THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL MANAGEMENT GUIDELINES FOR THE HEALTH SECTOR RESPONSE TO AND PREVENTION OF GENDER-BASED VIOLENCE (GBV)

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FOREWORD

Gender-based violence (GBV) is a serious public health concern and a human rights violation with negative consequences that impact people's lives, particularly those of women, girls, and boys in many countries, and Tanzania is not an exception. GBV also hinders the fight against the spread of HIV and improvements in sexual reproductive and child health. This situation calls for a comprehensive health sector response. These national management guidelines are designed to support healthcare providers, in their efforts to prevent and respond to gender-based violence.

The development of the GBV Management Guidelines are guided by the Health Policy and key strategic documents in the health sector, namely, the Health Sector Strategic Plan III 9HSSP III 2009–2015), Primary Health Services Development Program (MMAM 2007–2017), the Human Resource, for Health Strategic Plan (2008–2013), the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child deaths in Tanzania "One Plan" (2008–2015), National Family Planning Costed Implementation Program (2010–2015), and the National Plan of Action for Orphans Vulnerable Children (OVC).

These guidelines provide standards for the provision of high-quality and comprehensive medical services and procedures to GBV survivors, and encourage providers to identify and quickly mobilize the required resources, materials and essential medication for GBV, at health facilities. The guidelines build on the existing National Health Policy and provide a framework to guide comprehensive management of GBV survivors, encompassing medical management, referral for psychosocial care and support, with linkages to social and legal protection systems. Hence, comprehensive management of GBV survivors demands coordination within the health sector and close collaboration with other sectors and key stakeholders, as well as a comprehensive system for monitoring and evaluation of GBV interventions.

The management guidelines are timely because this was the first time that gender-based violence was included in Tanzania Demographic and Health Survey (TDHS 2010). The findings of the TDHS revealed a high prevalence of GBV. Although various prevention and response efforts related to GBV have been initiated—for example, the formulation of the National Plan of Action for the Prevention and Eradication of Violence Against Women and Children 2001–2015, establishment of a gender and children desk at police stations and involvement of numerous non-governmental organizations in complementing government initiatives—in the health sector, the lack of national GBV guidelines has hampered the provision of high-quality and standardized GBV services. These guidelines will further complement efforts of the government, civil society organizations, and faith-based organizations to prevent and respond to GBV.

These management guidelines are a valuable tool, in the hands of health managers and healthcare providers. The ministry shall ensure that the guidelines are available in all health facilities and that their implementation will help to effectively address the needs of GBV survivors in Tanzania in a holistic and comprehensive manner. I personally call upon all healthcare providers to use these guidelines and join with other stakeholders to make Tanzania free from GBV.

Dr. Deo M. Mtasiwa
Chief Medical Officer
Ministry of Health and Social Welfare

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The National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) would not have been developed without the support and contribution of many stakeholders working on GBV. The Ministry of Health and Social Welfare (MOHSW) sincerely acknowledges the great effort, dedication, and hard work of many tireless representatives from numerous organizations in developing the guidelines.

Foremost, the MOHSW expresses deep gratitude to the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief for their generous financial support. The MOHSW greatly acknowledges the USAID | Health Policy Initiative, Task Order 5, implemented by Futures Group, for providing continuous guidance and invaluable technical assistance. The project also provided the Secretariat as well as considerable support to the GBV Technical Working Group (TWG), which played an important role in preparing the guidelines.

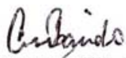
Similarly, the MOHSW extends its sincere appreciation to the United Nations Joint Program on Reduction of Maternal and Newborn Mortality—managed by United Nations Population Fund and comprising the World Health Organization, United Nations Children's Fund, International Labor Organization, World Food Program, and United Nations Educational, Scientific and Cultural Organization—for the continuous and valuable technical and financial support for development of these guidelines.

The MOHSW appreciates and commends the role played by its Reproductive and Child Health Section in providing leadership and effective coordination. The ministry also takes the opportunity to thank other ministries, departments, and agencies for their participation and contribution to development of the guidelines—in particular, the Ministry of Community Development, Gender, and Children; Ministry of Education and Vocational Training; Ministry of Justice and Constitutional Affairs; Ministry of Home Affairs; Ministry of Finance and Economic Affairs; Prime Minister's Office-Regional Administration and Local Government; Tanzania Commission for AIDS; Muhimbili National Hospital; Muhimbili University of Health And Allied Science; Bugando Medical Centre; and Kilimanjaro Christian Medical Center.

The MOHSW also thanks all the local and international NGOs that shared their experiences in GBV work and made useful contributions, including but not limited to the Medical Women Association of Tanzania; House of Peace; Women's Dignity Project; Women in Law and Development in Africa; Women's Legal Aid Center; Tanzania Media Women Association; Mwalimu Nyerere Gender Institute; and Pathfinder International.

Last but not least, great recognition goes to GBV TWG members, including representatives from the government ministries, CSOs, and development partners and healthcare providers who participated in preparing these guidelines. They truly created a multi-disciplinary team of experts who ensured completion of the guidelines.

Finally, a special tribute goes to the consultants who spent many hours contributing to the drafting of this document and to those who edited and finalized the document.



Dr. Donan W. Mmbando
Director for Preventive Services
Ministry of Health and Social Welfare

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BPA	Beijing Platform of Action
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CSO	civil society organizations
DNA	Deoxyribonucleic Acid
EC	emergency contraceptive
ECSA	East, Central, and Southern African (ECSA) Health Community
FBO	faith-based organization
FGC	female genital cutting
FGM	female genital mutilation
FP	family planning
GBV	gender-based violence
GFP	gender focal point
HIV	Human Immune Deficiency Virus
HTC	HIV testing and counseling
IASC	Inter-Agency Standing Committee
MCDGC	Ministry of Community Development Gender and Children
MCH	maternal and child health
MDA	ministry, department, agency
MDG	Millennium Development Goal
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini' Tanzania
MOEVT	Ministry of Education and Vocational Training
MOHA	Ministry of Home Affairs
MOHSW	Ministry of Health and Social Welfare
MOJCA	Ministry of Justice and Constitutional Affairs
MOU	Memorandum of Understanding
MTEF	Medium-Term Expenditure Framework
MVC	most vulnerable children
NGO	nongovernmental organization
NSA	non-state actor
PAF	Performance Assessment Framework
PEP	post-exposure prophylaxis
PF3	Police Form number 3
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RCHS	Reproductive and Child Health Section
RH	reproductive health
RTI	reproductive tract infection
SOP	standard operation procedure
SOSPA	Sexual Offences Special Provisions Act
STI	sexually transmitted infection
TARWOC	Tanzania Rural Women and Children Development Foundation
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	violence against children
VAW	violence against women
VEO	Village Executive Officer
VICOBA	village community bank
WEO	Ward Executive Officer

WILDAF	Women in Law and Development in Africa
WHO	World Health Organization
YWCA	Young Women Christian Association

GLOSSARY

Abuse: Misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inflicting or inciting fear of that harm. Abuse prevents persons from making free decisions and forces them to behave against *their will*.

Adolescent: The transitional stage of development between childhood and full adulthood, representing the period of time during which a person is biologically an adult but emotionally has not achieved full maturity. The time is identified with dramatic changes in the body associated with onset of puberty, along with developments in a person's psychology. In the onset of adolescence, children pursuing an academic career usually complete primary school and enter secondary schools.

Child: According to the Tanzanian constitution and the law of the child act, a child is a person who is less than 18 years of age.

Child abuse: An umbrella term that includes deliberate and intentional words or overt actions that cause harm, potential for harm, or threat of harm to a child. Child abuse can take three broad forms: physical, sexual, and psychological abuse.

Child sexual abuse: The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power—the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity, the exploitative use of child in prostitution or other unlawful sexual practices, and the exploitative use of children in pornographic performances and materials. Child abuse is an umbrella term that includes deliberate and intentional words or overt actions that cause harm, potential for harm, or threat of harm to a child.

Coercion: Forcing, or attempting to force, another person to engage in behavior against her/his will by using threats, verbal insistence, manipulation, deception, cultural expectations, or economic power.

Comprehensive: Covering and involving broadly all relevant aspects and key players at all levels.

Consent: Making an informed choice freely and voluntarily to do something. There is no consent when agreement is obtained through the use of threats, force, or other forms of coercion, abduction, fraud, deception, or misrepresentation. Threatening to withhold or promising to provide a benefit in order to obtain the agreement of a person constitutes an abuse of power. Any agreement obtained in such a way, or from a person who is below the legal (statutory) age of consent, or is defined as a child under applicable laws, is not considered to be consensual.

Domestic violence: A pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation. Domestic violence has many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, throwing objects) or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation, alcohol consumption, and mental illness can be co-morbid with abuse and present additional challenges when present alongside patterns of abuse.

Drop-in center: A place for information, safety, referral, first aid, and other immediate needs of GBV survivors who need a safe and confidential place for a limited period of time.

Fit institution: An approved residential or approved school, retention home, or a home for socially deprived children and street children. This includes a person or institution that has care and control of children.

Fit person: A person of full age who is of high moral character and of sound mind; who is not a relative of the child; and who is capable of looking after a child and has been approved by social welfare as being able to provide a caring home for a child.

Forced widow inheritance: A type of marriage in which a widow marries a kinsman of her late husband, often his brother. It can have various forms and functions in different cultures, serving in relative proportions as a social protection for, and control over, the widow and her children. The custom is sometimes justified on the basis that it ensures that the wealth does not leave the patrilineal family. It is also sometimes justified as a protection for the widow and her children.

Forced prostitution: Forced/coerced sex trade in exchange for material resources, services, and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children.

Gender: The term used to denote the social characteristics assigned to men and women. People are born female or male (sex); they learn how to be girls and boys and then become women and men (gender). Gender is constructed on the basis of different factors, such as age; religion; and national, ethnic, and social origin. Gender differs both within and between cultures and defines identities, status, roles, responsibilities, and power relations among the members of any culture or society. Gender is learned through socialization. It is not static or innate but evolves to respond to changes in the social, political, and cultural environment. Gender refers to what it means to be a boy or a girl, woman or man, in a particular society or culture. Society teaches expected attitudes, behaviors, roles, responsibilities, constraints, opportunities, and privileges of men and women in any context.

Gender-based violence: An umbrella term for any act, omission, or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females. In this context, GBV includes but is not limited to sexual violence, physical violence and harmful traditional practices, and economic and social violence. The term refers to violence that targets individuals or groups on the basis of their being female or male.

GBV Response: The reaction and support of stakeholders in initiating strategies and activities towards GBV survivors.

Harmful traditional practices:

- *Female genital mutilation (FGM)*—Comprises all procedures that involve partial or total removal of the external female genitalia, or other injury inflicted to the female genital organs for non-medical reasons.
- *Early marriage*—Marriage under the age of legal consent—most commonly for girls. Sexual intercourse in such relationships constitutes statutory rape under Tanzania laws, as the girls are not legally competent to agree to such unions. Early marriages are associated with negative health consequences to the mother and the child that include among others, complicated labor, disabilities, and maternal and neonatal deaths.
- *Forced marriage*—An arranged marriage usually against a woman's, a girl's, or a boy's wishes and exposure to violent and/or abusive consequences if she/he refuses to comply.
- *Widow cleansing*—A practice in which a widow has sex with a brother-in-law or other relative or a village cleanser. This is done before she is taken in marriage by the brother-in-law or other relative.

Human rights: Basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion, language, or other status.

Incidence of violence: An act or a series of harmful acts by a perpetrator or a group of perpetrators against a person or a group of individuals. It may involve multiple types of and repeated acts of violence over a period of time, with variable durations. It can take minutes, hours, days, or a lifetime. It may occur at home (domestic) or elsewhere.

Intimate partner violence: A pattern of abusive behavior by one or both partners in an intimate relationship such as marriage, dating, family, friends, or cohabitation. Intimate partner violence has many forms, including physical aggression (hitting, kicking, biting, shoving, restraining, slapping, throwing objects) or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

Multisectoral stakeholders: Organizations whose roles overlap with that of the MOHSW in GBV-related work, such as the community, relevant government ministries (Ministry of Community Development, Gender, and Children; Ministry of Justice and Constitutional Affairs; Ministry of Home Affairs, Prime Ministers' Office Regional Administration and Local Government), human rights organizations, civil society organizations, and faith-based organizations.

Perpetrator: A person, group, or institution that directly or indirectly inflicts, supports, and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision making, and/or authority and can thus exert control over their survivors.

Physical violence or physical assault: Beating, punching, kicking, biting, burning, maiming, or killing, with or without weapons—often in combination with other forms of gender-based violence.

Power: In the context of GBV, power is directly related to choice; the more power one has, the more choices available. Conversely, with less power, fewer choices are available, with potentially increased vulnerability to abuse. Gender-based violence involves the abuse of power when unequal power relationships are exploited or abused. For example, using any kind of pressure to obtain sexual favors from a weaker person in exchange for benefits or promises constitutes an abuse of power. Gender differentials contribute to men's overall socioeconomic standing. Men are, overall, in more powerful positions than women, and they often control money as well as access to goods, services, and favors. Men often have more physical strength and are bigger than women; more often use weapons; and control access or security. Power is also age-related, and, often, the young and elderly have the least power. Husbands/boyfriends are often older than their wives/girlfriends.

Rape: The invasion of any part of the body of the survivor by the perpetrator with a sexual organ or of the anal or genital opening of the survivor with any object or any other part of the body by force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (1998 Rome Statute of the International Criminal Court.

Marital rape: Marital rape is any unwanted sexual acts by a spouse committed without consent and/or against a person's will, obtained by force or threat of force, intimidation, or when a person is unable to consent. These sexual acts include intercourse, anal or oral sex, forced sexual behavior with other individuals, and other sexual activities that are considered by the victim as degrading, humiliating, painful, and unwanted.

Safe house: A place of temporary refuge, suitable for hiding or keeping safe GBV survivors, witnesses, or other persons perceived as being in danger; a place where a trusted adult, family, or a community or charity organization provides a safe haven for GBV survivors.

Sexual abuse: Actual or threatened physical intrusion of a sexual nature, including inappropriate touching by force or under unequal or coercive conditions.

Sexual coercion: Act of forcing or attempting to force another individual through violence, threats, verbal insistence, deception, cultural expectations, or economic circumstances to engage in sexual behaviors against her/his will. It includes a wide range of behaviors from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choosing.

Sexual exploitation: Any abuse for sexual purposes of another person in a vulnerable situation. This includes situations where there is unequal power differential; breach of relationships based on trust; or monetary, social, or political profiting from the sexual exploitation of another person. Sexual exploitation is one of the purposes of trafficking in persons. The definition of sexual exploitation also includes a coercive, manipulative, or otherwise exploitative pattern, practice, or scheme of conduct, which may include sexual contact that can be reasonably construed as being for the purposes of sexual arousal or gratification.

Sexual harassment: Any unwelcome, usually repeated, and unreciprocated sexual advance; unsolicited sexual attention; demand for sexual access or favors; sexual innuendo or other verbal or physical conduct of a sexual nature; and display of pornographic material when it interferes with work is made a condition of employment or creates an intimidating, hostile, or offensive work environment.

Sexual violence: Includes sexual exploitation and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that results, or is likely to result, in physical, psychological, and emotional harm.

Socioeconomic violence: Discrimination and/or denial of opportunities and services, including exclusion and denial of access to education, health assistance, or remunerated employment; and denial of property rights, including property grabbing and the associated psychological stress.

Survivor: Someone, a child or an adult male or female, who has been physically, sexually, and/or psychologically violated because of his/her gender.

Violence: Control and oppression that can include emotional, social, or economic force, coercion, or pressure, as well as physical harm. It can be overt, in the form of physical assault or threatening someone with a weapon; it can also be covert, in the form of intimidation, threats, persecution, deception, or other forms of psychological or social pressure. The person targeted by this kind of violence is compelled to behave as expected or to act against her will out of fear.

Violence against women: Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering for women, including threats of such acts, coercion, or arbitrary deprivations of liberty, whether occurring in public or in private life.

SECTION ONE: INTRODUCTION

Worldwide, gender-based violence (GBV) is a serious problem that limits the ability of men, women, and children to enjoy their basic human rights and fundamental freedoms. Despite its prevalence in most countries, GBV is often not addressed. GBV is rooted in gender inequality and gender norms, often serving to reinforce gender inequality at different levels. Women's subordinate social, economic, and legal status often makes it difficult for them to get help once violence occurs.[1]

1.1 Global and Regional Overview of Gender-Based Violence

(a) Magnitude of GBV

A 2005 WHO study[2] on women's health and domestic violence in 10 countries reported that ever-partnered women's lifetime prevalence of physical violence by an intimate partner was between 13 percent and 61 percent; the range of sexual violence by an intimate partner was between 6 percent and 59 percent; and for both sexual and physical violence between 15 percent and 71 percent.

In addition, many women said that their first sexual experience was not consensual (24% in rural Peru, 17% in rural Tanzania, 30% in rural Bangladesh, and 17% in rural Ethiopia). Between 4 percent and 12 percent of women reported physical violence during pregnancy. (In a representative sample of women and their partners in two districts in Uganda, 41 percent of women reported beating or physically being harmed by a partner and 41 percent of men reported beating their partner.)[3]

Worldwide, up to one in five women and one in 10 men report experiencing sexual abuse as children.[4] Moreover, trafficking of women and girls for forced labor and sex is widespread and often affects the most vulnerable. Forced and/or child marriages violate the human rights of women and girls, yet they are widely practiced in many countries in Asia, the Middle East, and sub-Saharan Africa.

There is paucity of information, data, and research on GBV in the East African Region. In Kenya, no nationally representative data on sexual violence existed until the 2003 Kenya Demographic and Health Survey.[5] In this survey, 29 percent women reported experiencing sexual violence in the year preceding the survey, and the highest proportion is among women ages 20–29 years old. Another survey of domestic violence in Kenya by the Federation of Kenya Women Lawyers [6] showed that 51 percent of women visiting four antenatal clinics in Nairobi reported having been victims of violence at some point in their lives—65 percent from their husbands and 22 percent from strangers.

During the post-election violence in Kenya (2008), 40 percent of the women who were raped contracted HIV. In one month, 337 women, 275 children, and 44 men were treated at the Gender Recovery Centre in Nairobi. A study to look into GBV related to post-election violence that was conducted in the Kibera slums—an area of Nairobi Kenya inhabited by about 1 million people and one of the largest slums in the world—found that the ages of rape survivors ranged from 25–68 years old—the majority in their 30s. GBV affected women of all ages. Interviews revealed that some of the survivors contracted HIV.[7] In 2008, Amnesty International reported that 40 women are raped every

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[1] Interagency Gender Working Group of USAID. 2008. *Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers.* Washington, DC: USAID | Health Policy Initiative, Task Order 1.
[2] World Health Organization (WHO). 2005. *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Summary Report of Initial Results on Prevalence, Health Outcomes and Women's Responses*. Geneva: WHO.
[3] UNICEF. 2000. "Domestic Violence Against Women and Girls." *Innocenti Digest* No 6.
[4] "*Violence Against Women."* Available at www.who.int/mediacentre/factsheets.
[5] Central Bureau of Statistics MOH & OM. 2004. *Kenya Demographic Health Survey* 2003. 2 ed. Calverton, Maryland: Central Bureau of Statistics MOH & OM.
[6] FIDA. 2002. *Domestic Violence in Kenya—Report of a Baseline Survey Among Women in Nairobi*. Nairobi: Apex Communications.
[7] Testimony by Millicent Obaso formerly with Care International, currently with Futures Group (Record of evidence-Commission of Inquiry into the Post Election Violence (CIPEV) chapter 6–15 July 2008 at Kenyatta International Conference Centre day 5 published: CIPEV Hansard Day 5.

day in Northern Kivu in the Democratic Republic of the Congo; the estimated figure by the United Nations (UN) in 2007 was around 350 women in a month.[8] In Tanzania, GBV is widespread and there are a number of challenges and gaps to be addressed.[9]

1.2 Consequences of GBV

GBV can cause serious health problems that undermine women's energy, compromise physical and mental health, erode self-esteem, and tears too deep to wipe. In addition to causing injuries, GBV increases the risk of other long-term health problems such as chronic pain, physical disabilities, drug and alcohol abuse, and depression. GBV also results in a range of health consequences, such as unintended pregnancy, miscarriage, and sexually transmitted infections (STIs) including HIV.[10] The WHO's 2005 multi-country study reported that in the majority of the survey settings, women who had ever experienced physical or sexual partner violence, or both, were significantly more likely to report poor or very poor health than women who had never experienced partner violence. They were also more likely to have had problems in walking and carrying out daily activities and experienced pain, memory loss, dizziness, and vaginal discharge in the four weeks prior to the interview. In the most extreme cases, GBV can lead to loss of life of female infants, girls, and women. Studies have demonstrated a link between GBV and HIV infection with violence as a risk factor for HIV as well as a consequence of being identified as having HIV. For example, according to the 2005 WHO study, HIV-positive women report higher rates of interpersonal violence, and GBV survivors face an increased risk of HIV through direct risk of infection and the creation of an environment where women are unable to adequately protect themselves from HIV. The WHO study also indicates that children subjected to sexual abuse are much more likely to encounter other forms of abuse later in life than are children who are not subjected to violence. In addition, a history of sexual abuse in childhood and adolescence has consistently been found to be significantly associated with increased health risks and health-risk behaviors in adult women and men survivors of abuse.

1.3 Overview of Gender-Based Violence in Tanzania

In Tanzania, many types of violence are practiced; and all have a negative impact on individuals and the society, especially women and children. Domestic violence or intimate partner violence perpetrated against women by their husbands or intimate partners is a significant problem in Tanzania; due to this, many girls and boys are also exposed to violence in their homes as well as being exposed to forms of violence against children in their families, schools, and communities.

