularly informed about the referral network and any changes to it.

[Clinic coordinator, in-charge, or other designated individual] is responsible for monitoring and assessing the effectiveness and efficiency of routine inquiry; GBV identification; provision of first-line support, referral, and support activities; and for working with program staff to improve strategies, including through supportive supervision, as needed to provide the best possible violence-related support to clients, as outlined in this SOP.

[Clinic coordinator, in-charge, or other designated individual] is ultimately responsibility for ensuring that all applicable staff members follow this SOP.

Procedures

1.0 GBV routine inquiry

1.1. *[Staff members who provide PrEP services]* will conduct GBV routine inquiry at each clinic visit with all clients who are considering or currently using PrEP.

1.1.1. Prior to conducting GBV routine inquiry, staff will confirm that the client is alone or accompanied by a child under the age of two and that the conversation is taking place in a private location where the conversation cannot be overheard.

1.1.2. Before asking about violence, the staff member will:

- Communicate any limits to confidentiality, such as mandatory reporting requirements. *[Program to outline limits according to local policy]*
- Explain why questions about violence are being asked, including an explanation that these questions are asked of all clients. *[Program to outline standard statements for initial and follow-up visits]*

1.1.3. The staff member will then begin GBV routine inquiry using the standard set of questions below. *[Program to outline routine inquiry questions, including any additional questions tailored for key populations]*

1.1.4. Staff members will not pressure a client to disclose violence even if they believe it is occurring. Instead, they will remind those who do not disclose violence that the clinic and clinic staff are there to provide support in the future if violence occurs.

1.1.5. No service will ever be denied to a client because they did or did not disclose violence.

1.1.6. Regardless of whether a client discloses violence, the staff member will offer:

- PrEP, if the client has had no potential human immunodeficiency virus (HIV) exposure within the past 72 hours
- PEP, if the client has had a potential HIV exposure within the past 72 hours *[Program to outline PEP screening process and reference PEP provision and/or referral SOPs]*

1.1.7. If the client shares an experience that requires mandatory reporting, the staff member will follow all local procedures for reporting and let the client know what will be done.

2.0 Provision of first-line support to clients who disclose violence

2.1. All clients who disclose experiences or fears of violence, even non-partner violence, with or without being asked about violence, will receive or be referred for first-line support.

2.1.1. Disclosures of violence during the GBV routine inquiry process:

- The staff member conducting routine inquiry will immediately provide first-line support to the client. *[Describe first-line support that staff who conduct GBV routine inquiry will provide. At a minimum, this should include the supports outlined in the World Health Organization (WHO) LIVES approach, or equivalent.]*

2.1.2. Spontaneous disclosures inside of the clinic setting:

- If a disclosure is made in a setting where privacy is not possible, the staff member will move the conversation to a private location.
- Once the client and staff member are in the private setting, or if the disclosure was made in a private setting, the staff member should listen empathetically, inquire about the client's immediate needs and concerns, and validate the client's experience.
- If a staff member who has expertise in counseling clients on GBV (such as a therapist or social worker) is available, the original staff member will offer to accompany the client to the more experienced staff member who can provide safety planning and referral services. This may be appropriate when the person receiving the spontaneous disclosure does not have time to provide sufficient support to the client. However, the final decision as to whether the client will receive further support from an additional staff member with more expertise must be made by the client. To limit the need for clients to repeat themselves, the person who receives the spontaneous disclosure will offer to summarize what the client disclosed for the staff with more expertise, if the client accepts to speak to a second staff member.
- If the staff member with more expertise is not available or if the client does not want to talk to that staff member, the staff member receiving the spontaneous disclosure should cover all the steps of first-line support, including providing safety planning and referral services.

2.1.3. Spontaneous disclosures outside of the clinic setting to a staff member who is not trained in first-line support: The staff member will thank the client for sharing, provide information on the services available to survivors, and offer to accompany the client back to the clinic (or provide information to allow for connection via phone) to link them with someone who has been trained on first-line support.