The 2005 WHO study established that domestic violence in general and violence against women in particular are prevalent across Tanzania. The study involved 1,820 and 1,450 ever partnered women in Dar es Salaam and Mbeya, respectively. It indicated that 41 percent of respondents in Dar es Salaam and 55 percent of respondents in Mbeya experienced various forms of violence. In some areas, between 15 percent and 71 percent of the women reported physical or sexual violence by a husband or partner. According to the same study, 15 percent of women reported that their first sexual encounter was forced, while 4–12 percent of women reported being physically abused during pregnancy. More than 60 percent of Tanzanian GBV survivors have not taken any action to report the violence to any formal or law enforcement authorities.

GBV-related physical injuries predispose women to HIV transmission, and thus, bruising during sexual assault [11] and emotional control by spouses[12] contributes to the high HIV prevalence among

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[8] Amnesty International Report 2008. Human Rights in Democratic Republic of the Congo.
[9] National Bureau of Statistics. *Tanzania Demographic and Health Survey Report 2010*. Calverton, Maryland: ICF Macro.
[10] Campbell, R. et al. 2002. "Health Consequences of Intimate Partner Violence." *Lancet* 359(9314): A1331–1337.
[11] UNAIDS. 2004. Report on Global Tends in the HIV/AIDS Epidemic. New York: UNAIDS.

women of childbearing age. In Tanzania, a study shows that HIV-positive women were two and half times more likely to have experienced violence by their partners than their HIV-negative counterparts.[13]

Similarly, the Demographic and Health Survey (2010) in Tanzania[14] reported that the overall prevalence of domestic violence among women ages 15–49 was more than 45 percent. This includes physical violence (25%) and sexual violence (7%) and 14 percent for both. Nine percent (9%) of pregnant women reported physical abuse. The survey also showed that 60 percent of women had ever experienced controlling behavior exhibited by partner/husband. There is considerable regional variation in prevalence of physical violence—highest in Dodoma (71%) and the lowest in Tanga (16%). In the case of sexual violence, the highest prevalence was in Rukwa (32%) and lowest was in Shinyanga (5%). The perpetrators of sexual violence on ever-married women were current husbands/partners (48%), former husbands/partners (21%), and current/former boyfriends (7%). In the case of never-married women, 27 percent of perpetrators were by current or former boyfriends.

1.4 GBV among Children and Adolescent in Tanzania

The National Survey on Violence Against Children (VAC) in Tanzania[15] provides national estimates of the magnitude and nature of sexual, physical, and emotional violence experienced by girls and boys in Tanzania. The estimates show that violence against children is so serious that, at the age of 18, more than a quarter of girls (28%) and more than 10 percent of boys (13%) have experienced sexual violence.

Physical violence rates are higher than sexual violence rates. Just over half of Tanzanian boys and girls said that they had experienced some form of physical violence in the past 12 months. During their childhood, 73.5 percent of girls and 71.7 percent of boys experienced physical violence—mostly in the form of being punched, whipped, or kicked. Nearly 60 percent of Tanzanian girls and boys who reported physical abuse were abused by a relative (58.4% and 57.2 %, respectively).

One quarter of Tanzanian children, both boys and girls, said they had experienced emotional violence, with name calling being the most common form of emotional violence (21.6% for boys and 17.7% for girls). Almost 9 percent of girls said they felt unwanted, and 4 percent had been threatened with abandonment.

Correlations exist between sexual, emotional, and physical violence; 9 percent of girls who reported that they had experienced physical violence also experienced emotional violence, while 8 out of 10 boys experienced both types of violence.

The profile of violence against children (VAC) in Tanzania—disaggregated by whom, where, when, and how—reveals data that indicates that perpetrators of child abuse are mainly adults. Sexual abuse occurs mainly in homes. In Zanzibar, 45 percent of girls and 63 percent of boys who were physically abused suffered at the hands of a relative. Parents were clearly the main perpetrators of physical violence against their children. These patterns that show who is responsible for child abuse and where

[12] Dunkle, K. L., R. K Jewkes, H. C, Brown, G. E. Gray, J. A. McIntyre, S. D. Harlow. 2004. "Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa." *Lancet* 363(9149): 1415–1412.

[13] S. Maman, J. Mbwambo, N. Hogan, G. Kilonzo, et al. 2002. "HIV-Positive Women Report Increased Partner Violence in Tanzania." *American Journal of Public Health* 92(8): 1331–1337.

[14] National Bureau of Statistics (NBS), Tanzania, and ICF Macro. 2011. *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS and ICF Macro.

[15] United Nations Children's Fund, U.S. Centers for Disease Control and Prevention, and Muhimbili University of Health and Allied Sciences. 2011. *Violence Against Children in Tanzania: Findings from National Survey 2009*. Dar es Salaam: Government of Tanzania.

it occurs provide important evidence for targeting and organizing national prevention and response strategies and policies.

The high occurrence of child abuse in Tanzania is a major challenge for improving and strengthening legal, health, and social response services. Two major constrains in providing services are (1) overcoming the social pressures that inhibit children and their guardians from reporting sexual violence and (2) the unavailability of high-quality, child-friendly services.

1.5 Tanzania Policy Environment for GBV

Tanzania national policies are rooted in the international conventions and regional instruments that the country has signed and ratified: the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) signed and ratified by Tanzania in 1995; the Beijing Platform for Action in 1995; and the Millennium Development Goals in 2000. In addition, Tanzania is also a signatory to the Protocol to the African Charter on Human and People's Rights on the Rights of Women (Maputo Protocol, 2005) and the Southern African Development Community Protocol.

Tanzania has laid a strong foundation for preventing and responding to GBV, as evidenced by several policies and strategies that support gender equity. The policies include the National Development Vision 2025, National Health Policy (2007), National HIV/AIDS Policy (2001), National Gender and Women Development Policy (2000), and National Strategy for Growth and Poverty Reduction (MKUKUTA II, 2010). MKUKUTA II identifies among its goals sexual abuse and domestic violence: "improved personal and material security, reduced crime, and elimination of sexual abuse and domestic violence."

The key sectors addressing GBV prevention and response include the Ministry of Health and Social Welfare (MOHSW); Ministry of Community Development Gender and Children (MCDGC); Ministry of Home Affairs (MOHA); Ministry of Justice and Constitutional Affairs (MOJCA); Ministry of Education and Vocational Training (MOEVT); Prime Minister's Office Regional Authorities and Local Government; development partners; and civil society organizations (CSOs).

However, existing policies, particularly the National Health Policy, that guide health services do not adequately address GBV issues. At the national level, there are neither GBV policy guidelines nor GBV management guidelines to guide GBV efforts.

1.6 Tanzania's Legal Environment for GBV

(a) The Constitution of the United Republic of Tanzania

The Constitution of the United Republic of Tanzania, as amended in 1977 and subsequently amended in 2001, recognizes the universal rights of every human being. Article 13:6(e) stipulates that "no person shall be subjected to torture or inhuman or degrading punishment or treatment." Article 14 states that "every person has the right to live and to the protection of his life by the society in accordance with the law." Article 16(1) states that "every person is entitled to respect and protection of his person, the privacy of his own person, his family and of his matrimonial life and respect and protection of his residence and private communication."

(b) Law of Marriage Act Revised Edition 2002

The existing Law of Marriage Act Revised Edition, 2002, does not specify actions to be taken related to GBV. The minimum legal age of marriage allowed in the law is 18 years old for males and 15 years old for females; however, the law enables the court, at its discretion, to allow marriage where the parties are below ages 18 or 15, respectively, provided each party has reached age 14. The law in this regard allows early marriage for girls. Early marriage is associated with gender-based violence. Women who are married before age 20 are more likely to report experiences of physical or sexual

violence. An analysis of data from 10 country Demographic and Health Surveys (DHS) found that in six countries (Bangladesh, Bolivia, Dominican Republic, Kenya, Rwanda, and Zimbabwe), women who married before age 20 were more likely to report experiences of physical or sexual violence when they started living with their current husbands/partners. These findings and other research show that early marriage is associated with gender-based violence.[16]

(c) Sexual Offences Special Provisions Act of 1998 (SOSPA)

The Parliament of the United Republic of Tanzania enacted the "Sexual Offences Special Provision Act 1998," which is part of the Penal Code. Section 130 of the Penal Code was reviewed and expanded to include a broader definition of rape. Chapter 2 of the Penal Code classifies a variety of forms of GBV, including intimate partner violence, defilement, rape, sodomy, human trafficking, sexual assault, sexual harassment, socio-economic denial, psychological/emotional abuse, and physical violence. The legislation has improved protection of women and children against sexual violence and harmful traditional practices; however, its implementation is still hampered by social pressure to settle out of court. Perpetrators are likely to face stiff penalties of up to 30 years or life imprisonment. However, lack of public awareness and lack of GBV policies and guidelines has impacted Tanzania's ability to respond to GBV regardless of this law. The law has a noticeable gap in that when it was enacted, SOSPA was silent on domestic violence and did not recognize marital rape unless the husband and wife were separated. SOSPA further qualifies rape if a girl is below age 18; but if the survivor is married and experiences forced sex from her husband, this is not considered rape.

(d) The Law of the Child Act 2009

Tanzania ratified the UN Convention on the Rights of the Child in 1991. It was not domesticated into municipal laws until 2009, when Tanzania's Parliament passed a bill known as the Law of the Child Act 2009. This landmark legislation effectively domesticated the UN Convention of the Rights of the Child, providing the legal framework to protect and realize the rights of the country's children. It contains a broad range of protections that reflect the most serious challenges facing children in Tanzania today, including issues such as non-discrimination, the right to a name and nationality, the rights and duties of parents, the right to opinion, and the right to protection from torture and degrading treatment. The law lays out the system for ensuring justice for children when they come in contact with the legal system as offenders, witnesses, or survivors; and defines processes to ensure protection for children without families, including international adoption. However, this new law still has some shortcomings. For example, it does not address discrimination regarding the legal age of marriage, which remains age 15 for girls and age 18 for boys (and both boys and girls can marry at age 14 with the court's permission); and it does not abolish corporal punishment. In spite of the gaps, the new law can make an enormous difference for children in Tanzania.

1.7 Government and Multi Sectorial Initiatives to Respond to GBV

The national GBV response includes institutional reforms within ministries to ensure gender mainstreaming. The appointment of gender focal persons to coordinate the gender activities and to formulate programs and budgets related to GBV plays an important role in the fight against GBV. The Tanzania Police Force has instituted reforms to make it more responsive to community problems including GBV. Currently, GBV-related training and capacity building of police officers are ongoing. The creation of the Tanzania Police Female Network, which has established gender desks in several police stations, was a milestone in making the police force more accessible to GBV survivors, mostly women and children.

Despite the supportive policy environment in Tanzania, the provision of comprehensive GBV services has yet to be fully addressed, and many studies and reports have revealed the inadequate quality of

[16] Hindin, M.S. et al. 2008. "Intimate Partner Violence Among Couples in 10 DHS Countries: Predictors and Health Outcomes." *DHS Analytical Studies* No. 18. Calverton, MD: Macro International.

services and insufficient resources for supporting GBV survivors in the country. For example, an assessment the USAID | Health Policy Initiative conducted in Tanzania in 2008 reported that while there is a supportive policy environment, the number of facilities, the quality of services, and resources available to GBV survivors are minimal.[17] In addition, protocols for working with GBV survivors were lacking. In 2010, the USAID | Health Policy Initiative's assessment in Iringa showed that no policies, protocols, or guidelines were available to doctors and police to manage GBV survivors. While some nongovernmental organizations (NGOs) run legal aid services and safe houses, they have limited budgets. In July 2009, the MOHSW, in collaboration with the United Nations Joint Program on Reduction of Maternal and Newborn Mortality, conducted a study on the health sector's response to GBV. The study identified problems related to a shortage of staff, deficient or little training to provide GBV care, and lack of awareness among health service practitioners of GBV as both a human rights issue and a public health problem.

1.8 National Health and Social Welfare Services Infrastructure

National health and social welfare service delivery infrastructure under the MOHSW includes central, regional/city, and district/municipal council authorities. The infrastructure includes delivery of health promotion, disease prevention, curative, rehabilitation, and social welfare services in health facilities that include dispensaries, medical clinics, health centers, and hospitals. There is a national referral system of patients and survivors that starts from dispensaries to health centers and hospitals at district, regional, and national levels. The district and municipal council authorities are responsible and accountable for the provision of healthcare services to the population in their area, including services related to the prevention of and response to GBV.

(a) District/Municipal Council Authorities

The District Health Board[18] is accountable and responsible for the delivery of comprehensive healthcare services to the population in the district. The Council Health Management Team (CHMT) provides the technical structure for implementing decisions passed by the board.

(b) District Level

The CHMT's roles and functions are to prepare and implement the Comprehensive Council Health Plan; monitor and evaluate health services in hospitals, health centers, dispensaries, medical clinics, and communities in the district; and conduct operational research. The Hospital Governing Committee oversees the planning and proper management of the first referral district hospital.

(c) Ward Level

The Ward Health Committee oversees the planning, initialization, and coordination of community health plans; supervision and mobilization of resources; and collection and use of funds, including the Community Health Fund. Health centers deliver comprehensive health and social welfare services to the population within the ward. The Health Center Committee oversees the provision of adequate services to the people and mobilization of adequate resources for these services. The Health Center Management Team is responsible for the day-to-day management of the Health Center.

The Health Center Management Team is responsible for planning and managing community-based health initiatives within its catchment area in the context of the Ward Development Plan.

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[17] M. Betron. 2008. *Gender-based Violence in Tanzania: An Assessment of Policies, Services, and Promising Interventions*. Washington, DC: USAID | Health Policy Initiative, Task Order 1, Futures Group.

[18] The District Council Health Service Board Establishment [Instrument 2001] Under Local Government [District Authorities] Act, No. 7 of 1982, Section 86A, Dar es Salaam, Tanzania.

(d) Village Level

The Dispensary Committee ensures that the population in its area receives appropriate and affordable health services by overseeing the planning of and resource mobilization for implementation of the dispensary plan. The Dispensary Management Team is responsible for planning and managing community-based health initiatives within its catchment area in the context of the Ward Development Plan. The Village Social Services Committee mobilizes and sensitizes the people to participate and be involved in health promotion.

SECTION TWO: RATIONALE AND OBJECTIVES

2.1 Why Guidelines for Management of GBV

Development of the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) is in keeping with directives of the National Policy Guideline for the Health Sector Prevention of and Response to Gender-Based Violence (GBV). The policy directive is to provide for comprehensive management of GBV survivors at health facilities at all levels in the country for both children and adults. The comprehensive care of survivors within the health sector will include the provision of high-quality medical and psychosocial care and support services, with clear linkages to the community and police and legal systems. These services have to be provided under a complex health service infrastructure that includes a national referral system for survivor care—below which there are many health facilities under different management ownerships and different medical cadres with varying qualifications and competencies. The provision of high-quality and comprehensive services to survivors of any age by a health provider at any health facility demands clear prescription of minimal standards for the level of facility and range of medical services for adults and children. In addition, the provision of healthcare to GBV survivors is to be integrated into existing services at health facilities and in the community. This situation calls for the elaboration of clear guidelines for managers and providers in health facilities.

Healthcare facilities and providers may be the first or only point of contact outside the home for GBV survivors. Health providers are strategically placed to provide information and assistance before violence escalates, raise society's awareness to GBV as a public health problem, and counsel survivors and then family. Health providers who are uninformed or unprepared may inadvertently put survivors at further risk of misdiagnosis or may offer inappropriate care.

These national management guidelines will support healthcare providers in providing high-quality and comprehensive services to survivors and the community. They also serve as a guide for healthcare managers and providers to identify and quickly mobilize the required resources, materials, and drugs for GBV service delivery points. The guidelines will provide medical providers with protocols to manage GBV survivors and help to train medical staff on how to establish service delivery points and how best to manage GBV survivors.

2.2 Users of these Guidelines

These guidelines were prepared to guide managers and healthcare providers at health facilities in providing comprehensive, high-quality services for GBV survivors. Healthcare managers in the public and private sectors will use these guidelines to plan, integrate, coordinate, monitor, and evaluate the provision of GBV services in facilities and the community. Healthcare providers will be equipped to handle the medical aspects of GBV, including psychosocial care and support, collection of forensic evidence, and referral to the police or legal systems. Inspectors and supervisors involved in ensuring high-quality, comprehensive GBV services will have a standardized framework for monitoring, evaluating, and supporting the performance of managers and providers.

2.3 Objective of the GBV Management Guidelines

The guidelines primarily aim to ensure that those who experience GBV receive holistic, effective, and comprehensive medical care.

(a) Broad Objective

The broad objective is to provide a framework for comprehensive medical management and referral of GBV survivors for pertinent services at all levels for both adults and children.

(b) The Specific Objectives

1. Guide GBV medical service provision, including obtaining informed consent, managing injuries, providing psychosocial counseling and support, and referring patients for additional medical care, when necessary.
2. Ensure standardized medical management of GBV survivors including collection, storage and processing of forensic evidence (with the consent of the survivor), in collaboration with the key multisectoral partners.
3. Strengthen linkages between the health facilities and communities to increase timely and effective use of comprehensive GBV services.
4. Build the capacity of and train healthcare providers to deliver effective GBV-related prevention and response services.
5. Guide advocacy for increasing resources for GBV activities, improving coordination, and ensuring the sustainability of GBV services at all levels of services delivery points.
6. Guide the procedures for monitoring, evaluation, and quality assurance for comprehensive GBV-related services.
7. Provide procedures for managing confidentiality.
8. Provide procedures for collecting and storing forensic evidence.

SECTION THREE: LINKAGES OF HEALTH FACILITY WITH THE COMMUNITY REGARDING GBV SERVICES

Health facility management teams at all levels shall establish links with the community and other stakeholders like social welfare and law enforcement agencies (police and court) to provide effective GBV prevention and response efforts. Opportunities for linkages with the community can be through survivor's family members; community leaders; and community individuals and organizations such as Community Health Workers (CHWs), community-based distributors, Traditional Birth Attendants (TBAs), community-based organizations, and faith-based organizations. Health facility management teams shall work closely with community representatives through dispensary, health center, and hospital governing committees at all levels. These will include other committees focused on HIV/AIDS, social services and security. Hhealthcare providers at all levels shall inform the community and survivors on where to access services, including safe houses, drop-in centers, dispensaries, health centers, and hospitals; and shall implement outreach activities.

3.1 Health Providers Messages to Survivor and Community

The healthcare provider shall be responsible for sharing the following key messages with the survivor and community:

(a) Actions to Take When GBV Occurs

i. Individuals who are at risk or experience violence need to find a safe space immediately (with a neighbor, relative, local leader, or police).

ii. Individuals who experience violence shall immediately inform a trusted individual or contact the police. The police can be reached at the police hotline (112).

iii. As soon as possible, survivors of violence should report to a medical facility.

- In case of sexual violence, it is recommended that survivors do not clean themselves or bathe, as this will destroy any evidence that needs to be collected.
- If possible, survivors should not change clothing. If changing clothing is necessary, then survivor should place the soiled clothes in a paper bag or wrap them in a newspaper, **BUT NOT** in a plastic bag.
- If possible, survivors should wait to urinate or defecate until they reach the health facilities. Survivors should use clean containers to collect urine or stool samples if they cannot wait.

iv. Report immediately to a health facility for emergency medical care.

v. At the health facility, report to the reception/triage desk. Do not wait in line. Get a card and report to a healthcare provider immediately.

vi. Survivors that experience violence should report to any of the facilities that offer GBV services (health care facility, police, drop in centre, safe house, social welfare centre). If the survivor reports to a health care facility first; he/she should be treated without making a prior police statement and later report to a police station/post. If the survivor reports to the police first he/she should from there go to a health care facility

vii. If you happen to go to the police station first, ensure that you visit the hospital as soon as possible or within 72 hours of the offense.

viii. At the police station, report the incident, make a statement, and obtain a PF3 form. The PF3 form is FREE of charge.

ix. Before signing any statement at the police station, read it carefully to confirm its contents.

x. Survivors should relinquish any evidence (e.g., clothing) with the police that might be pertinent to pressing criminal charges against an assailant.

(b) Messages to Be Shared with the Survivor, Community, and Counselors

i. GBV is a human rights violation in which a person is physically, sexually, or psychologically harmed by another person who feels that he/she has more power and control over the other.

ii. Feelings of guilt and self-blame are common among survivors, however, GBV is never the fault of the survivor.

iii. Survivors of gender-based violence, especially children, may be intimidated and threatened so that they may fear reporting the incident. It is important for community, family, and healthcare providers to create safe spaces for survivors of violence and have mechanisms with which to remove survivors from violent living situations.

3.2 Support Structures for the Ccommunity for a GBV Response

The Dispensary Health Committee is responsible for assisting and facilitation of the Dispensary Health Management Team with planning and managing health-related initiatives within its catchment area in the context of the Ward Development Plan. The annual dispensary plans are part of the annual comprehensive ward and council health plans. Healthcare providers play a crucial role in empowering the community and identifying initiatives and opportunities for promoting community participation, involvement, and resource mobilization for GBV prevention and response efforts.

(a) The Role of the Council Health Management Team and Healthcare Providers

i. Provide adequate information and data on demand for annual planning, allocation of resources, and the implementation of GBV prevention and response.

ii. Ensure the provision of basic needs, psychosocial care and support and referrals to the police, legal representatives, and paralegals; testify in court when summoned; and help the survivor reintegrate into the community.

iii. Ensure the availability, accessibility, and adequacy of safe houses and drop-in centers within the community.

iv. Create awareness and empower the community to prevent and respond to GBV by advocating adherence to basic human rights principles, gender equity, rights of women and children, justice, and elimination of GBV.

(b) Empowering the Community Response

Health facility committees and healthcare providers shall ensure that the community is well informed on how to respond to an incident of GBV:

i. Reassure the survivor and try to calm her/him.

ii. If the survivor is a child, report to the relevant child protection authority such as the social welfare office, local leaders, or police in order to rescue the child.

iii. If injured, take the survivor to a health facility for emergency management.

iv. While waiting for transport to take the survivor to a health facility or police station, emotionally support the survivor by listening, consoling, assuring, and empathizing.

v. Inform him/her not to bathe and if she/he has to change clothes then they should be stored in a paper bag or newspaper but NOT in a plastic bag.

vi. Identify and do not interfere with the crime scene, as this might destroy crucial evidence. The crime scene may contain reliable evidence—such as small samples of hair, sperm, clothing, and blood—that can help identify the perpetrator through forensic tests (e.g., DNA testing that may help convict the perpetrator, especially in cases where there is a suspect but no other physical proof).

vii. Arrest the perpetrator and escort him/her to the police station/post if possible.

viii. Report the case to the police station. If the survivor is injured and admitted in a hospital, it is recommended that the police visit the survivor in the health facility to collect relevant information and to fill the PF3 form.

(c) Health Facility and Community Support to Survivor

The health facility team and community shall support the survivor from the point of incidence, during referral, through physical and emotional recovery, and to final integration into the family and community.

i. Provide the survivor with security. Community structures and leaders (e.g., Village/Ward Social Service Committee, Village/Ward Social Security Committee, drop-in centers and shelters, faith-based organizations, and police posts/stations can provide security to the survivor.

ii. Provide basic needs (e.g., food, shelter, clothes) during the period the survivor is in crisis.

iii. Provide psychosocial care and support to survivors and family member(s). A Social Welfare Officer will help the survivor in this regard, but if he/she is not available, the community leaders trained in counseling will provide psychosocial support.

iv. Accompany the survivor to the health facility for appropriate management and demand fast tracking and medical management immediately or within 72 hours in case he/she requires post-exposure prophylaxis and/or within 120 hours if she requires emergency contraception.

v. Refer him/her to the relevant appropriate authority such as police and other organizations that offer legal services and advice after the medical management has been completed.

vi. Provide evidence to the police and testify in a court of law where and when summoned.

3.3 Drop-in Center

A drop-in center serves to rehabilitate and empower GBV survivors by providing temporary shelter, psychosocial support, job skills training, and access to medical care and other essential services. A drop-in center provides a place to obtain information, ensure safety, receive referrals and first aid, and address other issues of immediate attention after GBV has occurred. The center provides the survivor with a safe and confidential place for a limited period of time. The following are key functions for a drop-in center:

i. Provide a temporary shelter for a short period while the survivor is undergoing a needs assessment.

ii. Provide immediate psychosocial care and support, such as trauma counseling, individual counseling, support groups, and basic needs.

iii. Follow up with survivors for a continuum of care and support, and when possible, link with socioeconomic empowerment programs.

iv. Refer survivors to other GBV-related services, such as those provided by the police and legal system, including preparation to give evidence in court.

v. Link with social workers and community development officers and other personnel for a continuum of care and follow-up.

vi. Safely reintegrate survivors back into the community.

vii. Provide safety and protection for GBV survivors.

viii. Provide rehabilitation services to GBV survivors.

3.4 Safe House

This service may be supported by the community, government, NGOs, and other key stakeholders. In the community, there are informal safe places where GBV survivors seek refuge. These include the survivors' homes, neighbors' homes, religious houses, and local leaders' homes. The challenges faced by these informal places include inadequate resources and capacity to provide GBV survivors with security and basic needs. In most cases, the hosts will negotiate with the survivor and convince him/her to return home to the perpetrator. A formal safe house or drop-in center provides a solution as a temporary shelter.

(a) Key Functions of a Safe House

i. The safe house is intended to protect the survivor and refer him/her to the appropriate authorities (e.g., local government leaders, police, or health facility).

ii. All survivors, including those with no physical injuries, will first visit a health facility where they will be assessed and provided with medical care before going to the police post/station and/or to a safe place. Survivors arriving at the safe house will be escorted to the health facility and to the police post/station if they have not been to the police station.

iii. The drop-in center or safe house should be able to provide security to the survivor and a safe place that is not accessible to the perpetrator.

iv. All child survivors should first be taken to a health facility for assessment and medical management and thereafter be referred to a fit person or fit institution (children's home) or be accommodated in a safe place where they will receive psychosocial care and support.

v. Child survivors need special child-friendly services from a fit person or in a fit institution accredited or registered by the government. In some cases, other relatives or well-wishers may want to accommodate them temporarily.

(b) Services to Be Provided at a Safe House

i. Shelter for a temporary period while the survivor is undergoing a needs assessment.

ii. Psychosocial care and support, such as trauma counseling, individual counseling, and support from individuals or groups.

iii. Follow-up of survivors previously discharged from the shelter, socioeconomic empowerment, and referral to other partners for other forms of support, for example, legal aid and preparation to give evidence in court.

iv. Referrals to and linkages with social welfare officers or community development officers when appropriate and other key actors for a continuum of care and follow-up.

v. If possible, linkage of the survivor to socioeconomic empowerment institutions and life skills support for survivors to reintegrate into the community.

vi. Safety planning, including helping the survivor safely reintegrate back into the community.

SECTION FOUR: STANDARDS FOR MEDICAL MANAGEMENT OF GBV SURVIVORS

Comprehensive management of GBV services at different levels of the healthcare system demands minimum standards for staffing, healthcare facility settings, materials, equipment, drugs, medical supplies, and administrative supplies. Healthcare providers need to adhere to minimum standards for service provision at different levels. The adoption of minimum standards takes into consideration the requirement of integrating GBV services into existing health services.

4.1 Integrating GBV Services into Existing Health Services

Setting up high-quality and comprehensive GBV services at different healthcare facilities requires an audit of existing health facility settings and services. The proposed minimum standards for medical management of GBV survivors at the health facility level will include the following:

(a) Location, Furniture, and Setting

GBV services should be integrated into all healthcare points of entry including; casualty or emergency departments, Prevention of Mother-to-Child Transmission (PMTCT), Reproductive and Child Health/Family Planning (RCH)/FP, HIV Testing and Counseling (HTC), Care and Treatment Clinics (CTC), Antenatal (ANC) and Out Patient (OP) department. At a minimum, survivors will be screened at their point of entry, given information on how GBV impacts their health, and provided with services and support according with the level of the facility.

i. GBV services should be provided in quiet, private, easily accessible rooms near toilets. In a small facility or where there is inadequate space, healthcare providers shall create a private space to ensure privacy and confidentiality.
ii. The examination room should have chair(s), a screen, an examination table, sufficient light, and infection protection equipment and supplies for collecting specimens.
iii. In a large facility, there should be at least two rooms for clinicians, nurses, social welfare officers, and counselors, depending on the level of the health facility and availability of space.
iv. Healthcare facilities shall provide separate child-friendly rooms with toys, drawing materials, colorful walls, and posters.

(b) Availability of Trained Human Resources

All health care facilities shall provide a minimum package of services for GBV survivors. The minimum package of services that all health care facilities should provide are: informed consent, immediate medical management (history taking, physical exam), treatment for all injuries that they facility has the capacity to treat, HIV PEP, STI screening and treatment, basic psycho-social assessment and counseling, referral of survivors to higher level facilities for additional medical care, and referral to other community services available for GBV survivors. All healthcare providers at all levels of the health facility will be trained on appropriate engagement with GBV survivors.

Additionally, selected healthcare providers from each facility should receive specialized training on engaging survivors, using medical protocols, collecting forensic evidence, and providing crisis counseling and psychosocial care and support. A training needs assessment will be conducted to cover all cadres of staff. The MOHSW will develop standardized GBV training packages for this purpose. The table below shows the anticipated training needs of healthcare providers in facilities at different levels.

(c) Health Cadres and Training Needs

Healthcare Providers by Cadre	Training Needs and Responsible Party
Clinicians (clinical officers, assistant medical officers, medical officers, and medical specialists)	i. MOHSW and other stakeholders will provide training for clinicians on comprehensive management of GBV survivors. ii. MOHSW and other stakeholders will conduct training-of-trainers (TOTs) of clinical staff on comprehensive management of GBV. iii. The training will focus on gender and GBV, history taking, physical examination, treatment and counseling skills, and documentation, including forensic evidence and referrals and linkages to other services. iv. Depending on its level, each health facility must have trained clinicians who are available at all times to observe, treat, and/or refer GBV survivors.
Social welfare officers	Social welfare officers will be trained on their role in GBV, interaction with the survivor and the community, and psychosocial care and support, including counseling.
Nurses	i. MOHSW and other stakeholders will provide training for nurses on comprehensive management of GBV survivors. ii. MOHSW and other stakeholders will conduct TOTs for other cadres on comprehensive management of GBV. iii. The training will focus on gender and GBV, history taking, nursing care, physical examination, and documentation, including forensic evidence and referrals and linkages to other services. iv. Depending on its level, each health facility shall have trained nurses who are available to provide immediate assistance by observing, treating, and referring GBV survivors.
Laboratory technicians and technologists	i. MOHSW and other stakeholders will provide training for laboratory personnel on forensic sample collection, storage, reporting of specimen, and transportation of sample, as well as on management of GBV survivors. ii. Each laboratory in a health facility shall have trained personnel on comprehensive management of GBV. Depending on its level, each health facility should have trained laboratory technicians and technologists to provide necessary laboratory services for caring for GBV survivors.
Hospital support staff	Hospital management teams shall orient and sensitize all hospital support staff on management of GBV survivors, including gender and GBV issues and respectful and appropriate behavior toward GBV survivors.
Pharmacy staff	Hospital management teams shall sensitize and orient pharmacy staff in drug management of GBV survivors, as necessary.
Community healthcare providers	Health center and dispensary management committees shall orient community healthcare providers, including community health workers and traditional birth attendants in managing GBV survivors, including referrals, when appropriate.
Medical records/ health management information system	Hospital management teams shall conduct training and orientation on GBV record keeping.
MCDGC, MOHA, MOJCA, MOEVT	MOHSW, in consultation with multisectoral partners, shall conduct a training needs assessment and identify areas of discussion in seminars and workshops. Examples of training areas are given below: i. MCDGC—Areas of collaboration with multisectoral partners and coordination of GBV prevention and response efforts. ii. MOHA—PF3 and taking of forensic evidence. iii. MOJCA—Laws that hinder the prevention of and response to GBV. Medical legal aspects of GBV. iv. MOEVT—GBV curricula in schools and prevention of VAC in schools.

(d) Medical Supplies

All health facilities must have the supplies necessary to provide the minimum standard of care for GBV survivors. The MOHSW will ensure availability of these supplies through routine procurement for health facilities.

i. A rape kit that includes post-exposure prophylaxis (PEP; emergency contraception (EC); items for collecting forensic evidence (syringe, speculum, empty sterile bottle, and high vaginal swab); sterile gloves; sterile swabs; and medication for symptomatic conditions. In the absence of a pre-prepared rape kit, a health facility should collect these items on a tray.
ii. Supplies and equipment for preventing and controling infection
iii. Resuscitation equipment.
iv. Sterile stitches and dressing trays.
v. Extra clothes for survivors whose clothes may be collected for evidence.
vi. Sanitary supplies.
vii. Pregnancy test kits.

(e) Medication

i. Treatment for STIs
ii. Post Exposure Prophylaxis (PEP)
iii. EC, such as combined oral contraceptives, " morning after pills", Progesterone Only Pills (POP)
iv. Tetanus Toxoid (TT)
v. Analgesics
vi. Anxiolytics (e.g., propranolol)
vii. Sedatives (e.g., phenergan)
viii. Local anesthesia for suturing (lignocaine)
ix. Antibiotics

(f) Administrative Supplies

i. Consent Form (Annex 1)
ii. Pictogram (Annex 2)
iii. GBV Medical Form (Annex 3)
iv. Police Form PF3 (Annex 4)
v. GBV Register (Annex 5)

4.2 Summary of Comprehensive GBV Medical Services Package

i. Reception of the survivor
ii. Initial counseling of the survivor
iii. History taking
iv. Physical and mental status examination
v. Laboratory examination for medical and forensic purposes
vi. Collection of forensic evidence
vii. Medical treatment of injuries, and when necessary, referral of serious injuries for emergency care
viii. Detailed documentation of medical case notes

ix. Social work assessment and case management
x. Psychosocial care and support including trauma counseling, pre- and post-test counseling for HIV, adherence counseling, and other forms of counseling
xi. Collection, labeling, and appropriate and secure storage of forensic evidence
xii. Provision of HIV and pregnancy testing
xiii. Provision of PEP within 72 hours (time-sensitive)
xiv. Provision of STI treatment
xv. Provision of EC for women and girls of reproductive age (time-sensitive)
xvi. Referral of survivors to network partners for other GBV services
xvii. Medico-legal consultation and preparation to give evidence

4.3 Minimum Standards of GBV Services by Level of Health Facility

At each level of care, healthcare providers must strive to give the best available care to GBV survivors**.** At lower-level facilities, healthcare providers must promptly provide the services available as needed, and if necessary, without delay, refer to a higher level for further management. They are also responsible for educating and linking survivors to other GBV services.

(a) Dispensary Level

Medical services

Clinical officer/nurse will

i. Receive and triage GBV survivors for appropriate care;
ii. Take history, using the checklist and GBV Medical Form provided in this document;
iii. Conduct physical and mental state examinations;
iv. Request or perform investigations as required depending on the nature of GBV (Annex 6);
v. Manage minor physical injuries like bruises and lacerations;
vi. Provide GBV survivors of sexual assault with time-sensitive treatment (e.g., PEP and EC), according to guidelines (sexual assault and other forms of GBV);
vii. Provide the survivor of sexual assault with STI treatment as necessary; and
viii. Fill out the GBV medical form (Annex 3).

Psychosocial services

Clinical officer/nurse will

i. Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on principles of Positive Interpersonal Relationship; and
ii. Provide survivors with assurance.

If trained, provide counseling to survivors based on their needs:

i. Post-traumatic counseling
ii. HIV pre- and post-test counseling
iii. Adherence counseling, as needed for PEP
iv. If the survivor is pregnant, a trained healthcare worker, peer educator, community development officer, social welfare officer, or community-owned resource person will identify the basic, local social services available for survivors and facilitate provision of these services

Referral and linkages

Clinical officer/nurse will

i. Refer survivors with complications to a higher facility level for provision of appropriate services; and
ii. Educate, orient, and provide information about other available GBV services.

Forensic services

Clinical officer/nurse will

i. Collect forensic evidence;
ii. Document findings from forensic evidence, history, physical examinations, and investigations;
iii. Complete the PF3 and refer survivor to the police; and
iv. Serve as an expert/factual witness in court, if summoned by a magistrate or judge.

(b) Heath Center Level

Medical services

Clinical officer/nurse will

i. Receive and triage survivors for appropriate care;
ii. Take history, using the checklist and GBV Medical Form provided in this document;
iii. Conduct physical and mental state examinations;
iv. Request or perform investigations as indicated depending on nature of GBV (Annex 6);
v. Attend to physical injuries—minor injuries (e.g., bruises, lacerations) and some major injuries;
vi. Provide GBV survivors with time-sensitive PEP and EC (sexual assault) and TT (sexual assault and other forms of GBV); and
vii. Provide STI treatment if indicated.

Laboratory assistant, if available, should

i. Perform the tests requested by clinical officer/nurse;
ii. Perform analyses of tests done and provide a report; and
iii. Fill out the investigation and medical forms.

Psychosocial support

Any trained healthcare provider, peer educator, community health worker, community-owned resource person, and social worker shall

i. Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on principles of Positive Interpersonal Relationship;
ii. Provide survivors with
    - Assurance,
    - Individual counseling based on their needs,
    - Post-traumatic counseling,
    - Pre- and post-test HIV counseling,
    - Adherence counseling;
iii. Link survivors with other GBV services; and
iv. Follow up with GBV survivors.

Referral and linkages

Clinical officer, nurse, community-owned resource person, community health worker, and peer educator will

i. Refer complicated cases to a higher facility level for provision of appropriate services; and
ii. Educate, orient, and provide information about other available GBV services.

Forensic services

Clinical officer/nurse and laboratory assistant shall

i. Collect specimens for forensic investigations;
ii. Document findings related to forensic evidence from history and physical examinations;
iii. Complete the PF3 and other forensic-related documents; and
iv. Serve as an expert/factual witness in court, if summoned by a magistrate or judge.

(c) District Hospital

Medical services

Nurse shall

i. Receive and triage survivors for appropriate care; and
ii. Provide initial counseling, ensuring confidentiality.

Medical officer/assistant medical officer shall

i. Take history, using a checklist and GBV Medical Form provided in this document;
ii. Conduct physical and mental state examinations;
iii. Request or perform investigations as indicated, depending on nature of GBV (Annex 6);
iv. Manage minor and major physical injuries, including some operative procedures;
v. Provide GBV survivors with time-sensitive PEP and EC (of sexual assault) and TT, according to guidelines (sexual assault and other forms of GBV);
vi. Provide STI, HIV, and anemia treatment if indicated; and
vii. Address anxiety or other psycho-trauma.

Laboratory technical/laboratory technologist, if available, will

i. Perform the tests requested by the medical doctor/nurse;
ii. Perform analyses of tests done and provide a report; and
iii. Fill out the investigation and medical forms.

Psychosocial care and support

Social welfare officer, medical officer, assistant medical officer, mental health nurse, and other healthcare workers, if trained, shall

i. Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on principles of Positive Interpersonal Relationship;
ii. Provide survivors with
    - Assurance,
    - Individual counseling based on their needs,
    - Post-traumatic counseling,
    - Pre- and post-test HIV counseling,
    - Adherence counseling;
iii. Link survivors with other GBV services; and
iv. Follow up with the GBV survivor.

Referral and linkages

Medical officer, assistant medical officer, mental health nurse, and other trained healthcare providers, such as a social welfare officer, shall

i. Refer complicated cases to a higher level facility for provision of appropriate services; and
ii. Educate, orient, and provide information about other available GBV services.

Forensic services

Medical officer, assistant medical officer, nurse, and laboratory technician or assistant, if applicable, shall

i. Collect specimens for forensic investigations;
ii. Document findings related to forensic evidence from history and physical examinations;
iii. Complete the PF3 and other forensic-related documents;
iv. Serve as an expert/factual witness in court, if summoned by a magistrate or judge; and
v. If certain types of healthcare providers do not have a legal mandate to serve as expert witnesses in court, a medical officer must be called during the initial encounter with the GBV survivor.

(d) Regional Hospital

Medical services

Nurse shall

i. Receive and triage a survivor for appropriate care; and
ii. Provide initial counseling and ensure confidentiality to the survivor.

Medical specialist/medical officer and assistant medical officer shall

i. Take history, using a checklist and GBV Medical Form provided in this document;
ii. Conduct physical and mental state examinations;
iii. Request or perform investigations as indicated, depending on nature of GBV (Annex 6);
iv. Manage minor and major physical injuries, including some operative procedures;
v. Provide GBV survivors with time-sensitive PEP and EC (of sexual assault) and TT, according to guidelines (sexual assault and other GBV);
vi. Provide STI, HIV, and anemia treatment if indicated; and
vii. Investigate mental state to address anxiety or other psycho-trauma.

Laboratory technician shall

i. Performed the tests requested by the medical specialist/medical officer and assistant medical officer; and
ii. Perform analyses of tests done and provide a report.

Rehabilitation expert shall

i. Provide occupational therapy, along with mental and physical rehabilitation to survivors if indicated.

Psychosocial support

Social welfare officer, medical specialist, medical officer, mental health nurse, and other healthcare providers, if trained, shall

i. Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on principles of Positive Interpersonal Relationship; and
ii. Provide survivors with
    - Assurance,
    - Individual counseling to survivors based on their needs,
    - Post-traumatic counseling,
    - HIV pre- and post-test counseling,
    - Adherence counseling,
    - Linkage with other GBV services, and
    - Follow-up care.

Forensic services

Medical specialist, medical officer, nurse, and laboratory technician, if applicable, will

i. Collect forensic-related evidence;
ii. Document findings related to forensic evidence from history and physical examinations;
iii. Complete the PF3 and other forensic-related documents;
iv. Serve as an expert/factual witness in court, if summoned by a magistrate or judge; and
v. If certain types of healthcare providers do not have a legal mandate to serve as expert witnesses in court, a medical officer must be called during the initial encounter with the GBV survivor.

(e) Consultant Hospital

Medical services

Nurse shall

i. Receive and triage survivors for appropriate care; and
ii. Provide initial counseling, ensuring confidentiality.

Medical specialist/medical officer shall

i. Take history, using a checklist and GBV Medical Form provided in this document;
ii. Conduct physical and mental state examinations;
iii. Request or perform investigations as indicated, depending on nature of GBV (Annex 6);
iv. Manage minor and major physical injuries, including complicated conditions and major operative procedures;
v. Provide GBV survivors with time-sensitive PEP and EC (of sexual assault) and TT, according to guidelines (sexual assault and other forms of GBV);
vi. Provide STI, HIV, and anemia treatment if indicated; and
vii. Address anxiety or other trauma as needed.

Laboratory technician, radiologist, pathologist, or microbiologist, if available, will

i. Perform the tests requested by the medical specialist/medical officer and assistant medical officer; and
ii. Perform analyses of tests done and provide a report.

Pharmacist will

i. Plan for and procure all medical equipment and medication necessary for survivors; and
ii. Assist survivors in obtaining prescribed medication(s) in a timely manner.

Rehabilitation officer, psychologist, psychiatrist will

i. Provide rehabilitative services to survivors, as needed.