2.2. Referral services will be offered to all clients who disclose violence or fears of violence based on available referral resources. *[Program to add reference to Referral Directory or similar document]*

2.2.1. When possible, *[program to designate referral staff]* will accompany clients for walk-ins or other in-person referral processes. The staff person will provide the referral organization a referral letter (see Attachment 4), including a detailed reason for the referral (only if the client gives permission for this information to be included in the referral letter).

2.2.2. If accompanied referral is not possible, other forms of active referral will be offered. Staff members may: offer to help the client make an appointment by calling the referral organization for them (ask the client in advance what information about their experience or needs should be shared), make a call with the client, or offer a private place where the client can make a call. The staff member will offer the client a completed referral letter (see Attachment 5) to take to the referral organization. In this situation, the reason for referral will be more general, such as "the client is being referred for additional counseling" or "the client is being referred for health services" to reduce the risk of harm if someone else finds the letter.

2.2.3. Staff members will offer printed copies of the program Referral Directory, if safe and appropriate for the client.

2.2.4. Staff members will note client preferences for follow-up (phone or in person), in particular, considering the means of follow-up that the client thinks is safest. Clients who agree to be contacted should be contacted by the agreed-upon staff member(s) to determine whether the client received the services for which they were referred and what their experience was like at the referral organization. This will be documented *[reference program referral documentation procedures and forms]*. Clients who do not take up referrals or do not agree to be contacted about the issue again will be reassured that resources are available for them in the future should they change their minds.

2.2.5. No service will ever be denied to a client because they did not complete a referral.

3.0 PrEP counseling

3.1. All PrEP clients will be allowed an opportunity to learn about the PrEP methods that are available to them prior to initiating conversations about safe PrEP use and PrEP disclosure. Staff members providing PrEP counseling will support clients to make a tentative choice about the method that might work best for them prior to initiating the below counseling process. *[Program to reference PrEP method counseling SOPs, tools, and procedures]*

3.2. The staff member providing PrEP counseling will utilize *[insert reference to program PrEP counseling scripts (Attachment 6) below and any additional tools available]* to walk all clients through important considerations around PrEP use, their partner relationships, and PrEP use disclosure or non-disclosure. If violence or concerns of violence are reported in this conversation, staff will provide first-line support and referrals as described in section 2 of this SOP.

3.3. Clients will be allowed to change their chosen PrEP method at any time throughout the counseling process.

4.0 Preventing vicarious trauma among staff

4.1. In order to prevent vicarious trauma among staff who support people experiencing violence, the following measures will be taken: *[program to adapt or add to the below list as feasible]*

4.1.1. Debrief sessions — The team will hold group debrief sessions *[program to add timing and frequency of sessions]* to anonymously discuss client experiences using a survivor-centered approach and assess general staff and clinic capacity to respond.

Sessions will be monitored by *[insert relevant staff]* to identify learnings and potential improvements in response. Sessions that include discussion of challenging situations will also include time to discuss the well-being of staff members involved in the case.

4.1.2. Supportive supervision — Those who supervise staff working with survivors will check in with staff about their well-being and their feelings about the work with survivors during regularly scheduled supervisory meetings. Supervisors will also ensure that staff know the services available to them and ask whether the staff members would like support.

4.1.3. Referral for staff — Program leadership *[or insert relevant staff]* will work with staff members who have been affected about their needs, including referrals to relevant organizations for further support.

4.1.4. Additional paid leave time — When possible, additional paid leave time will be provided for staff who are experiencing vicarious trauma.

5.0 Documentation

5.1. GBV reporting and provision of care and referrals will be documented as follows:

- Referral log: to document GBV incidence, care, and referrals, including initial referral and follow-up information *[program to adjust based on standard procedures]*
- *[If the program has GEND_GBV targets]* GEND_GBV PEPFAR MER indicator: to document the number of clients who receive post-violence care as well as the type of violence that was reported (sexual or emotional/physical) and PEP provision and completion as relevant

5.2. The staff member providing PrEP counseling will utilize *[insert reference to program PrEP counseling scripts (Appendix X) below and any additional tools available]* to walk all clients through important considerations around PrEP use, their partner relationships, and PrEP use disclosure or non-disclosure. If violence or concerns of violence are reported in this conversation, staff will provide first-line support and referrals as described in Section 2 of this SOP.