Psychosocial support

Medical officer, mental health nurse, social worker, and other trained healthcare providers will

i. Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on principles of Positive Interpersonal Relationship; and

ii. Provide survivors with
    - Assurance,
    - Individual counseling based on their needs,
    - Post-traumatic counseling,
    - HIV pre- and post-test counseling,
    - Adherence counseling,
    - Linkage with other GBV services, and
    - Follow-up care.

Psychologist/psychiatrist will

i. Provide specialized psychotherapeutic interventions if indicated;
ii. Counsel survivors with complicated cases, such as post-traumatic stress disorder if indicated;
iii. Provide cognitive behavioral therapy if indicated; and
iv. Initiate relaxation therapy if indicated.

Forensic services

Medical specialist, medical officer, nurse, and laboratory technician, if applicable, will

i. Collect and document findings from the forensic-related investigations;
ii. Document findings related to forensic evidence from history and physical examinations;
iii. Complete the PF3 and other forensic-related documents; and
iv. Serve as an expert/factual witness in court, if summoned by a magistrate or judge.

NOTE: If certain types of healthcare providers do not have a legal mandate to serve as expert witnesses in court, a medical officer must be called during the initial encounter with the GBV survivor.

4.4. Table of Comprehensive GBV Services and Standards

Table 4.4.1 summarizes the provision of minimum standards of care for GBV survivors at different levels. Lower levels of service delivery, such as dispensaries, provide basic emergency treatment and make referrals to provide a complete package of services.

Table 4.4.1. Summary of Comprehensive GBV Services Being Provided at Health Facilities

Responses	Dispensary	Health Center	District Hospital	Regional Hospital	Consultant Hospital
Medical Services					
Receive and triage survivor for appropriate care	√	√	√	√	√
Providing initial counseling, ensuring confidentiality	√	√	√	√	√
Take history and undertake examination using a checklist	√	√	√	√	√
Request and perform baseline investigations	√	√	√	√	√
Manage minor injuries	√	√	√	√	√
Manage major injuries	x	x	√	√	√
Provide Post Exposure prophylaxis (PEP)	x	√	√	√	√
Provide Emergency Contraception (EC),	√	√	√	√	√
Provide Tetanus Toxoid Vaccination (TT vaccination)	√	√	√	√	√
Treat STI	√	√	√	√	√
Treat HIV	x	√	√	√	√
Treat HIV and anemia	√	√	√	√	√
Psychosocial Services					
Establish good interpersonal relationship with survivor	√	√	√	√	√
Address anxiety and other trauma as needed	x	x	√	√	√
Provide survivor with counseling	x	x	√	√	√
Link survivor with other GBV services	√	√	√	√	√
Follow up with the survivor	√	√	√	√	√
Forensic Services					
Collect and document findings from forensic-related investigations	x	x	√	√	√
Document findings related to forensic history and physical examinations	x	x	√	√	√
Complete PF3 forms and other forensic documents	x	x	√	√	√
Serve as a factual/expert witness in the court of law	x	x	√	√	√
Referrals and Linkages Services					
Refer complications to higher level facilities	√	√	√	√	x
Educate, orient, and provide information about other GBV services	√	√	√	√	√
Consult a qualified person with a legal mandate to serve as an expert witness in court during the initial encounter with a GBV survivor	√	√	x	x	x

Key: x =service is absent V = service is present

SECTION FIVE: GUIDING PRINCIPLES: HUMAN RIGHTS, ETHICS, AND COMPASSION

In medical management of GBV, the healthcare provider shall provide services in such a way as to show to the survivor that gender-based violence is unacceptable and that he/she as the survivor will receive compassion and support. The healthcare provider shall show concern about the well-being and safety of the survivor.

5.1 Guiding Principles

i. *Ensuring safety:* All actions taken on behalf of a survivor shall be aimed at restoring or maintaining safety.

ii. *Confidentiality:* At all times, confidentiality of the survivor and their families shall be respected. This means sharing only the necessary information, as requested and as agreed by the survivor with those actors involved in providing assistance.

iii. *Respect and dignity for the survivor:* Survivor's opinions, thoughts, and ideas shall be listened to and treated with respect.

iv. *Non-discrimination:* All survivors are equal and shall be treated the same and have equal access to services.

v. *Consent:* Consent shall be obtained for specific procedures and services. The survivor's decision to consent to either a, b, or c shall be respected:
   a. Physical examination and treatment only.
   b. Physical examination, treatment, and forensic investigation.
   c. Physical examination, treatment, forensic investigation, police investigation, and legal justice.

5.2 Procedures for Medical Care to a GBV Survivor

(a) Confidentiality and Consent

Before a full medical history and examination are done, it is necessary to obtain informed consent and a signed consent form (Annex 1). It is crucial that the survivor understands the options available. The information must be adequate to enable the survivor to make informed decisions about his/her care. Survivors have the right to medical care even if they do not consent to forensic evidence collection and police involvement.

i. Confidentiality

This is the right of an individual regardless of age, to have personal, identifiable medical information kept private. Such information should be available only to the healthcare providers managing the survivor. However, exceptions can be made to make medical information available to a third party other than the healthcare provider; for example, when a survivor causes bodily harm to himself or herself or to another survivor. Disclosure of medical information may be allowed in the following situations to

- Other treatment providers involved in the care of the survivor;
- Healthcare service payers (medical insurance agencies);
- The person in charge at the court of law /justice; and
- Other people requested by the survivor.

ii. Informed Consent

In informed consent, the healthcare provider makes correct and adequate medical information about the medical consultation available to the survivor. The healthcare provider ensures that the survivor has understood the available treatment options and the decisions he/she will have to make (e.g., compliance to treatment and choices of treatment options).

Due to the medico-legal aspect of GBV, it is important that the survivor signs the consent form after the provider has ensured that she/he has fully understood the information provided. The healthcare provider will explain to the survivor that when he/she consents to forensic evidence collection and police involvement that the information gathered during an examination may be presented in court. The healthcare provider shall inform the GBV survivor that she/he has the right to refuse consent to all or some aspects of medical consultation and treatment.

(b) Guidelines for Obtaining Consent

Healthcare providers shall

i. Provide information on the medical consequences related to GBV, including the risk of an STI, HIV, and pregnancy;

ii. Provide information on availability of Emergency Contraception (EC) and HIV testing.

iii. Explain to the survivor the health provider's role in treating him/her and the importance of documenting the medical examination for the survivor's records.

iv. Explain the procedures for gathering forensic evidence and that any evidence gathered may be used to provide evidence in court. Health care providers shall inform the survivor and his/her family on the rights that correspond to the type of GBV he/she has experienced;

v. Explain how the consequences of this incidence of GBV are going to be addressed; and

vi. Explain adequately the medical aspects (other consequences resulting from GBV will be explained by the police, social welfare officer, and legal system).

In the case of children, in addition,

i. Promote the child's best interest at all times;

ii. Comfort the child;

iii. Involve the child in decision making where applicable;

iv. Treat every child fairly and equally; and

v. Promote the child's resiliencies.

5.3 Rights of the Survivor

All actors shall use a survivor-centered approach, which means respecting the survivor's rights to be

i. Treated with respect and not encounter stigma, discrimination, and "blame the victim" attitudes;

ii. Given correct and understandable information to determine informed consent and not to be told what to do, which contributes to feelings of powerlessness;

iii. Given privacy and confidentiality and not be subject to gossiping and shaming;

iv. Protected from discrimination, including differential treatment based on gender, ethnicity, or other factors;

v. Given a cchoice in being attended by a male or female service provider; and

vi. Given a choice in being accompanied by a relative or caretaker.

5.4 Obligations of the Healthcare Provider

i. Show empathy and be sensitive, discreet, friendly, and compassionate when dealing with the survivor.

ii. Provide correct information to the survivor and handle evidence according to guidelines to safeguard the chain of evidence.

iii. Focus on the best interest of the survivor and respect her/his wishes in all instances.

iv. Ensure physical protection and safety of the survivor and prevent any further suffering.

v. Keep written information on the survivor safe and confidential at all times.

vi. Refer the survivor for further services as appropriate, depending on the nature and extent of physical, emotional, and psychological trauma.

vii. If trained, provide counseling to the survivor prior to referral for further medical care and other services that the survivor has given consent for.

Addition obligations when caring for children:

i. Ensure a child-friendly management and age-appropriate environment.

ii. Ensure that a parent/guardian is present at all times if the child so wishes (while also ensuring that the parent/guardian does not present a threat to the child).

iii. Always prepare the child on what to expect, including ensuring that the child understands what is going to happen.

iv. For young children below age 18, obtain the parent/guardian's consent on their behalf.

5.5 Criteria of Obtaining Informed Consent Regarding Children[19]

i. Children 16 years old and older are generally sufficiently mature to make decisions.

ii. Children between ages 14 and 16 are presumed to be mature enough to make a major contribution.

iii. Children between ages 9 and 14 can meaningfully participate in the decision-making procedure, but maturity must be assessed on an individual basis.

iv. Children younger than age 9 have the right to give their informed opinion and be heard. They may be able to participate in the decision-making procedure to a certain degree, but caution shall be advised to avoid burdening them by giving them a feeling of becoming decision makers.

v. Ultimately, however, the recommendation is that the views of the child shall be weighed and decisions taken on a case-by-case basis, depending on his/her age, level of maturity, and developmental stage and on cultural, traditional, and environmental factors.

[19] UNHCR. 2006. *Guidelines on Formal Determination of the Best Interests of the Child*. Geneva: UNHCR.

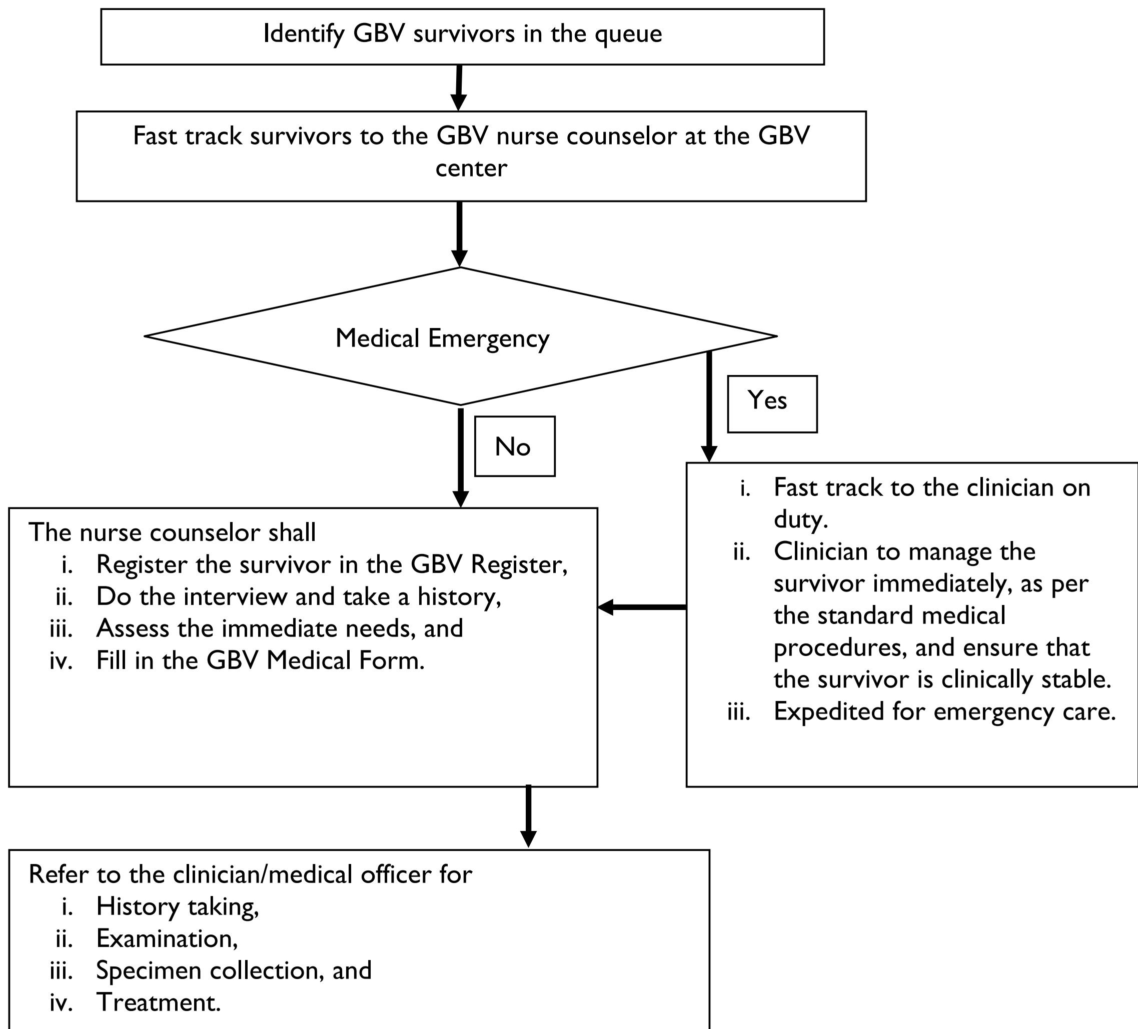
SECTION SIX: MEDICAL MANAGEMENT OF GBV (OVER 18 YEARS OLD)

6.1 Introduction

Medical management of GBV survivors involves treating potentially life threatening injuries and infections that occur as a result of the violence. The management of medical emergencies should be a priority, but at the same time, the time-dependent preventive treatments should be provided. This chapter highlights the procedures and guidelines for medical management of GBV for males and females over age 18.

6.2 Receiving the Survivor

Flow Chart of Receiving



6.3 History Taking

Healthcare providers shall take a thorough and systematic history to obtain background information related to the survivor's medical history as well as information about any medical symptoms that have arisen or resulted from the violence. This information wili assist in the medical management and the forensic sampling of the survivor. In addition the nature of the violence and consequences, such as loss of consioussness, is described. The past medical, surgical, and gynaecological history is also detailed. The medical history should cover any known health problems including allergies, immunization status, and medications. The details are entered into to the GBV Medical Form simultaneously to ensure that no details are left out.

History taking, examination, and documentation provide the crucial links among the occurrence, the survivor, and the healthcare and criminal justice systems. Paperwork brought in by the survivor shall be reviewed before taking the history.

(a) Procedures for History Taking

i. Introduce oneself to the survivor.

ii. Ask if the survivor wants to have a specific support person present.

iii. Limit the number of people allowed in the room during the examination; if others are present, explain their role and ask permission from the survivor.

iv. Explain that the survivor is in control of the pace, timing, and components of the examination.

v. Reassure the survivor that the examination findings will be kept confidential; ask her/him if she/he has any questions.

vi. Explain what is going to happen during each step of the examination and the importance of the examination.

vii. Provide relevant information on the GBV incident and the need for medico-legal documentation.

viii. Have the survivor sign the consent form (Annex 1).

ix. After the survivor has signed the consent form, undertake the examination as soon as possible.

(b) The Main Elements of History Taking

i. General information

- Name, address, residence, telephone number, sex, date of birth (or age in years)
- Date and time of the examination and the name(s) of any staff or support persons present

The survivor may or may not request for a relative to be present during history taking and examination. Either way the wishes of the survivor should be respected. Any staff member to be present must be with the consent of the survivor.

ii. Description of the incident

- Describe what happened and note the date, time, and place.
- Obtain information about the perpetrator.

It is important that the healthcare provider understands the details of exactly what happened in order to check for possible injuries. For example, when did the assault take place? Was there penetration (oral, vaginal, or anal? Did the assailant use physical or psychological force? Did the assailant use a physical object? How many assailants were there? Was it a single assault or was it repeated over hours or days? Did the survivor lose consciousness, and was the assailant known to the survivor? What did the survivor do after the incidence? Ask whether the

survivor has bathed, urinated, vomited, etc., since the incident. This may affect the collection of forensic evidence.

(c) Gynecologic History

i. Obtain the first date of the last menstrual period.

ii. Obtain history on prior sexual encounters, as well as whether they were consensual. Find out if the survivor has a sexual partner(s). Determine the last time the survivor had sexual intercourse prior to the incident.

iii. Determine if the survivor has had STIs before and if she was treated.

iv. Determine if the survivor has ever tested for HIV before and his/her HIV status.

v. Determine if the survivor has been pregnant before. If so, when and what was the outcome.

vi. Determine if the survivor uses contraception. If so, the type, since when, and the compliance, when relevant.

(d) Mental Health Status

Assessing and treating the mental health issues of survivors is done to support them in coping with trauma associated with GBV and preventing any negative health consequences. The assessment and treatment processes should in no way re-victimize, stigmatize, or blame the survivor.

i. Assess the current emotional state of the survivor.

ii. Obtain a mental health history. Salient points include previous and current psychiatric diagnoses, prior hospitalization, previous and current medication, drug use, and family history of mental illness.

iii. Survivors that display any of the symptoms listed below in the mental health checklist shall be referred to a psychiatrist, psychologist, or medical doctor experienced in managing clients in need of mental health services.

Mental health checklist

Assessment of the following psychological symptoms:

i. *Depression:* The person is often sad, irritable, or angry; has feelings of hopelessness; stops pleasurable activities; looses or gains weight loss; looses sleeping or oversleeps; does not feel like eating; experiences fatigue, energy loss, poor concentration, and low self-esteem; makes statements such as “nobody likes me or I’m stupid”; is very self-critical; and becomes socially withdrawn.

ii. *Anxiety:* The person feels restless, has trouble sleeping, looses sleep, is nervous, has specific fears like fear of dying, experiences heart racing or trouble breathing, is irritable, will not leave caregiver’s side, has nausea, or will not go to school or leave home.

iii. *Mood problem:* The survivor has great difficulty regulating his/her mood and emotional states, is unable to soothe him/herself (most of the time), has drastic mood swings, engages in high-risk behaviors, exhibits alternating mood extremes (“highs” and “lows”) frequently, or may often be physically aggressive.

iv. *Suicidal ideation/behavior:* The survivor expresses hopelessness/wish to be dead or attempts to harm himself/herself. If the survivor has these symptoms, gather a detailed history of suicidal behavior (how many times was suicide attempted? Methods of attempts? Current plan for suicide?), and make an immediate referral to a psychiatrist.

v. *Substance abuse:* The person has erratic behaviors, has a sudden change in school performance, engages in risk-taking and dangerous behaviors, or appears intoxicated.

vi. *Psychosis:* The survivor experiences thought disorganization, hears "voices" in head other than his/her own voice, sees things (people, objects) that are not really there, has very poor hygiene, exhibits disorganized behavior, delusions and speech disorders

(e) Past medical and surgical history:

Ask about possible medical conditions, allergies, use of alcohol/drugs, vaccination, HIV status, and previous surgery. These questions should help you to determine the best treatment and provide counseling and follow-up healthcare.

6.4 Physical Examination

(a) General Considerations for Physical Examination

i. The clinician should examine the survivor systematically.

ii. This should be done, from head to toe, paying special attention to the face, upper limbs, neck, breasts, thighs, and perineum when sexual violence is involved.

iii. Specimens should be collected as the physical examination is being conducted.

iv. The clothes should be collected for forensic examination and put in a paper sheet/ bag when sexual and physical violence has occurred. If the survivor is going to be undressed, she can do this over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs that would support her information about the assault or violence.

v. All findings should be recorded in a GBV Medical Form. if this form is not available, this should be recorded on any extra sheet of paper provided that the GBV form format is followed.

vi. The examination is best done under natural light. However, there are special lamps that can be used to see injuries better, such as a woods lamp or UV light.

vii. At the same time, obtain smears from the skin, oral mucosal, external and internal vagina, and rectum and collect urine and blood samples systematically.

viii. Provide emergency contraception for those survivors of reproductive age and treatment for physical injuries.

ix. Legally, if specimens are collected (urine, semen, and other evidence in general), they should be sealed appropriately and signed and delivered to the lab by certified personnel (police) to preserve the chain of evidence.

x. The survivor should be told what to expect at every step of the physical examination and what will happen next.

xi. The survivor should be informed that at any point during the physical examination, he/she can ask the provider to stop.

(b) Head to Toe Examination

i. Note the general appearance of the survivor.

ii. Take vital signs.

iii. Examine the upper limbs for any signs of injuries.

iv. Inspect the face, eyes, and ears.

v. Examine the scalp for any injuries and signs of inflammation.

vi. Examine the neck for bruises and life-threatening assaults.

vii. Examine the breasts and trunk for bites and other injuries.

viii. Do abdominal and chest examinations for any internal injuries/pregnancy.

ix. Examine the lower limbs thoroughly.

x. Collect any forensic specimens as you examine the survivor as described above.

(c) Genital and Anal Examination

i. Explain the procedure to the survivor, providing details of each step.

ii. Examine the external genitalia.

iii. Examine the labia and other related structures.

iv. Take all the swabs, in the following order: external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swab. The other swabs are oral swabs for secretor factors in cases where oral sex is implicated and skin swabs when a suspicious seminal stain is present on the skin.

v. Do speculum and digital examinations (under no circumstance should this be done prior to taking the swabs). Speculum examination on girls who have not reached puberty causes pain and may cause injury, so it should only be done when necessary (e.g., when the child may have had internal bleeding from a penetrating vaginal injury); in this case, one may use the ear speculum. Speculum examination in girls is done under a general anesthesia or sedation.

vi. Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.

vii. Document any wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration).

viii. Control for bleeding, if any.

(d) Documentation

i. The clinician shall complete the medical section of the PF3 (Annex 4) and/or fill in the GBV Medical Form (Annex 3) in triplicate.

ii. The healthcare provider is responsible for safe custody of the documentation (PF3, GBV documentation forms, medical records, and forensic specimens).

6.5 Laboratory Investigations

(a) General Consideration

Laboratory tests are performed at the (1) health institution and (2) government chemist. The investigations are done to address medical problems as a result of violence and to collect evidence that may help prove or disprove contact between individuals and/or between the offender and survivor, respectively. The forensic evidence may be used for medical and legal purposes to support the survivor's account, confirm recent sexual contact, show the force or coercion used, and help identify the perpetrator. The evidence should be collected as soon as possible after the incident to ensure that the time-sensitive aspects are addressed. Collecting forensic evidence during the examination helps minimize the number of examinations the survivor must undergo.

(b) Laboratory Tests

i. The common laboratory test for GBV survivor may include HIV Testing and Counseling (HTC), pregnancy tests, urinalysis and screening for STIs but additional tests can be done according to the clinician's opinion and recommended procedures for level of health facility.

ii. GBV survivors may contract an STI as a direct result of the assault. Infections most frequently contracted by survivors, and for which there are effective treatment options, are as follows:
   - HIV
   - Chlamydia
   - Gonorrhoea

- Syphilis
- Trichomoniasis
- Human papilloma virus
- Herpes simplex virus type 2
- Hepatitis B and C

Performing the tests for Hepatitis B and C will depend on the availability of laboratory facilities.

6.6 Diagnosis

Based on the above, the healthcare provider shall make the following diagnoses:

(a) Medical diagnosis
(b) Surgical diagnosis
(c) Gynecological diagnosis
(d) Psychological diagnosis

6.7 Treatment of GBV Survivors

(a) General Consideration

i. All GBV survivors should be treated as an emergency and should not be allowed to queue in the line.

ii. Any trained GBV medical officer, clinical officer, or nurse may manage a GBV survivor and fill in the GBV documentation forms.

iii. Healthcare providers should ensure proper documentation and safe keeping of medical records for purposes of security and for future use.

iv. Healthcare providers delivering GBV services may be called to give evidence in court. They should, as much as possible, follow the stated procedures, including on taking the history of the survivor, which may be needed in court.

v. All health institutions providing GBV services shall have a network directory of GBV healthcare providers within their locality for purposes of referral.

(b) Medical Management of GBV Injuries

The classification of and procedures for managing GBV and genital injuries are shown in Annex 12.

6.8 Preventive Treatments

(a) Guidelines on PEP for Adult Survivors

The procedures for provision of PEP should be based on the national guidelines for HIV and AIDS management. See the summary in Annex 10.

i. PEP should be initiated within 72 hours.

ii. HIV pre- and post-test counseling should be done before and after the HIV test is done, respectively. Adherence counseling for PEP should be done before administering the drugs.

iii. If the test is negative, give PEP for 28 days.

iv. If the result is positive, discontinue the PEP, as this shows that the survivor had HIV prior to the GBV incidence, and refer the survivor to an HIV Care and Treatment Clinic (CTC)

v. The survivor shall be informed that PEP only reduces the chances of acquiring HIV.

vi. The survivor needs to be followed up after two weeks to ensure adherence to treatment.

vii. Before PEP is initiated, the survivor should be informed about its potential side effects.

viii. The healthcare provider shall tell the survivor how to deal with the side effects and that they will diminish with time.

ix. Remember, the longer it takes to start administering these preventive measures for HIV, the lower the efficiency of the procedures.

x. Blood should be monitored for Hemoglobin, Alanine Amino Transferase, and Aspirate Amino Transferase.

(b) Family Planning and Pregnancy Prevention

Many GBV survivors have unmet need for contraception. They often have a partner and are at risk for unintended or mistimed pregnancy. For this reason, healthcare providers shall do the following:

i. Explore current family planning use and whether the survivor needs it.

ii. Provide family planning counseling and a contraceptive method, as needed, according to national standards. Make a referral if the facility is not able to provide the FP method selected.

iii. If the partner of the survivor is unsupportive of or unwilling to allow the use of FP methods such as oral contraceptives, then other methods such as Depo-Provera may be preferable.

iv. Some GBV survivors may be pregnant prior to seeking GBV services. For some women, partner violence increases during pregnancy. Other survivors may seek GBV services some time after the rape and when they are already pregnant. If the GBV survivor is pregnant; the healthcare provider shall:
   - Explore the circumstances surrounding the pregnancy and the survivor's feelings about it,
   - Explore her overall physical and mental health;
   - Provide appropriate services including antennal care (ANC) and prevention of mother-to-child transmission (PMTCT), if necessary.
   - Ensure effective referral if the facility is not able to provide the FP method selected.

(c) Guidelines for Pregnancy Prevention

Emergency contraceptive should be offered to non-pregnant, female GBV survivors of child-bearing age in the case of sexual violence.

i. A baseline pregnancy test should be done first, though this should not delay the dose of EC.

ii. Girls who have started menstruating are at risk of unwanted pregnancies and should also receive EC.

iii. EC is most effective when given within 120 hours (5 days) of assault.

iv. Another pregnancy test should be done 6 weeks after the incident at the follow-up visit, whether or not they took EC after the rape.

(d) Alternative EC Regimes and Doses

Serial No.	Régime	Doze
i.	Progestin only pills	Postinor 2®(Levonogestrel) 1tab every 12 hours (total 2 tabs per day) or 2 tabs once a day at the same time
ii.	Combined oral contraceptive pills with high dose of oestrogen (50µg)	Ovral® 2 tabs every 12 hours (total 4 tabs per day)
iii.	Combined oral contraceptive pills with low dose of oestrogen (30µg)	Nordette® 4 tabs every 12 hours (total 8 tabs per day)

Note: The survivor can be given any of the above three regimens.

6.9 Psychosocial Care and Ssupport

(a) General Consideration

i. GBV survivors undergo psychological distress, some immediately, while others may suffer in the short or long term.

ii. The duration will vary depending on the individual and the degree of trauma.

iii. The counselor should apply the survivor-centered approach to counseling. This approach focuses on "DOING GOOD and NOT DOING HARM" when counseling the survivors.

iv. One key principle in providing basic counseling is "not blaming the victim" for the incident.

v. All healthcare providers delivering GBV services should also be able to provide basic counseling to GBV survivors, including children.

vi. Clinicians, nurses, and trained social workers should offer counseling services to all GBV survivors, depending on the need.

vii. The counselor should at all times adhere to professional ethics and apply the principle of "doing good and not doing harm" in counseling a survivor.

(b) Types of Counseling in GBV Services

i. Appropriate types of counseling need to be offered to GBV survivors.

ii. Some counselors, social workers, nurses, and clinicians caring for GBV survivors are already trained in other types of counseling related to family planning, HIV pre- and post-test counseling, or adherence counseling.

iii. For those who have these other counseling skills, the focus should then be on trauma counseling.

iv. When other counseling is needed, counselors need to consult the related national guidelines.

(c) Importance of Trauma Counseling to Help Survivors

i. Understand their situation more clearly

ii. Identify options for improving the situation

iii. Make choices that fit their values, feelings, and needs

iv. Make their own decisions and act on them

v. Cope better with a problem

vi. Develop life skills

vii. Provide support for others while preserving their own strength

(d) Definition of Trauma Counseling

i. Counseling is a collaborative effort between a counselor and a client aimed at identifying goals and potential solutions to problems that cause emotional turmoil.

ii. It seeks to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental health.

iii. Trauma counseling is a key component in comprehensive GBV care, and its main purpose is to empower the survivor to cope and continue to live a normal life.

iv. Trauma counseling helps to reduce effects of the GBV trauma syndrome, a condition comprising symptoms commonly seen in rape and other GBV survivors.

6.10 Follow-Up Care, Treatment, and Referral

Healthcare providers shall use guidelines to plan follow-up after examination and treatment. Time-sensitive treatments and a schedule for psychological therapies shall be carefully considered in planning survivor follow-up. In addition, healthcare providers shall assess GBV survivors' needs in a holistic manner and explore the needs beyond treatment for GBV.

6.11 Documentation

i. The healthcare provider shall ensure that the necessary paperwork, including the GBV documentation forms, are available and there are facilities for safe custody of medical and other records for GBV survivors.

ii. The clinician will complete the medical section of the PF3 (Annex 4) and fill in the GBV Medical Form Annex 3 in triplicate.

iii. The healthcare provider is responsible for safe custody of the PF3, GBV documentation forms, medical records, and forensic specimens.

SECTION SEVEN: MEDICAL MANAGEMENT: CHILDREN AND ADOLESCENT ABUSE

7.1 Introduction

The medical management of child and adolescent abuse involves providing comprehensive services at health facility settings at all levels. The prerequisites for establishing these services at healthcare facilities include availability of basic essentials, adherence to minimum standards of care, and availability of trained skilled staff. In addition, healthcare providers need to recognize children and adolescents as a special group that require timely attention, treatment with empathy, and support and follow-up to the satisfaction of the child, parent, or guardian and the community. Medical management of young survivors by trained healthcare providers demands strict adherence to medical ethics of consent and confidentiality; systematic review of history; clinical examination; investigations; definitive diagnosis; medical, surgical, and psychological treatments; and referral and follow-up. Care of abused children and adolescents demands sensitivity to clues of forensic procedures, medical legal documentation, and linkage with the police and legal systems. Medical management of children and adolescent abuse within the broad framework of the national healthcare delivery infrastructure ensures two-way referral practices—from community, frontline healthcare facilities to comprehensive regional- or national-level health facilities. Comprehensive care for children and adolescent abuse also goes beyond medical management, requiring established linkages to other services for reintegration and rehabilitation of the survivor into their families and community.

Any actors who can appropriately play a role in responding to incidences of GBV in children shall develop joint agreements on how, when, and by whom an interview of a child survivor of sexual abuse shall take place. These actors shall establish when and how this information shall be ethically shared in a confidential and respectful way.

(a) General Considerations

i. Parents, guardians, or any supportive adults who suspect that a child or adolescent has experienced an incident of GBV such as sexual assault should take the child to see a doctor/gynecologist, social worker, and, if available, psychologist or psychiatrist.

ii. Any child or adolescent who is raped or sexually assaulted shall be immediately taken to an emergency room to receive medical treatment and to ensure that forensic evidence against the perpetrator is collected.

iii. Healthcare providers shall be trained on how to manage child/adolescent GBV survivors.

iv. The child survivor shall be assessed in a child-friendly environment, which may include the following:
- Colorful rooms with adequate space for the counselor to be able to play with the child.
- Adequate toys to represent basic household items.
- Dolls of different gender and age, preferably of the same color as the child. Puppets are preferred when possible.
- Drawing paper and color pencils.
- Balls and puzzles.

v. Ideally, there should be adequate security personnel to ensure the safety of the child survivor in the clinic, health facility, or ward when the child is admitted.

vi. In most cases, admission is recommended for sufficient time, depending on the condition of the survivor, to perform a thorough medical assessment and organize placement if necessary.

vii. Involvement of the children’s department, social welfare worker, and police is important for investigations to start while the child is in a safe place.

(b) Consent

Prior to conducting a physical examination on a child, the healthcare provider shall explain to the child (and his/her parent) the process of care and treatment, including the interview and medical examination. Consent for each part of healthcare and treatment shall be obtained at every step. For child survivors, a consent form is signed by the child's parent or caregiver, unless the child's parent is the suspected abuser. If the parent is the suspected abuser, a consent form may be signed by a representative from the health facility, keeping in line with the laws of Tanzania. The most crucial aspect in consent, however, is while legally children cannot give consent to examination and services, they shall not be compelled or forced to undergo an examination or treatment, unless it is necessary to save the life of the child.[20]

Consent regarding children and adolescents occurs at three levels:

i. Consent for medical management only
ii. Consent for medical management and forensic management
iii. Consent for medical management, forensic management, and police referral

Some child survivors of sexual abuse may present with no physical injuries or signs of trauma. Others may present with emotional or behavioral symptoms first noticed by the class teacher or parents. The most important determinant for abuse is the child's (or a witness's) account of the incident.

(c) Types of Gender-Based Violence in Children

Sexual violations involving a child may include the following activities:

i. Contact sexual abuse (e.g., touching the child's genitalia or the child touching an adult's genitalia).
ii. Penetrating injury (e.g., penile, digital, and object insertion into the vagina, mouth, or anus) and non-penetrating injury (e.g., instance of fondling or sexual kissing).
iii. Non-contact sexual abuse, which may include exhibitionism or voyeurism.
iv. The involvement of a child in verbal sexual propositions.
v. The making of pornography.
vi. Female genital mutilation.
vii. Bullying in schools

(d) Who Are the Perpetrators?

Incest or child and adolescent sexual abuse within the family is one of the most invisible forms of violence. It is usually perpetrated by a close relative, most often by a father, stepfather, grandfather, brother, uncle, or another male relative in a position of trust. In some cases, the rights of the child are usually sacrificed in order to protect the name of the family and that of the adult perpetrator. In some cases, female and male house workers sexually abuse small girls and boys.

(e) Risk Factors for GBV in Children and Adolescents

When risks associated with GBV are suspected or noticed, healthcare providers and community stakeholders should seek additional support from the social welfare officer, children's department, or police.

Possible warning signs regarding the social environment include the following:

i. Parents who share intimate feelings and emotions in front of their children.

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[20] IRC and UCLA Center for International Medicine. 2008. *Clinical Care for Sexual Assault Survivors: A multimedia training tool, facilitators guide*. Los Angeles, CA: UCLA Center for International Medicine.

ii. Parents who know little about the child's health or have vague recollections of past medical history.
iii. Parents who are overly concerned with custody issues.
iv. Social isolation.
v. Alcohol and/or drug abuse.
vi. Intimate partner violence or other violence in the home environment of the child.
vii. Multiple caretakers for the child; caretaker or parent, who has multiple sexual partners, drug and/or alcohol abuse, stress associated with poverty, social isolation and family secrecy.
viii. Child with poor self-esteem or other vulnerable state.
ix. A history of other family members or siblings having been abused.

7.2 Receiving the Survivor

The child/adolescent survivors will be received at the Reproductive and Child Health Clinic (RCHC) or Outpatient Department (OPD of the health facilities. Healthcare providers shall identify children and adolescent GBV survivors in the queue or OPD waiting area and assist them in fast tracking so that they do not have to wait unnecessarily long for services while seated or standing with other patients in the OPD.

7.3 History Taking

Healthcare providers shall take a thorough and systematic history to obtain the routine background medical information of the child or adolescent survivor as well as information about any medical symptoms that have arisen or resulted from the violence. This information wili assist in the medical management and forensic sampling of the survivor. In addition, the nature of the violence and consequences, such as loss of consioussness, should be described. The past medical history such as easy bruising and surgical and gynaecological history is also detailed. At a minimum, the medical history shall cover any known health problems including allergies, immunization status, and medications. The details are entered into to the medical treatment records and the GBV Medical form (annex 3) simultaneously to ensure that all the details are recorded.

History taking, examination, and documentation provide the crucial links among the occurrence, the child survivor, and the healthcare and criminal justice systems. Any additional paperwork brought by the survivor to the healthcare institution shall be reviewed before taking the history.

(a) The Main Elements of History Taking

i. Particulars of the child survivor:
    - Name, address, residence, telephone number, sex, date of birth (or age in years).
    - Note date and time of the examination and the name(s) of any staff or support person present during the interview and examination. Presence of a support person shall be by the request and consent of the child survivor and presence of medical care staff to assist the clinician shall be explained to the child survivor and explained that she/he has a right to agree or refuse her/his being present.

ii. Description of the incident by child survivor or caretaker

- Describe what happened; note the date, time, and place and the name of the perpetrator and his/her relation to the child. It is important that the healthcare provider understand the details of exactly what happened in order to check for possible injuries. For example, when did the assault take place? Was there penetration (oral, vaginal, or anal)? Did the assailant use physical or psychological force? Did the assailant use a foreign object? How many assailants were there? Was it a single assault or was it repeated over hours or days? Did the survivor lose consciousness? Was the assailant known to the survivor? Determine whether the survivor has bathed, urinated, vomited, etc., since the incident occurred, as this may affect the collection of forensic evidence.

iii. Gynecologic history (if appropriate)
- Ask the girl if she has acquired menarche.
- Obtain the first day of the last menstrual period.
- Obtain history on prior sexual encounters, as well as whether they were consensual. Find out if the survivor has a sexual partner(s).
- Determine the last time the survivor had sexual intercourse prior to the incident.
- Determine if the survivor has been pregnant before. If so, when and what was the outcome.
- Determine if the survivor uses contraception. If so, the type and the compliance where relevant.
- Determine the HIV status.

iv. Mental health state

Assessing and treating mental health issues are done to support the child in coping with trauma associated with GBV and to prevent negative health consequences. These processes should in no way re-victimize, stigmatize, or blame the child.

Communicating With Children—Guide

i. Remember, you are already an expert in working with children; you already possess the ability to communicate with children!
ii. Even though the child survivor is young and may be physically weak, information shall be given to him/her. The child survivor is strong enough to receive information about his/her illness. Not talking about the problem and keeping it a secret elicits more harm to the child and family.
iii. Always describe to the child survivor your role as a GBV service provider, specifically in the provision of GBV services to children. You can start with, "I am here to help you and your family and help you to feel better." With older children, you can include more of your job-specific information.
iv. At the beginning of treatment, take time to get to know the child; adapt your strategy according to age (play with younger children; draw and talk with older children/adolescents).
v. Adjust yourself to height of the child (get down and play on floor with very young children, sit on floor or on a low chair with young children, etc.).
vi. Words may not always work with children; find alternative ways of communicating (drawing, art materials, listening to music, playing); discover the form of communication that works best with the child.
vii. Some children feel more comfortable with caregivers being present in the room until the child develops trust in you.
viii. Never rush a child to express him/herself; always be survivor-centered and allow the child to express himself/herself in his/her own time.
ix. Always give the child necessary information in an age-appropriate manner; avoid keeping information from the child.
x. Design your clinic in a child-friendly manner (have appropriate toys and art supplies available, carpeted/soft place to sit on the floor, comfortable chairs, pleasing colors on walls); create a warm and friendly atmosphere that allows the child to feel more comfortable and less afraid.

- Assess current emotional state of the child.
- Obtain a mental health history. Salient points include previous or current psychiatric diagnoses, prior hospitalization, previous or current medication and drug use, and any family history of mental illness.
- Children who display any of the symptoms listed in Annex 7 should be referred to a psychiatrist, psychologist, or medical doctor experienced in managing children in need of mental health services.

v. Past medical and surgical history.

Ask about possible medical conditions, allergies, use of alcohol/drugs, vaccination, HIV status, and previous surgery. These questions will help the healthcare provider to determine the best treatment and provide counseling and follow-up healthcare.

(b) Procedures for History Taking

The procedure will depend on the emotional and physical state of the child survivor. In some cases, the interview may be difficult due to the distress and sense of insecurity in the child. The age and cognitive development of the child will influence the way in which the interview will be done. In some cases, the parent or guardian may be asked to wait outside and the child may be interviewed alone. A strong alliance between the counselor and the child/guardian is crucial to successful sessions.

Common Complaints of Child and Adolescent Abuse

i. **Physical complaints**
- General somatic complaints including headaches, abdominal pain, constipation, diarrhea, encopresis, and general fatigue.
- Painful defecation or urination, vaginal discharge, bleeding, or itching.
- For female adolescents, ask about the date of last menstrual period, number of pregnancies, possible gynecologic surgery, or traumatic injury to the genital area.
- Date of the last consensual intercourse and use of contraceptives.
- Enquire about prior STIs and subsequent treatments, if any.

ii. **Behavioral and emotional issues**
- Ask about sleep patterns, sleep disorders, appetite, mood, and social interactions; and abrupt behavioral changes, such as aggression, depression, suicidal behavior, withdrawal, low self-esteem, nightmares, phobias, regression, and school problems.

iii. **Emotional isolation**
- Children who are abused can be emotionally isolated.
- A perpetrator can force the child to keep the abuse a secret, and the child may worry about what will happen to the family or to her/him if the secret is told. The burden of the secret can be carried into adulthood, making the child abnormal.

iv. **Self-blame and guilt**
- Children tend to blame themselves for the abuse. Some may have felt that the abuse was punishment for something they had done wrong. This may have also been told to them by the abuser. Most children believe that adults are usually right.

v. **Betrayed trust**
- Children who are abused are likely not to trust people again following the betrayed trust. This feeling may continue into adulthood.

vi. **Self-destructive behaviors**
- Substance abuse, prostitution, self-mutilation.

vii. **Sexualized behavior inappropriate for developmental level**
- Excessive masturbation, forced sexual acts on other children.

Every effort should be made to minimize the number of times the child is interviewed. If a facility has a social worker; he/she should be present during the interview. The procedure for establishing rapport with the child/adolescent and caretaker is summarized and shown in the flow chart below:

i. Introduce yourself to the survivor.

ii. For adolescents, they should be asked if they want to be alone or with a trusted adult. Ask if the child survivor wants to have a specific support person present.

iii. Limit the number of people allowed in the room during the examination; if others are present, explain their role and ask permission from the child survivor.

iv. Explain in a language that the child survivor can understand that he/she is in control of the pace, timing, and components of the examination.

v. Reassure the survivor that the examination findings will be kept confidential. Ask her/him if she/he has any questions.

vi. Explain what is going to happen during each step of the examination—why it is important, what it should tell you, and how it will influence the care you provide to the survivor.

vii. Provide relevant information on the GBV incident and the need for medico-legal documentation if the child can comprehend such information.

viii. Have the survivor/guardian/parent sign the consent form (Annex 1).

ix. After the consent form has been signed, undertake the examination as soon as possible.

x. Always explain to the child survivor what you plan to do before the examination or before moving to the next stage.