5.3. Clients will be allowed to change their chosen PrEP method at any time throughout the counseling process.

6.0 Adapted procedures during COVID-19 or other contingencies

6.1. Staff will seek to understand and communicate any changes to GBV risk within the local setting. If the program makes changes to their operations, staff will communicate this to clients.

6.2. Staff will make efforts to increase clinic accessibility by *[program to outline measures for increased accessibility, including telephone contacts, after-hours services, or other options]*.

6.3. Additional efforts will be made with clients who are experiencing violence within the home to develop safety plans in case of lockdowns or quarantines. Safe communication, including code words, will be established with clients as needed.

6.4. The program Referral Directory will be updated more often than normal to identify changes to services, hours of availability, or other operations. Clients known to be utilizing these services will be notified of changes at their next visit.

6.5. Counseling for anyone who discloses violence will include finding ways to discreetly and safely use PrEP during quarantine or lockdown, as needed.

6.6. Additional phone and/or internet credit will be provided to staff who respond to violence to support the availability of services virtually.

List of Abbreviations and Acronyms

GBV	Gender-based violence
HIV	Human immunodeficiency virus
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SOP	Standard operating procedure
WHO	World Health Organization

[Insert additional as applicable]

Attachments

Attachment 1: Summary of local laws related to provider obligations and mandatory reporting on GBV
Attachment 2: GBV Routine Inquiry Questions
Attachment 3: GBV Routine Inquiry Questions for Key Populations
Attachment 4: Referral Directory
Attachment 5: Referral letter template
Attachment 6: Counseling messages for safe PrEP use and PrEP disclosure or non-disclosure
Attachment 7: List of supports and services for staff who work with GBV survivors
[List any additional as needed, including forms required by police or local policies]

References

[List related SOPs as needed, including PrEP choice counseling SOPs and provision of clinical sexual assault response services (injury treatment, STI screening and treatment, emergency contraception, PEP provision, mental health screening and treatment, forensic exams, etc.)]

History

Version	Effective Date	Supersedes	Review Date	Change
1.0	*DD MMM YYYY*	NA	*DD MMM YYYY*	Initial Release

Approval

Author, Author's Title _____ Date _____

Reviewer, Reviewer's Title _____ Date _____

Appendix D: Referral Network Template

COMMUNITY SERVICE ORGANIZATIONS – **HEALTH SERVICES**

Includes post-exposure prophylaxis (PEP), forensic exams, family planning, emergency contraception, STI screening and treatment, OB/GYN, mental health screening and treatment, psychological support/counseling, substance abuse treatment

[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]

COMMUNITY SERVICE ORGANIZATIONS – **SOCIAL SERVICES**

Includes gender-based violence services, child protective services, psychosocial support including crisis counseling and support groups, women's groups, organizations working with marginalized or special needs populations, childcare, housing/shelters, transportation assistance, food assistance, employment training and financial aid

[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]

COMMUNITY SERVICE ORGANIZATIONS – **LEGAL SERVICES**

Includes legal aid (representation and provision of information), police/law enforcement and protection services, child protective services, local courts

[Organization/Facility Name] Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]	**[Organization/Facility Name]** Phone number: Fax: Email: Address: Hours: Services offered: Populations served: Send referral letters by: [phone/email/hard copy/fax]

Appendix E: Referral Letter Template

Date:_____ **Referral to:** _____

To whom it may concern,

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

Name:_____

Address:_____ **Telephone No.:**_____

_____

Reason for referral:

_____

_____

_____

_____

_____

_____

Referred by

Name:_____ **Signature:**_____

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