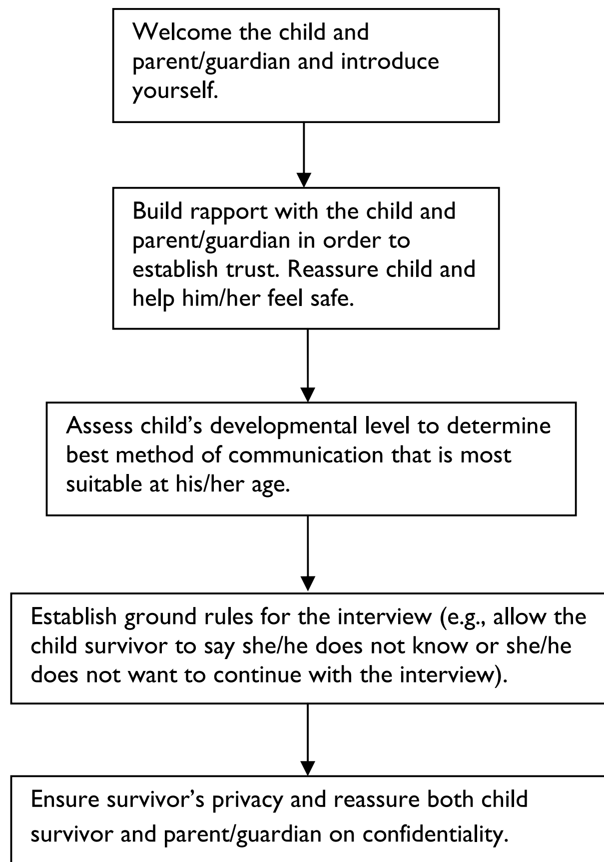
xi. Do not force the child survivor to do anything against her/his will.

xii. Stop the interview in case the child is uncomfortable.

xiii. Encourage the child to ask questions or seek permission from the child to ask a trusted adult (e.g., a parent or a guardian).

xiv. Keep identifying yourself as a helping person.

Flow Chart: Process of Establishing Rapport with the Child/Adolescent and Caretaker



7.4 Physical Examination

Physical and Behavioral Indicators of Child Sexual Abuse

Physical Indicators	Behavioral Indicators
i. Unexplained genital injury ii. Recurrent vulvo-vaginitis iii. Vaginal or penile discharge iv. Bedwetting and fecal soiling beyond the usual age v. Anal complaints (e.g., fissures, pain, bleeding) vi. Pain on urination vii. Urinary tract infection viii. STIs ix. Pregnancy/presence of sperm	i. Regression in behavior, school performance, or attaining developmental milestones ii. Acute traumatic response such as clingy behavior and irritability in young children iii. Sleep disturbances iv. Eating disorders v. Problems at school vi. Depression vii. Poor self-esteem viii. Inappropriate sexualized behaviors

Some child survivors of sexual abuse may present with no physical injuries or signs of trauma. Others may present with emotional or behavioral symptoms first noticed by the class teacher or parents. The most important determinant for abuse is the child's (or a witness's) account of the incident.

(a) General Consideration

Whereas adult survivors of sexual violence often present a medical emergency, children are often brought to the attention of a healthcare provider through different routes and circumstances. As a result, the timing and extent of the physical examination will depend on the nature and timing of the complaint. Regarding decisions about the timing of the physical examination:

i. If last contact with the abuser was more than 72 hours ago, and the child has no medical symptoms, an examination is needed as soon as possible, but not urgently.

ii. If the last contact with the abuser was within 72 hours and/or the child is complaining of symptoms (i.e., pain, bleeding, discharge), the child should be seen immediately.[21]
   - Examine survivor thoroughly and systematically.
   - Examination should be done from head to toe, paying special attention to the face, upper limbs, neck, breasts, thighs, and perineum in the case of sexual violence.
   - The examination is best done under natural light. However, there are special lamps that can be used to see injuries better, such as a woods lamp or UV light.
   - Collect evidence when present.
   - Procedures for physical examination go hand-in-hand with collection of Forensic Evidence.
   - Document all findings in a systematic manner.
   - Specimens should be collected as the physical examination is being conducted, obtaining smears from the skin, oral mucosal, external and internal vagina, and rectum and urine and blood samples systematically.
   - Legally, if specimens are collected (urine, semen, and other evidence in general), these should be sealed appropriately and signed and delivered to the laboratory by certified personnel (police) to preserve the chain of evidence.
   - In the case of sexual and physical violence, the child survivor's clothes should be collected for forensic examination and put in a paper sheet/ bag. If the survivor is going to be undressed, she can do this over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs that would support his/her information about the assault or violence.

[21] WHO and UNHCR. 2002. *Clinical Management of Survivors of Rape: A guide to the development of protocols for use in refugee and internally displaced person situations*. Accessed at: www.who.int/reproductive-health/publications/rhr_02_8/clinical_management.pdf.

iii. All findings should be recorded in GBV documentation forms. If these forms are not available, findings should be recorded on any sheets of paper, provided that the GBV form's format is followed.

iv. Head-to-toe examination of a child or adolescent survivor:

- Record the general appearance.
- Take vital signs.
- Examine the upper limbs for any signs of injuries.
- Inspect the face, eyes, and ears.
- Examine the scalp for any injuries and signs of inflammation.
- Examine the neck for bruises and life-threatening assaults.
- Examine the breasts and trunk for bites and other injuries.
- Examine the heart and chest for abnormalities and injury.
- Do an abdominal examination for any internal injuries and pregnancy.
- Examine the lower limbs thoroughly.
- Collect any forensic specimens as you examine the survivor as described above.

When performing the head-to-toe examination of children, the following points are important:

- Record the height and weight of the child.
- In the mouth/pharynx, note poeticize of the palate or posterior pharynx, and look for any tears in the fermium.
- Record the child's sexual development and check the breasts for signs of injury.
- Use of a digital camera to take photographs as part of evidence is crucial. Use of film cameras provides strong evidence in court and is preferred to digital cameras, which can be easily edited.

(b) Genital and Anal Examination for Girls

i. Explain each step of the examination.

ii. Examine the external genitalia.

iii. Examine the labia and other related structures.

iv. Take all the swabs in the following order: external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swab. Take other swabs such as oral swabs for secretor factors in cases where oral sex is implicated. Skin swabs are collected where a seminal stain is suspected on the skin.

v. Do speculum and digital examination. Under no circumstance should digital and speculum examination be done prior to taking the swabs. Speculum examination for children should be done only if the child has internal bleeding from a penetrating vaginal injury. In this case, speculum examination is done under general anesthesia. A nasal speculum may be used for this purpose in small girls. For small girls, a pediatric speculum is recommended. Note that speculum examination on girls who have not reached puberty causes pain and may cause injury and should be avoided unless, as said, there is internal bleeding from the vagina. The child may need to be referred to a higher level health facility for this procedure.

vi. Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.

vii. Document wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration).

viii. Control for bleeding, if any.

ix. Examine the anus; look for bruises, tears, or discharge.

x. Help the child lie on her back or on her side.

xi. Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outward and downward. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymeneal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.

xii. Girls should have an anal examination as well as a genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it. Look for bruises, tears, or discharge and help the child lie on her back or on her side.

xiii. Do not carry out a digital examination to assess anal sphincter tone (i.e., inserting fingers into the vaginal orifice to assess its size).

xiv. Record the position of any anal fissures or tears. Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.

(c) Genital and Anal Examination for Boys

i. Check for injuries to the skin that connects the foreskin to the penis.

ii. Check for discharge at the urethral meatus (tip of penis).

iii. In an older child, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child.

iv. Examine the anus, looking for bruises, tears, or discharge, and help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated.

v. Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

vi. Check for injuries to the frenulum of the prepuce and for anal or urethral discharge; take swabs if indicated.

vii. Do not carry out a digital examination to assess anal sphincter tone. Record the position of any anal fissures or tears. Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.

7.5 Laboratory Investigations

Laboratory investigations are done to help address medical problems as a result of violence and to collect evidence that may help prove or disprove a contact between individuals and/or between the offender and survivor, respectively. The forensic evidence may be used for medical and legal purposes to support the survivor's account, confirm recent sexual contact, show the force or coercion used, and help identify the perpetrator. The evidence should be collected as soon as possible after the incident to ensure that the time-sensitive aspects are addressed. Collecting forensic evidence during the examination helps minimize the number of examinations that the child must undergo.

(a) General Consideration

i. The evidence should be collected as soon as possible after the incident.

ii. Transportation and preservation regulations of specimens should be observed to ensure reliable results.

iii. Documentation and record keeping should allow reproduction of information and prevent mix-up of results.

iv. Laboratory tests are performed at the (1) health institution and (2) government chemist.

(b) Laboratory Tests

i. The laboratory tests include HIV testing, pregnancy tests, urinalysis, and screening for STIs, but additional tests can be done according to the clinician's opinion and recommended procedures for the level of health facility.

ii. GBV survivors may contract an STI as a direct result of the assault. Infections most frequently contracted by the survivors, and for which there are effective treatment options, are as follows:

- HIV
- Chlamydia
- Gonorrhoea
- Syphilis
- Trichomoniasis
- Human papilloma virus
- Herpes simplex virus type 2
- Hepatitis B and C

Performing the tests for Hepatitis B and C will depend on the availability of laboratory facilities.

7.6 Diagnosis

History taking, physical examination, and laboratory investigations will help the health provider arrive at one or more of the listed diagnoses:

(a) Medical diagnosis
(b) Surgical diagnosis
(c) Gynecological diagnosis
(d) Psychological diagnosis

7.7 Treatment

(a) General Considerations

i. A thorough general physical examination should be done first before starting treatment for a child survivor.

ii. Serious injuries like tears and fistulae in children are usually life threatening and require admission for specialized pediatric surgical or gynecologic operations.

iii. Vaginal injuries with cuts requiring sutures should be managed under sedation or anesthesia.

(b) Procedures for Managing Injuries in Children

When the survivor visits the health facility, any injuries shall be attended to as first priority before all other aspects of GBV care are done.

i. All children with life-threatening injuries should be admitted for management and further GBV assessment.

ii. Time-sensitive preventive treatments (e.g., PEP, EC, STI, and TT) should proceed concurrently with other medical procedures.

iii. Abrasions and superficial injuries should be cleaned with antiseptic and either dressed or painted with a tincture of iodine.

iv. Major injuries may require further investigations such as X-rays and appropriate surgical management according to standard medical procedures.

v. All GBV survivors require GBV psychosocial assessment, counseling, psychosocial care and support, and follow-up.

7.8 Preventive Treatments

(a) Guidelines on PEP for Child Survivors

The procedures for provision of PEP should be based on the national guidelines for HIV and AIDS management.

i. PEP should be initiated within 72 hours.

ii. HIV pre- and post-test counseling should be done before and after the HIV test is done, respectively. Adherence counseling for PEP (Annex 8) should be done before administering the drugs.

iii. If the HIV test is negative, give PEP for 28 days.

iv. If the result is positive, discontinue the PEP, as that shows that the survivor had HIV prior to the GBV incident, and refer the child survivor to an HIV care and treatment clinic.

v. The survivor should be informed that PEP only reduces the chances for acquiring HIV.

vi. Before PEP is initiated, the survivor shall be informed about its potential side effects.

vii. Follow up with the survivor after two weeks to ensure that she/he is adhering to treatment.

viii. Healthcare providers shall tell the survivor or caregiver how to deal with side effects and that they will diminish with time.

ix. Remember, the longer it takes to start administering these preventive measures for HIV, the lower the efficiency of the procedures.

x. Blood should be monitored for Hemoglobin, Alanine Amino Transferase, and Asparate Amino Transferase.

Syrups are the recommended regimens, as dosing can be more precise. However, in situations where syrups are not available, regimens using tablets have been developed based on weight bands.

Syrup-Based Regimen for Children

	Medicine	Application
First Line	AZT + 3TC: Zinovudine: 2 mg/kg Lamuvidine 4 mg/kg	Twice a day for 28 days
Second Line	D4T* + 3TC: Stavudine: 1 mg/kg (only if a fridge is available) Lamuvidine: 4 mg/kg	Twice a day for 28 days

Note: Syrups require refrigeration so they are not appropriate unless the healthcare providers have a fridge.

Tablet-Based Regimen for Children

Weight Band	Dose AZT	Dose 3TC
10-20 kg 20-40 kg > 40 kg	100 mg three times a day 2 x 100mg twice a day Adult regime	1/2 x 150 mg tab twice a day (75 mg) 1 x 150 mg tab twice a day (150 mg) Adult regime

Weight Band	Dose D4T	Dose 3TC
10-14 kg 15-19 kg 20-60 kg	1 x 15 mg cap twice a day 1 x 20 mg cap twice a day 30 mg cap (or adult FDC)	1/2 x 150 mg tab twice a day (75 mg) 1 x 150 mg tab twice a day (150 mg) Adult regime

(b) Family Planning and Pregnancy Prevention

i. General considerations

Many adolescent girl GBV survivors who are sexually active need a contraceptive method to prevent unwanted pregnancy. They may have a partner and are at risk for pregnancy. For this reason, healthcare providers shall

- Explore current family planning use and whether the adolescent girl needs it;
- Provide family planning counseling and a contraceptive method as needed, according to national standards, or ensure effective referral if the facility is not able to provide the method selected;
- If the adolescent is married and her partner is unsupportive of or unwilling to allow use of family planning methods such as oral contraceptives, then other methods such as Depo Provera may be preferable;
- Some adolescents may be pregnant when they seek GBV services. For many adolescents, partner violence increases during pregnancy. Adolescent GBV survivors may seek GBV services some time after the rape and when they are already pregnant;
- Provide pregnancy-related services; and
- Provide appropriate referrals, including for antenatal care and prevention of mother-to-child transmission services.

ii. Guidelines for pregnancy prevention

When the adolescent GBV survivor is not pregnant:

- Emergency contraceptive (EC) should be offered to non-pregnant female adolescent GBV survivors of child-bearing age in the case of sexual violence.
- A baseline pregnancy test should be done first, though this should not delay the dose of EC.
- Girls who have started menstruating are at risk of unwanted pregnancies and should also receive EC.
- EC is most effective when given within 120 hours (5 days) of assault.
- Another pregnancy test should be done 6 weeks after the incident at the follow-up visit whether or not they took EC after the rape.

(c) EC Regimes and Doses

Serial No.	Regime	Dose
i.	Progestin only pills	Postinor 2®(Levonogestrel) 1 tab every 12 hours (total 2 tabs per day) or 2 tabs at one time
ii.	Combined oral contraceptive pills with high dose of oestrogen (50µg)	Ovral® 2 tabs every 12 hours (total 4 tabs per day)
iii.	Combined oral contraceptive pills with low dose of oestrogen (30µg)	Nordette® 4 tabs every 12 hours (total 8 tabs per day)

Note: The survivor can be given any of the above three regimens for the appropriate age.

7.9 Psychosocial Care and Support

Psychosocial counseling is a collaborative effort between a counselor and a survivor that aims to identify goals and potential solutions to problems that cause emotional turmoil; improve communication and coping skills, strengthen self-esteem, and promote behavior change and optimal mental health. The main purpose of counseling is to empower the survivor to cope and continue living a normal life.

(a) Types of Ccounseling in GBV Services

Various types of counseling need to be offered to the GBV survivors depending on history and examination findings: counseling for emergency contraception and unwanted pregnancies, pre- and post-test counseling for HIV (Annex 8), follow-up supportive counseling, and family counseling

i. Some counselors, social welfare officers, nurses, and clinicians in Tanzania who will be caring for GBV survivors have already been trained in counseling in family planning, HIV pre- and post-test counseling, or adherence counseling. They need to be trained in GBV counseling.

ii. For those who have these other counseling skills, the focus should then be on trauma counseling.

iii. When other counseling is needed, counselors need to consult other national guidelines for specific counseling.

(b) General Considerations

i. GBV survivors undergo psychological distress, some immediately, while others may suffer in the short or long term.

ii. The duration will vary depending on the individual and degree of trauma.

iii. The counselor shall apply the survivor-centered approach and professional ethical conduct to counseling. This approach focuses on “DOING GOOD and NOT DOING HARM” when counseling survivors.

iv. One key principle in the provision of basic counseling is “not blaming the victim” for the incident.

v. All healthcare providers providing GBV services shall also be able to provide basic counseling to GBV survivors including children.

vi. Clinicians, nurses, and trained social welfare officers shall offer counseling services to all GBV survivors, depending on the need.

(c) Importance of Trauma Counseling

i. To help survivors
   - Identify options for improving the situation and make choices that fit their values, feelings, and needs;
   - Make their own decisions and act on them and cope better with a problem;
   - Develop life skills; and
   - Provide support for others while preserving their own strength.

ii. Counseling is a collaborative effort between a counselor and a client aimed at identifying goals and potential solutions to problems that cause emotional turmoil.

iii. It seeks to improve communication and coping skills; strengthen self-esteem; and promote behavior change and optimal mental health.

iv. Trauma counseling is a key component in comprehensive GBV care services that aims to empower the survivor to cope and continue to live a normal life.

v. Trauma counseling helps to reduce the effects of the GBV trauma syndrome, a condition comprising symptoms commonly seen in rape and other GBV survivors.

Basic Psychosocial Interventions Guide for a Child and Adolescent Survivor

These are basic psychosocial interventions that may be helpful during treatment.

i. Ensure treatment confidentiality.
ii. Employ active listening; really listen to what the child and caregiver is saying; paraphrase what they say and repeat back: (What I hear you saying is…(REPEAT what client has said)…do I have it right?).
iii. Be non-judgmental; understand that most often your survivors are trying to do the best they can.
iv. Regularly check in with caregivers and child survivor about how treatment is proceeding. What is working well? What is not working so well? Where does the survivor need help?
v. Always praise caregivers and child survivors for coming to treatment.
vi. Always encourage caregivers and child survivors to talk with each other during sessions about disclosure issues, feelings, fears, stigma, loss, successes, treatment adherence, joys etc.
vii. Always encourage and coach interactions between the child and caregivers; try not to talk to the child when he/she is communicating with the caregiver or to the caregiver when he/she is communicating with the child, especially when the child or caregivers are in distress. Spend time listening to what is upsetting them.
viii. Strategize with caregivers on how to increase their child's social/community support system.
ix. Refer the child and caregivers to various support groups.
x. Develop support groups in your clinic (for children, adolescents, caregivers, siblings of children with HIV).
xi. Make a referral to a psychiatrist or other mental health professionals when the child or family presents with symptoms/problems that require ongoing psychosocial intervention.
xii. Help children and caregivers establish a vision of what they want for their future; instill hope and regularly discuss survivors' level of motivation toward treatment.
xiii. Use role plays often in sessions to help children and caregivers practice initiating the disclosure process and practice/develop healthy communication between them.

(d) Symptoms of Rape Trauma Syndrome

Some child survivors of sexual abuse may present with no physical injuries or signs of trauma. Others may present with emotional or behavioral symptoms first noticed by the class teacher or parents. The most important determinant for abuse is the child's (or a witness's) account of the incident.

i. Physical symptoms
   - Shock, feeling cold, fainting, confusion and disorientated trembles, nausea, and sometimes vomiting, as a result of pregnancy.

ii. Behavioral symptoms
   - Crying more than usual, difficulty concentrating, restlessness and agitation, unable to relax, unmotivated, withdrawn, stuttering and stammering, avoidance of reminders, easily startled or frightened, very alert and watchful, easily upset by small things, frequently disagrees with family or friends, fear of sex or loss of sexual pleasure if adolescent has had sexual experience, change in lifestyle, increase in substance abuse, increased washing or bathing, denial as if nothing had happened.

iii. Psychological symptoms
   - Increased fear and anxiety, self-blame and guilt, helplessness, no longer feeling in control of life, humiliation and shame, lowered self-esteem, feeling dirty, anger, feeling alone and that no one understands, losing hope for the future, emotional numbness, confusion, memory loss, constantly thinking about rape, flashbacks to the rape, feeling it is

happening again, nightmares, depression, and suicidal ideas commonly seen in rape and other GBV survivors.

(e) Rape Trauma Counseling

A trained person provides rape trauma counseling to a survivor. Rape counseling ideally begins at the time the crime is first reported. Initially, the counselor offers sensitive support for the survivor by accepting him/her in a non-prejudicial, non-critical way. The survivor's response to the trauma of the assault is empathetically elicited, and three basic statements are made: the counselor is sorry that the rape happened, is glad that the injuries are not worse, and does not think that the survivor was wrong or did anything wrong.

Symptoms of Rape Trauma Syndrome in Children

- Recurrent memories or flashbacks of the incident
- Nightmares
- Insomnia
- Mood swings
- Difficulty concentrating
- Panic attacks
- Emotional numbness
- Depression

7.10 Follow up Care, Treatment, and Referral

After examination, diagnosis, and treatment, healthcare providers use guidelines to plan follow-up. Time-sensitive treatments and a schedule for psychological therapies shall be carefully considered in planning survivor follow-up. In addition, healthcare providers must assess GBV survivors' needs in a holistic manner and explore needs beyond treatment for GBV. The healthcare provider shall

i. Make a referral and follow-up plan for the child to obtain police and legal services. Make a plan to follow up on forensic evidence and results of the forensic tests.
ii. Explain to the child and his/her parent/guardian the preventive treatment schedule.
iii. Document the problem diagnosed.
iv. Document the definitive treatment.
v. Follow up on medical, legal, and forensic evidence.
vi. Follow up with the child for reintegration into the family and the community

(a) Guideline on When to Refer

If a referral is made, it is important that the healthcare provider remain in close contact through the treatment process. You may need to refer a child to a mental health professional under the following circumstances:

i. The child has psychological symptoms (depression, anxiety, psychosis, aggression) that are severe, chronic, and significantly disrupt his/her daily functioning.
ii. The child expresses suicidal ideation, has attempted suicide, or expresses the intention to attempt suicide.
iii. The child expresses thoughts of wanting to harm others.
iv. The child presents with a significant substance abuse problem.
v. The child has a history of being sexually, physically, or emotionally abused/traumatized.
vi. The child presents with a developmental disability.

7.11 Documentation

The healthcare provider shall ensure that the necessary paperwork, including the GBV documentation forms, is available and there are facilities for safe custody of medical and other records for GBV survivors.

i. The clinician will complete the medical section of PF3 (Annex 4) and fill in the GBV Medical Form (Annex 3) in triplicate.

ii. The healthcare provider is responsible for safe custody of the PF3, GBV documentation forms, medical records, and forensic specimens.

SECTION EIGHT: LINKAGES FOR GBV PREVENTION AND SERVICES

8.1. Introduction

The provision of high-quality and comprehensive medical GBV services to adult, children, and adolescent survivors demands linkages among healthcare providers at all levels. Managers shall ensure adherence to minimal standards (see Section 4) for care and the provision of an integrated medical service package to the survivor at all relevant department and sections of the health facility. Healthcare providers at the health facilities shall be competent in executing the procedures under the medical package for adults and children (sections 6 and 7). The medical package includes two-way referrals of survivors within and between health facilities and to police; drop-in centers, and legal and paralegal services. In addition, healthcare providers are required to reach out to the community and be involved in GBV prevention and reintegration of the survivors back into their families and community. Health managers and healthcare providers at all levels are responsible for establishing and making effective use of linkages for comprehensive GBV prevention and the provision of medical services.

8.2. Linkage for Preventive Services

The council health services boards under the District Council Authority are responsible for GBV prevention efforts in the population and community in their area. The CHMTs are responsible for planning and implementing integrated GBV prevention and response services within the Comprehensive Council Heath Plan. Health facilities in the council, health centers and dispensaries, have health committees and management teams, respectively, including ward health committees. The ward health committe is responsible for initiating and coordinating the integration of health center and dispensary health plans into the Ward Development Plan. Council, health center, and dispensary health management teams include healthcare providers at the respective facilities. The role of the management teams and health providers at all levels shall be to

i. Prepare annual plans in GBV prevention and response and integrate them into the annual comprehensive village, ward, or council health plan;

ii. Ensure implementation of the integrated annual comprehensive village, ward, or council health plan;

iii. Monitor and evaluate GBV prevention and response efforts;

iv. Organize and support outreach activities for GBV prevention;

v. Support community initiatives toward mobilizing resources for
   - Advocacy and behavior change and comminication for GBV,
   - Establishment of drop-in centers and safe houses,
   - Referral of survivors for medical care and police and legal assistance,
   - Support integration of survivors into the family/community; and

vi. Collect relevant data and information on attitudes and practices related to GBV, its prevention, and the response in the community.

8.3. Linkage of GBV Services for Survivors

The hospital, health center, and dispensary management teams at all levels are responsible for planning and integrating GBV services for survivors at their respective health facilities. The teams include healthcare providers at facilities of varying sizes and complexity. The role of the management team/healthcare providers at all levels shall include

i. Annual planning for and implementation of an integrated GBV service package;

ii. Provision of minimal standards at health facility settings for delivering high-quality GBV services;

iii. Provision of equipment and medical supplies for GBV service packages for adults and children;
iv. Adequate staffing and regular continuing training for GBV services;
v. Supportive supervision of GBV services in health facilities; and
vi. Data collection, analysis, and use to improve GBV prevention and response efforts at the facility and community (e.g., to give feedback to healthcare providers and the community).

8.4. Integration and Coordination for GBV Services

Integrating and coordinating GBV prevention and response services is necessary for the effective provision of comprehensive care given the present limitation in availability of resources. It is not intended to create a new parallel service within a health facility but to integrate GBV services into existing health facilities. Therefore, integration and coordination shall be part of the planning and implementation processes for GBV services and prevention at the health facility, council, regional, and national levels. Managers at these levels shall audit existing services and determine the gap based on minimum standards provided in these guidelines (see Section 4).

(a) Integration

At facilities, departments, and units, within other programs, such as reproductive and child health, HIV, school health, and community-based healthcare programs, managers at all levels shall identify and fill the gaps in staffing, knowledge, and skills that are required (according to minimum standards) for providing comprehensive GBV prevention and response activities in their areas. Managers shall conduct a training needs assessment and provide this training to update staff knowledge and skills. In addition, managers shall supervise and follow up on the full integration of GBV services. Thus, GBV services will be integrated, depending on the availability of resources and the workload.

(b) Coordination

The close coordination of many actors (within and beyond the health sector, such as in the police and legal systems) is required to provide high-quality and comprehensive GBV services to survivors and to reintegrate them into the family and community. Managers and healthcare providers at all levels shall identify, plan, and monitor general and specific activities to be coordinated by key actors.

SECTION NINE: MONITORING, EVALUATION, AND QUALITY ASSURANCE

9.1 Monitoring and Evaluation

The provision of high-quality and comprehensive GBV services shall be ascertained through monitoring and evaluation using a set of selected indicators (Annex 11). Monitoring and evaluation will take place to examine the extent to which GBV incidents and their effects are being addressed in the country. More specifically, the evaluation will review the extent to which GBV survivors' needs are addressed in a survivor-centered and timely manner, perpetrators are dealt with in accordance with Tanzanian laws, and GBV service providers at different levels are able to respond to GBV survivors efficiently and effectively.

Available data from surveys, notably the Demographic and Health Survey (DHS), will be used as a baseline to guage improvement. An annual review will be done to show progress, and a 5-year review review will be done to correspond to the DHS.

GBV data collection and reporting shall be integrated into the Health Information Management System of the MOHSW. Health managers at all levels shall

i. Collect, compile, and disseminate to stakeholders relevant information and data on GBV prevention and response efforts at health facilities;

ii. Analyze gathered information and data to evaluate the performance of GBV prevention and services at facilities; and

iii. Use the monitoring and evaluation report to inform decisionmaking and identify areas for improvement and research.

9.2 Quality Assurance

Quality assurance plays an important role in medical services related to GBV prevention and response. The purpose of quality assurance is to ensure that GBV survivors receive holistic (effective and comprehensive) services provided with empathy by staff. Quality assurance encourages corrective action when needed. Continuous monitoring of GBV service provision needs to take place along with regular evaluation of results.

Quality assurance also ensures reproducibility and authenticity of the evidence in each case. It also ensures that there is an acceptable standard of care given.

The process begins at the time the offense is committed at the community level, and hence, there is the need to educate community health workers and community members to understand all aspects of preservation and documentation of evidence.

All activities and services related to GBV prevention and response efforts require supportive supervision, monitoring, evaluation of results, and good documentation. Supervisors and healthcare providers are responsible for actively participating in and supporting activities to ensure high quality. To provide good services, healthcare providers need a supportive work environment, appropriate knowledge and skills, and supplies and equipment to provide high-quality GBV services. This includes appropriate infection prevention to protect the survivors and providers.

If the facility already has ongoing quality assurance/improvement activities, GBV supervisors and healthcare providers should participate in these activities. If not, they should consider developing and using simple approaches and tools. In addition, if current quality assurance activities do not include those described below, the service providers should consider adopting them.

Quality assurance is an ongoing exercise involving the entire institution from the director to the junior-most members of staff.

9.3 Quality Assurance Procedures

Healthcare providers shall do the following to ensure the provision of high-quality GBV services in their health facilities:

(a) Review of the Processes and Documentation

i. Healthcare providers should review each survivor's GBV standardized forms.

ii. Did healthcare providers use standardized forms?

iii. Did healthcare providers fill in the forms correctly and completely?

iv. Did healthcare providers do tests as per the standards and record the samples taken?

v. Did healthcare providers perform the examination as per the standards?

vi. Did healthcare providers administer treatments as per the standards (including EC and PEP)?

vii. Did healthcare providers counsel as per the standards?

viii. Did healthcare providers make referrals as per the standards?

ix. Was the physical and mental health of survivor completely documented? Were the interview and examination findings documented in a clear, concise, and objective manner?

x. Is there a signed consent form by the survivor in the file? Are other required signatures in the file (from those who were in possession of evidence or collected it for analysis or for onward transmission to the police/court)?

xi. How was the evidence obtained, sealed, and preserved?

xii. Was there a chain of custody in place?

xiii. Who documented the injuries and how was this documented?

xiv. Who has the custody of the medical and laboratory reports?

(b) As a team, discuss the weaknesses identified and develop an action plan to address them.

(c) Monitor the action plan regularly at staff or team meetings and with supervisors; revise the action plan when new problems are identified and you are not able to solve them. Also keep track of the problems you have solved.

(d) If problems are persistent, explore new ways to perform the work, seeking assistance from CSOs or government, including mobilization of resources.

(e) Conduct team work and problem solving at the facility providing GBV services.

i. Ensure that all types of GBV service providers regularly meet to discuss challenges, provide support to each other, and continuously build GBV capacity.

ii. Review data collected on GBV survivors. What type of GBV is most common in the local community? What does this imply in terms of the community education that should take place? Does the facility work with relevant GBO service providers (police, court, CSOs) to solve problems and obtain resources and other assistance?

iii. Include problems identified in the action plan.

iv. Ensure that team members have opportunities to work with each other to observe and learn from each other, as well as relax and provide support to each other.

v. Invite resource persons to provide continuing education or other capacity building.

(f) Conduct team work and problem solving outside the facility providing GBV services.

i. Meet with other GBV service providers (referral sites, police, court, CSOs involved in GBV) to discuss and solve problems identified by any of the partners.

ii. Ask other GBV service providers (CSOs, safe house staff, referral sites, police) to provide feedback on the services provided (what do survivors say about the services, is referral provided as needed, is sampling/chain of evidence done correctly to enable the police to prosecute the case, etc?).

iii. Ask other GBV stakeholders (for example, those who provide psycho-social counseling) to explore survivors' views on the services you provide. This can be done in a very simple manner:

- What did the survivor think about the services? Were they satisfied with the services? If not satisfied, what do they propose should be changed? If satisfied, what was it that they liked?
- Did the survivor feel well treated? If no, what should be changed?

Include suggestions in the action plan.

ANNEX 1: CONSENT FORM

Name of Facility: ………………………………………………………………………

I………………………………………………………………..authorize the above named health facility to perform the following:

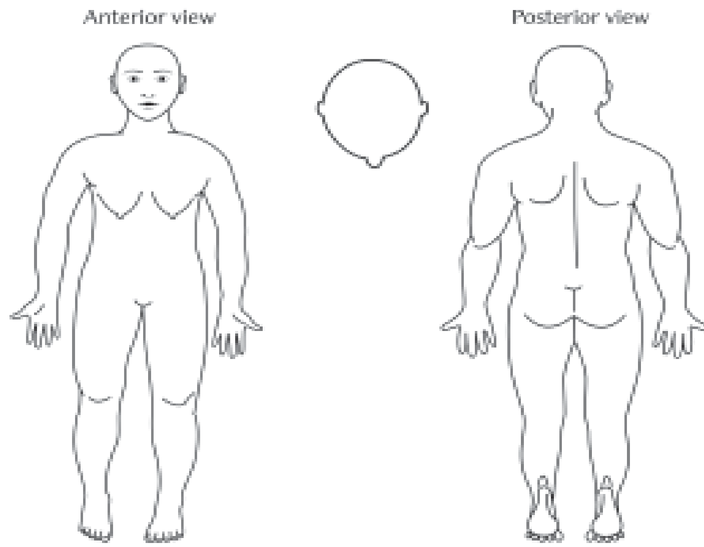
	Yes	No
Conduct a medical examination, including pelvic examination.		
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cutting of finger nails, blood samples, and photographs.		
Provide evidence and medical information to the police and law courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided.		

Signature:…………………………………………………………**Witness:**……………………..

Date: ______________________

ANNEX 2: PICTOGRAM

Sketch of person



Comments

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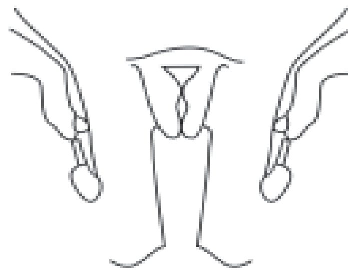
Female Genitalia



Male Genitalia

ANNEX 3: GBV MEDICAL FORM

Ministry of Health and Social Welfare
Examination Documentation Form For GBV Survivors

General Information	Name of Health Facility
Full Name(s)	Survivor Registration No
Date of Birth (MM/DD/YEAR)	Marital Status Single ○ Married ○ Divorced ○
Sex ☐ Male ☐ Female	Residence
Witness(es)	Contact (s)
Occupation	
Description Of Incidence	
Date of Assault MM DD YEAR	Time of Assault HOURS MIN AM PM
Place of Assault	Number of Assailant(s)
Alleged Assailants ☐ Unknown ☐ Known (indicate relationship with victim)	Type of Assault ☐ Sexual ☐ Physical ☐ Psychological
Presenting symptoms/complaints	Circumstances of incidence (penetration, how/where, and what was used?)
Did the assailant use of condom? ☐ No ☐ Yes	Did the survivor have bath? ☐ No ☐ Yes
Did the survivor vomited after assault? ☐ No ☐ Yes	Did the survivor go to toilet? ☐ No ☐ Yes
Is The Incident Reported Police? ☐ No ☐ Yes (Indicate the name Of station)	
Obs/Gyn History	
LNMP (Last Normal Mensural Period)	Gravida Parity
History of sexual intercourse prior this incidence? ☐ No	History of Pregnancy ☐ No ☐ Yes

☐ Yes	☐ Don't know
History of contraception ☐ No ☐ Yes (indicate the type(s))	Last sexual consensual intercourse MM DD YEAR
History of current sexual relationship ☐ No ☐ Yes	HIV status ☐ Positive ☐ Negative ☐ Unknown
Examination	Date Time MM DD YEAR HR MIN AM PM
Mental health state (comment(s)) ☐ Normal ☐ In shock ☐ Tearful ☐ Depressed	Anxious ☐ Confused ☐ Hyper arousal ☐ Coma ☐ Other(s)………………………………………………..
Physical Examination	
Comment on general condition of the survivor	☐ BP______________________mmHg ☐ Pulse Rate_______________beat/min ☐ Resp Rate_______________cycles/min ☐ Temp_______________0
Did the survivor changed clothes ☐ No ☐ Yes (where were the worn clothes taken?)……………..	State of the clothes ☐ Stains ☐ Tears ☐ Color
Any visible obvious injuries ☐ No ☐ Yes (if yes comment)………………	
Genital-Anal Examination	
Describe in details the physical state of the following structure(s):	
External genitalia	Cervix
Vaginal/hymen	Digital rectal examination
Other orifices (oral cavity, tongue, palate)	

Type of GBV Encountered	
Physical O Sexual O emotional O Physical and sexual O	
Emergency Treatment Given	
Stitching Surgery ☐ No ☐ Yes (comments)	Emergency contraception ☐ No ☐ Yes (indicate which drugs)
PEP ☐ No ☐ Yes	STI preventive treatment ☐ No ☐ Yes
Comment on any other medication/treatment/management given to the survivor:	
Laboratory Investigation	**Comments**
Urine-Pregnancy Test	
Microscopy	
Other(s)	
Vaginal Swab-Sperm	
Culture and sensitivity	
Blood	
DNA	
VDRL	
Hepatitis B surface antigen	
Full blood picture	
Hemoglobin (HB)	
X matching	
Blood chemistry	
Serological test for HIV	
Anal Swab	
Other(s)……………………………..	
Survivor Referred To…	
☐ Police Station	

☐ VCT Clinic ☐ HIV Clinic ☐ Other (s) (specify)……………………..	
Remarks	
Name and signature of examining doctor Name: ______________________________ Signature______________________________	Date
Name and signature of examining nurse Name: ______________________________ Signature______________________________	Date
END	

ANNEX 4: POLICE FORM THREE (PF3)

Tanzania Police Medical Examination Report

No.________________________
From____

THE MEDICAL OFFICER
_____________20____

Sir,

I have the honor to request the favor of your examination
____
____
____
___________________sent to hospital on the
____20___________

And of your furnishing me with a report or overleaf of the nature and extent of harm sustained by the said____

I have the Honor to be
Sir,
Your obedient servant

Signature_____________________________
(P.T.O.)

1	2	3	4	5
Nature of injury (physical or psychological) (e.g., cut or bruise, internal or external)	**Size of Injury** (in cms for length and depth)	**Part of the Body** (where inflicted or penetrated)	**Level of Harm** (harm, dangerous harm, grievous harm)	**By What Means** (weapons or organ inflicted)

Definitions

- "Harm" means any bodily hurt, disease, or disorder, whether permanent or temporary.
- "Dangerous harm" means harm endangering life.
- "Grievous harm" means any harm that amounts to a maim or that is "likely so to injure health, or which extends to permanent disfigurement, or to any permanent or serious injury to any eexternal or internal organ, member, or sense."
- "Maim" means the distraction or permanent disabling of any external organ, member, or sense.

NOTE- If in opinion of the Medical Officer, any harm which is
List "dangerous" or "grievous" at the time of examination
Eventually become "dangerous" or grievous." Note to that effect should be made under "Remarks

Remarks

Medical Officer ____

ANNEX 5: GBV REGISTER

Sn	Name	Sex	Age	Address	Occupation	Marital Status M=married S=single D=Divorced SE=separated	Next of Kin	Type Of Violence P = Physical S = Sexual E = Emotional			Type of Treatment Given P = Physical PEP = post-exposure prophylaxis STI = sexually transmitted infection EC = emergency contraception				Referral
								P	S	E	P	PEP	STI	EC	

Sn	Name	Sex	Age	Address	Occupation	Marital Status M=married S=single D=Divorced SE=separated	Next of Kin	Type Of Violence P = Physical S = Sexual E = Emotional			Type of Treatment Given P = Physical PEP = post-exposure prophylaxis STI = sexually transmitted infection EC = emergency contraception				Referral
								P	S	E	P	PEP	STI	EC	

ANNEX 6: LABORATORY INVESTIGATION FOR GBV

Levels of Health Care Facility	Investigations for Medical Treatment	Investigations for Forensic Purposes
Dispensary	**Blood** *Hemoglobin (Hb) level:* Use XXX to ascertain the extent of blood loss. *HIV infection:* The HIV test should be performed using a National HIV Testing algorithm using a screening test (determine and SD Bio-line) that will include pre - and post-test counseling; this test will allow the provider to know the HIV status of the survivor before taking PEP. *Sexually transmitted infections (STIs):* The syndromic approach for management of STIs can be done using national guidelines; however, some tests like Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection. *Hepatitis B infection:* Depending on the availability of a laboratory and test, an Hepatitis B test should be performed. *Full blood picture (FBP):* In facilities with a laboratory, perform FBP as per the clinician's opinion. *Culture and sensitivity:* In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated. **Urine** A urine pregnancy test (UPT) can be performed at all levels to test for pregnancy, Pregnancy testing in case of sexual assault for women of reproductive age; health care providers	Collection of evidence should be done as soon as possible (within 72 hours) and can be done concurrently with an examination of the survivor. Collection and securing of forensic evidence (sperm collection and other specimens and materials for testing in other facilities) should be done where possible. **Sperm analysis** *Sperm and seminal fluid:* Specimens from the vagina, anus, or oral cavity (if ejaculation took place in these locations) should be taken to look for the presence of sperm and for prostatic acid phosphatase analysis collection of wet fluids for wet preparation—spermatozoa **DNA testing** Sample collection for DNA testing should only be taken in the health facilities where it can be processed and later analyzed. Samples needed for DNA tests include blood, saliva, and a vaginal swab for sperms. Others include foreign hair found on the survivor's clothes or body, pubic, and head hair from the survivor is plucked or cut for comparison. Blood from the survivor is compared with blood of the perpetrator in addition to saliva, sperm, and other biological materials such as a mouth swab; urine of both the victim and the suspect; pubic and/or head hair; foreign fibers, grass, and soil; blood; semen; fingernails, scrapping or clippings; and bite marks left by the perpetrator on the survivor's body or at the crime scene.

	Other Tests *X-ray:* In case of fractures. *Radio-imaging:* In case of inner pathological conditions.	Other important materials include clothing, sanitary pads, handkerchiefs, condoms, bite marks, semen stains, fingernail cuttings, and swab samples from relevant orifices.
Health centre	**Blood** *Hemoglobin (Hb) level:* Use XXX to ascertain the extent of blood loss. *HIV infection:* The HIV test should be performed using a National HIV Testing algorithm using a screening test (determine and SD Bio-line) that will include pre- and post-test counseling; this test will allow the provider to know the HIV status of the survivor before taking PEP. *Sexually transmitted infections (STIs):* The syndromic approach for management of STIs can be done using national guidelines; however, some tests like Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection. *Hepatitis B infection:* Depending on the availability of a laboratory and test, a Hepatitis B Test should be performed. *Full blood picture (FBP):* In facilities with a laboratory, perform FBP as per a clinician's opinion. *Culture and sensitivity:* In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated. **Urine** A urine pregnancy test (UPT) can be performed at all levels to test for pregnancy, Pregnancy testing in case of sexual assault for women of reproductive age; health care providers	Collection of evidence should be done as soon as possible (within 72 hours) and can be done concurrently with an examination of the survivor. Collection and securing of forensic evidence (sperm collection and other specimens and materials for testing in other facilities) should be done where possible. **Sperm analysis** *Sperm and seminal fluid:* Specimens from the vagina, anus, or oral cavity (if ejaculation took place in these locations) should be taken to look for the presence of sperm and for prostatic acid phosphatase analysis collection of wet fluids for wet preparation—spermatozoa **DNA testing** Sample collection for DNA testing should only be taken in the health facilities where it can be processed and later analyzed. Samples needed for DNA tests include blood, saliva, and a vaginal swab for sperms. Others include foreign hair found on the survivor's clothes or body, pubic, and head hair from the survivor is plucked or cut for comparison. Blood from the survivor is compared with that of the perpetrator in addition to saliva, sperm, and other biological materials such as a mouth swab; urine of both the victim and the suspect; pubic and/or head hair; foreign fibers, grass, and soil; blood; semen; fingernails, scrappings, or clippings; and bite marks left by the perpetrator on the survivor's body or at the crime scene.

	Other Tests *X-ray:* In case of fractures. *Radio-imaging:* In case of inner pathological conditions.	Other important materials include clothing, sanitary pads, handkerchiefs, condoms, bite marks, semen stains, fingernail cuttings, and swab samples from relevant orifices.
District Hospital	**Blood** *Hemoglobin (Hb) level:* Use XXX to ascertain the extent of blood loss. *HIV infection:* The HIV test should be performed using a National HIV Testing algorithm using a screening test (determine and SD Bio-line) that will include pre- and post-test counseling; this test will allow the provider to know the HIV status of the survivor before taking PEP. *Sexually transmitted infections (STIs):* The syndromic approach for management of STIs can be done using national guidelines; however, some tests like Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection. *Hepatitis B infection:* Depending on the availability of a laboratory and test, a Hepatitis B test should be performed. *Full blood picture (FBP):* In facilities with a laboratory, perform FBP as per a clinician's opinion. *Culture and sensitivity:* In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated. **Urine** A urine pregnancy test (UPT) can be performed at all levels to test for pregnancy, Pregnancy testing in case of sexual assault for women of reproductive age; health care providers **Other Tests** *X-ray:* In case of fractures.	Forensic investigations (collection of wet fluids for wet preparation—spermatozoa), radiology and imaging, CD4 counts, liver function testing, renal function testing, full blood picture, and others as per clinical acumen) **Blood** 1. Hepatitis B infection Depending on availability of a laboratory and test, a Hepatitis B test should be performed. 2. HIV infection The HIV test should be performed using a National HIV Testing algorithm that will include pre- and post-test counseling. 3. Hemoglobin level To ascertain the extent of blood loss. 4. Sexually transmitted infections (STIs) Some STIs can be managed using national guidelines on the STIs Syndromic Approach; in addition, Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection. 5. Full blood picture (FPB) In facilities with a laboratory, perform FBP as per a clinician's opinion. 6. Culture and sensitivity In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated. **Urine** 7. Pregnancy

	Radio-imaging in case of inner pathological conditions	A urine pregnancy test can be performed at all levels to test for pregnancy.
Regional Hospital	**Blood** *Hemoglobin (Hb) level:* Use XXX to ascertain the extent of blood loss. *HIV infection:* The HIV test should be performed using a National HIV Testing algorithm using a screening test (determine and SD Bio-line) that will include pre- and post-test counseling; this test will allow the provider to know the HIV status of the survivor before taking PEP. *Sexually transmitted infections (STIs):* The syndromic approach for management of STIs can be done using national guidelines; however, some tests like Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection. *Hepatitis B infection:* Depending on the availability of a laboratory and test, a Hepatitis B test should be performed. *Full blood picture (FBP):* In facilities with a laboratory, perform FBP as per a clinician's opinion. *Culture and sensitivity:* In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated. **Urine** A urine pregnancy test (UPT) can be performed at all levels to test for pregnancy, Pregnancy testing in case of sexual assault for women of reproductive age; health care providers **Other Tests** *X-ray:* In case of fractures. *Radio-imaging:* In case of inner pathological conditions.	Collection of evidence should be done as soon as possible (within 72 hours) and can be done concurrently with examination of the survivor. Collection and securing of forensic evidence (sperm collection and other specimens and materials for testing in other facilities) should be done where possible. **Sperm analysis** *Sperm and seminal fluid:* Specimens from the vagina, anus, or oral cavity (if ejaculation took place in these locations) should be taken to look for the presence of sperm and for prostatic acid phosphatase analysis collection of wet fluids for wet preparation—spermatozoa **DNA testing** Sample collection for DNA testing should only be taken in the health facilities where it can be processed and later analyzed. Samples needed for DNA tests include blood, saliva, and a vaginal swab for sperms. Others include foreign hair found on the survivor's clothes or body, pubic, and head hair from the survivor is plucked or cut for comparison. Blood from the survivor is compared with that of the perpetrator in addition to saliva, sperm, and other biological materials such as a mouth swab; urine of both the victim and the suspect; pubic and/or head hair; foreign fibers, grass, and soil; blood; semen; fingernails, scrappings, or clippings; and bite marks left by the perpetrator on the survivor's body or at the crime scene. Other important materials include clothing, sanitary pads, handkerchiefs, condoms, bite marks, semen stain, fingernail cuttings, and swab samples from relevant orifices.

<table>
<tr>
<td>Consultant Hospital</td>
<td>Blood
Hemoglobin (Hb) level: Use XXX to ascertain the extent of blood loss.

HIV infection: The HIV test should be performed using a National HIV Testing algorithm using a screening test (determine and SD Bio-line) that will include pre- and post-test counseling; this test will allow the provider to know the HIV status of the survivor before taking PEP.

Sexually transmitted infections (STIs): The syndromic approach for management of STIs can be done using national guidelines; however, some tests like Rapid Plasmin Reagin (PRR) or VDRL can be performed to test for a syphilis infection.

Hepatitis B infection: Depending on the availability of a laboratory and test, a Hepatitis B test should be performed.

Full blood picture (FBP): In facilities with a laboratory, perform FBP as per a clinician’s opinion.

Culture and sensitivity: In facilities with a good laboratory, blood or swab for culture and sensitivity can be performed if indicated.

Urine
A urine pregnancy test (UPT) can be performed at all levels to test for pregnancy, Pregnancy testing in case of sexual assault for women of reproductive age; health care providers

Other Tests
X-ray: In case of fractures.
Radio-imaging: In case of inner pathological conditions.</td>
<td>Collection of evidence should be done as soon as possible (within 72 hours) and can be done concurrently with an examination of the survivor.

Collection and securing of forensic evidence (sperm collection and other specimens and materials for testing in other facilities) should be done where possible.

Sperm analysis
Sperm and seminal fluid: Specimens from the vagina, anus, or oral cavity (if ejaculation took place in these locations) should be taken to look for the presence of sperm and for prostatic acid phosphatase analysis collection of wet fluids for wet preparation—spermatozoa

DNA testing
Sample collection for DNA testing should only be taken in the health facilities where it can be processed and later analyzed.

Samples needed for DNA tests include blood, saliva, and a vaginal swab for sperms. Others include foreign hair found on the survivor's clothes or body, pubic, and head hair from the survivor is plucked or cut for comparison.

Blood from the survivor is compared with that of the perpetrator in addition to saliva, sperm, and other biological materials such as a mouth swab; urine of both the victim and the suspect; pubic and/or head hair; foreign fibers, grass, and soil; blood; semen; fingernails, scrappings, or clippings; and bite marks left by the perpetrator on the survivor’s body or at the crime scene.

Other important materials include clothing, sanitary pads, handkerchiefs, condoms, bite marks, semen stain, fingernail cuttings, and swab samples from relevant orifices.</td>
</tr>
</table>

ANNEX 7: MENTAL HEALTH CHECKLIST

Assessment of psychological symptoms when necessary.

i. **Depression:** The person is often sad, irritable, or angry; has feelings of hopelessness; stops pleasurable activities; looses or gains weight loss; looses sleeping or oversleeps; does not feel like eating; experiences fatigue, energy loss, poor concentration, and low self-esteem; makes statements such as "nobody likes me or I'm stupid"; is very self-critical; and becomes socially withdrawn.

ii. **Anxiety:** The person feels restless, has trouble sleeping, looses sleep, is nervous, has specific fears like fear of dying, experiences heart racing or trouble breathing, is irritable, will not leave caregiver's side, has nausea, or will not go to school or leave home.

iii. **Mood problem:** The survivor has great difficulty regulating his/her mood and emotional states, is unable to soothe him/herself (most of the time), has drastic mood swings, engages in high-risk behaviors, exhibits alternating mood extremes ("highs" and "lows") frequently, or may often be physically aggressive.

iv. **Suicidal ideation/behavior:** The survivor expresses hopelessness/wish to be dead or attempts to harm himself/herself. If the survivor has these symptoms, gather a detailed history of suicidal behavior (how many times was suicide attempted? Methods of attempts? Current plan for suicide?), and make an immediate referral to a psychiatrist.

v. **Substance Abuse:** The person has erratic behaviors, has a sudden change in school performance, engages in risk-taking and dangerous behaviors, or appears intoxicated.

vi. **Psychosis:** The survivor experiences thought disorganization, hears "voices" in head other than his/her own voice, sees things (people, objects) that are not really there, has very poor hygiene, exhibits disorganized behavior, delusions and speech disorders

ANNEX 8: ADHERENCE COUNSELING GUIDE

Discuss treatment adherence with child and family/guardian/caregiver.

i. Educate on the need to prevent HIV and other illnesses by adhering to treatment.
ii. Provide information on GBV conditions, covering all aspects, and provide medical information to children/adolescents in an age-appropriate manner.
iii. Give information to children in a manner that they will understand.
iv. Discuss the benefits of adherence and consequences of non-adherence.
v. Discuss the barriers to treatment adherence.
vi. Discuss current methods used to enhance treatment adherence (medication diary, reminders, alarm, and buddy?).
vii. Appoint someone to be in charge of medication dispensing.
viii. Discuss the importance of using a family system during the treatment process to enhance adherence.
ix. Discuss the importance of all family members getting involved and helping with a child's treatment; particularly with taking medications at home.
x. Work closely with the child and caregivers in addressing treatment adherence.
xi. Remind the parent or caretaker about the benefits of ARVs in prophylaxis of HIV, in that by preventing HIV infection, ARVs help children to live full and productive lives.

ANNEX 9: PSYCHOSOCIAL SUPPORT GUIDES

(a) Basic Psychosocial Interventions Guide (Child)

These are basic psychosocial interventions that you may find helpful during treatment:

i. Ensure treatment confidentiality.

ii. Employ active listening; really listen to what the child and caregiver is saying; paraphrase what they say and repeat back [What I hear you saying is…(REPEAT what client has said)…do I have it right?].

iii. Be non-judgmental; understand that most often your survivors are trying to do the best they can.

iv. Regularly check in with caregivers and the child about how treatment is proceeding. What is working well? What is not working so well? Where do you need help?

v. Always praise caregivers and the child for coming to treatment.

vi. Always encourage caregivers and the child to talk with each other during sessions about disclosure issues, feelings, fears, stigma, loss, successes, treatment adherence, joys, etc.

vii. Always encourage and coach interactions between the child and caregivers; try not to talk to the child for the caregiver or to the caregiver for the child if child or caregiver is in distress; spend some time listening to what is upsetting them.

viii. Strategize with caregivers on how to increase their/child's social/community support system.

ix. Refer the child and caregivers to various support groups.

x. Develop support groups in your clinic (for children, adolescents, caregivers, siblings of children with HIV).

xi. Refer the child to a psychiatrist or other mental health professional when the child or family presents with symptoms/problems that require ongoing psychosocial intervention.

xii. Help children and caregivers establish a vision of what they want for their future; instill hope and regularly discuss survivors' level of motivation toward treatment.

xiii. Use role plays often in sessions to help children and caregivers; practice initiating the disclosure process and practice/develop healthy communication.

(b) Pre-Test Counseling Guide

i. During the pre-test counseling session, the client is prepared for the test by a Counselor to receive pertinent information on HIV/AIDS and assess his/her readiness to take the test.

ii. The client is also given the opportunity to consider the meaning and impact of the test results on his/her life.

iii. No HIV test shall be performed without pre-test counseling.

iv. The Counselor will explore the reasons for a client's decision to test, conduct a personalized risk assessment and jointly develop a risk-reduction plan with the client, provide assurance of confidentiality, and inform the client on the manner in which the test results will be communicated.

v. To ensure a proper risk assessment in addition to the client's own perception of risk, it is important that the Counselor assesses the actual level of risk by asking explicit questions about the client's various practices, including sexual practices, drug using practices, occupational practices, and whether the client has undergone blood transfusion or any other surgical procedure.

(c) Post-Test Counseling Guide

Post-test counseling takes place after the test for HIV has been done. After being tested, the client is counseled again to prepare him/her to receive and cope with the test results.

In this counseling session, the Counselor will also work with the client to develop a risk-reduction plan for those who test negative and steps that the client can take to live positively for those who test positive.

Revealing test results is the most critical stage in the VCT process. HIV test results should be given within the shortest possible time. Delaying test results may result in clients' not coming back for them.

i. The Counselor shall ensure that the client is ready to receive the test results.

ii. The Counselor shall provide the test results in a manner that leaves no room for ambiguous interpretation.

iii. The Counselor shall disclose the test results directly, slowly, and in an even tone of voice, as devoid of emotion as it is possible under the circumstances.

iv. Test results are given verbally only to the tested client, and after adequate preparation.

v. Written test results MUST be certified by a registered laboratory technician or pathologist.

vi. Occasionally, a client may wish to have his/her test results communicated by telephone. While this may not be a major problem if the test is negative, if the test is positive, it may provide a loophole for erosion of confidentiality. Test results must NOT be communicated by telephone.

vii. The Counselor shall provide supportive counseling regardless of HIV test results.

viii. The Counselor shall review risk-reduction strategies developed during pre-test counseling and support their implementation.

ix. Clients who test negative shall be counseled to remain negative through reinforcement/adoption of safe sexual behavior and/or adherence to infection prevention practices.

x. For clients who test positive, the Counselor shall discuss a plan to reduce further HIV exposure risk and prevent HIV infection to others.

xi. The Counselor shall discuss strategies for partner disclosure and support their implementation.

xii. The Counselor shall discuss with the client the potential implications the test results might have for the individual and for his/her spouse and family.

xiii. The Counselor shall inform the client about relevant care and support services that exist depending on the client's needs.

xiv. The Counselor shall link clients to support groups such as those for PLHIV and post-test clubs or assist them to form such groups.

xv. The Counselor and the client shall agree on the need for follow-up counseling and schedule more sessions.

xvi. The client shall be given the option to return for further counseling as the need arises.

(d) Trauma Counseling Guide

i. Definition of rape trauma counseling

Counseling is a collaborative effort between a counselor and a client aimed at identifying goals and potential solutions to problems that cause emotional turmoil, improving communication and coping skills, strengthening self-esteem, and promoting behavior change and optimal mental health.

Trauma counseling is a key component in comprehensive GBV care services. The main purpose of counseling is to empower the survivor to be able to cope and continue living a normal life. Counseling helps to reduce the effects of GBV trauma syndrome, a condition comprising a group of symptoms commonly seen in rape and other GBV survivors.

ii. Rape trauma syndrome has the following symptoms:

Physical symptoms: Shock, feeling cold, fainting, confusion and disorientated trembles, nausea, and sometimes vomiting.

Behavioral symptoms: Crying more than usual, difficulty concentrating, restlessness and agitation, unable to relax, unmotivated, withdrawn, stuttering and stammering, avoidance of reminders, easily startled or frightened, very alert and watchful, easily upset by small things, frequently disagrees with family, friends etc, fear of sex or loss of sexual pleasure, change in lifestyle, increase in substance abuse, increased washing or bathing, or denial as if nothing had happened.

Psychological symptoms: Increased fear and anxiety, self-blame and guilt, helplessness, no longer feeling in control of life, humiliation and shame, lowered self-esteem, feeling dirty, anger, feeling alone and that no one understands, losing hope for the future, emotional numbness, confusion, memory loss, constantly thinking about rape, flashbacks to the rape, feeling it is happening again, nightmares, depression, and suicidal ideas.

iii. Rape trauma syndrome in children has the following symptoms:

- Recurrent memories or flashbacks of the incident
- Nightmares
- Insomnia
- Mood swings
- Difficulty concentrating
- Panic attacks
- Emotional numbness
- Depression

ANNEX 10: SUMMARY OF PREVENTIVE TREATMENTS

Disease/ Condition	Preparation	Drugs	Dose	Time Frame
HIV	Healthcare provider should do HIV counseling and testing and give the results to the GBV survivor. Survivor who tests negative for HIV infection should be offered post-exposure prophylaxis (PEP) when the violation is rape, defilement, or forced anal penetration. This will reduce the chance of HIV infection. The first dose of PEP should be given at the first contact Pre-test counseling Rapid HIV testing Eliza test for HIV Post-test counseling Adherence counseling for ARVs	*First Line* AZT + 3TC: Zinovudine Lamuvidine	 300 mg 150 mg	 Twice a day for 28 days Twice a day for 28 days
		Second Line D4T + 3TC: Stavudine (only if a fridge is available) Lamuvudine	 40 mg 150 mg	 Twice a day for 28 days Twice a day for 28 days
STIs	*Counseling and education on STIs* The preventive empirical treatment for STIs should be given to all vaginal rape cases, forced anal penetration, and defilement. Laboratory tests for STIs should be done for all rape cases, defilement, and forced anal penetration for purposes of medical records and management. STIs can be used to link an offender to the crime, particularly chlamydia and gonorrhea. In the case of oral sex. Treatment of STIs should follow the national guidelines using available STI drugs in the health facilities.	*Non-pregnant adults male or Female* 1. Norfloxacin 2. Doxycycline	 800 mg 100mg BD	 Stat One week
		Pregnant woman Spectinomycin Amoxicillin + Probenecid Erythromycin	 2g 3g 1g 500mg QDS	 Stat Stat Stat One week
		Children Amoxicillin Erythromycin 2nd Hep B dose 3rd Hep B dose	 15mg/kg TDS 10mg/kg QDS 1 month after 1st Hep B dose 5 months after 2nd Hep B dose	 One week One week 1–3 years 10 years
Pregnancy	Counseling and education on emergency contraceptives (ECs) should be offered to non-pregnant female GBV survivors of child-bearing age. EC is most effective when given within 120 hours (5 days) of the assault. Girls who have started menstruating and have secondary	Progestin only pills: Postinor 2	1-tabs 12 hours apart (total 2 tabs) or 2-tabs at a go	
		Combined oral contraceptive pills with high dose of oestrogen	2-tabs 12 hours apart (total 4 tabs)	

Disease/ Condition	Preparation	Drugs	Dose	Time Frame
	sexual characteristics are at risk of precocious puberty and should also receive EC. A baseline pregnancy test should be done first; though, this should not delay the dose of EC. The sooner EC is given after the rape, the more effective it will be. A follow-up pregnancy test should be done after 6 weeks of the incident (at the follow-up visit) whether or not they took EC after the rape. Note! For GBV survivors who are sexually active and who do not want to become pregnant, the healthcare provider should address the issue of contraception. If the survivor desires a method, the provider should provide family planning counseling and the desired method as per national guidelines. If the survivor did not select a method at the initial visit, the provider and/or counselor must offer FP counseling and services at the follow-up visit. They must refer the client if the selected method is not available in the facility.	(50µg): Oral		
		Combined oral contraceptive pills with low dose of oestrogen (30µg): Nordette or IUCD	4-tabs 12 hours apart (total 8 tabs)	
		Ideally, an anti-emetic should be given about 30 minutes before: Plasil	10mg stat., then as needed.	
Tetanus		Tetanus Toxoid Vaccine (TT) *Dosing Schedule:* 1st TT dose 2nd TT dose 3rd TT dose 4th TT dose 5th TT dose	*Administration Schedule:* At first contact 1 month after 1st TT 6 months after 2nd TT 1 Year after 3RD TT 1 Year after 4th TT	*Duration of Immunity conferred:* Nil 1–3 years 5 years 10 years 20 years

ANNEX 11: GBV INDICATORS FOR THE HEALTH SECTOR

1. Facility Level

1.1 Number of persons provided with GBV services at a health facility by type of services, age, and sex

1.2 Number of healthcare providers trained to provide GBV services

1.3 Number of healthcare providers oriented on GBV management guidelines

2. District Level

2.1 Number of persons provided with GBV services at a health facility by type of services, age, and sex

2.2 Proportion of health facilities with healthcare providers trained to provide GBV services

2.3 Proportion of health facilities with healthcare providers oriented on GBV management guidelines

2.4 Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV)

2.5 Proportion of health facilities that have essential supplies and equipment for the management of GBV

3. Regional Level

3.1 Number of persons provided with GBV services at the district level by type of services, age, and sex

3.2 Proportion of health facilities with healthcare providers trained to provide GBV services by district

3.3 Proportion of health facilities with healthcare providers oriented on the GBV management guidelines by district

3.4 Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) by district

3.5 Proportion of health facilities that have essential supplies and equipment for management of GBV by district

4. Ministry Level

4.1 Number of persons provided with GBV services at regional level by type of services, age, and sex

4.2 Proportion of health facilities with healthcare providers trained to provide GBV services by region

4.3 Proportion of health facilities with healthcare providers oriented on the GBV management guidelines by region

4.4 Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) by region

4.5 Proportion of health facilities that have essential supplies and equipment for the management of GBV by region

ANNEX 12: CLASSIFICATION OF GBV INJURIES ACCORDING TO OUTCOME

Severely Fatal Outcomes	Moderately Fatal Outcomes	Mildly Fatal Outcomes	Nonfatal Outcomes
• Femicide • Suicide • AIDS-related mortality • Maternal mortality	• Physical injuries • Chronic conditions • Fractures • Abdominal/thoracic • Injuries • Chronic pain syndromes • Fibromyalgia • Permanent disability • Gastrointestinal disorders • Irritable bowel syndrome • Lacerations and abrasions • Ocular damage • Sexual and reproductive sequelae	• Gynecological disorders • Pelvic Inflammatory disease • Sexually transmitted infections, including HIV • Unintended pregnancy • Pregnancy complications • Miscarriage/low-birth weight • Sexual dysfunction • Abortion • Psychological and behavioral outcomes • Depression and anxiety	• Eating and sleep disorders • Drug and alcohol abuse • Phobias and panic disorder • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Self-harm • Unsafe sexual behavior

HEALTH POLICY
INITIATIVE