GENDER-BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN

JOB AIDS

FOR HEALTH CARE PROVIDERS AND SOCIAL WELFARE OFFICERS

MAY 2017
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FOREWORD

Gender-based violence (GBV) has gained international recognition as a grave social and human rights concern. In Tanzania, GBV and violence against children (VAC) have become major problems due to negative cultural beliefs and practices, existing gender norms, and economic, social, and gender inequalities. Victims of GBV and VAC can be any age and sex, including women, men, girls, and boys. GBV includes but is not restricted to sexual acts. GBV and VAC are related to socially defined norms of gender and sexual identity and can be carried out by intimate partners, family members, community members, people of authority, and others. These acts can take place at home, in public, or in health care settings.

The World Health Organization’s 2005 Multi-Country Study (WHO 2005) and the 2010 Tanzania Demographic and Health Survey (TDHS) (NBS 2011a) provided evidence for the need to engage the health sector in GBV prevention and response services. The TDHS found that over 20 percent of Tanzanian women aged 15–49 years reported having experienced sexual violence in their lifetime; nearly 40 percent reported having experienced physical violence. The survey also indicates that 44 percent of ever-married women had experienced physical or sexual violence from an intimate partner in their lifetime. A nationally representative survey of violence against children (UNICEF 2011) also found that 75 percent of girls and boys had experienced physical violence (from a relative, authority figure, or intimate partner) by the age of 18 years and nearly 3 in 10 girls had experienced sexual violence before reaching adulthood (NBS 2011b).

The Tanzania Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) revised these Job Aids to provide updated guidance to trainers of health care providers and social welfare officers on the provision of effective and comprehensive services to GBV and VAC survivors. The revision was based on the GBV and VAC Competency-Based Education and Training, which was also revised in 2016. The rationale for the revision was to align the Training Package with newly documented evidence (WHO/ILO 2009; WHO 2014) and several advancements made on provision of quality GBV and VAC services since 2011 when the original Tanzania GBV and VAC Training Package was produced. The entire GBV and VAC training package has been updated in line with the newly documented evidence, which includes the HIV post-exposure prophylaxis (PEP) regimen (WHO 2014), World Health Organization Clinical and Policy Guidelines (WHO 2013), and guidance on responding to intimate partner violence and sexual violence against women (WHO 2013), as well as the National New PEP Guidelines (NACP 2015).

Much progress has been made in Tanzania in GBV and VAC prevention and response. Advances include, among others, development and implementation of national policy, management, and clinical guidelines; increased number of health facilities that provide post GBV and VAC services to survivors; increased number of survivors who are accessing health, social welfare, and legal services; and reduced incidences of GBV and VAC in some areas of the country. These guidelines have provided the framework and guidance for integrating GBV services into health services, linking health facilities and local communities, developing
social and legal protection systems, improving medical management, referral for psychosocial care, development of monitoring and evaluation (M&E) indicators and tools, as well as guidelines for multisectoral coordination (health, social welfare, police, legal, and community) of GBV and VAC prevention and response efforts.

Despite these achievements, challenges remain, including the lack of, or limited access to, health, psychosocial, and legal services; shortage of trained medical professionals; shortage of shelters for survivors; limited clinical mentorship; limited onsite sensitization on integrating GBV and VAC in health service provision; and limited number of health care providers and social welfare officers knowledgeable about comprehensive GBV and VAC services. The MOHCDGEC is taking the necessary measures to address these challenges because effective and comprehensive medical and psychosocial care for survivors require health care providers and social welfare officers to have appropriate competencies and skills in preventing acts of violence and providing the needed care to GBV and VAC survivors.

It is my hope that the use of these Job Aids will provide guidance, effective facilitation and learning modalities, knowledge, and skills required for GBV and VAC service trainers. The ultimate goal of this guide is to facilitate the creation of a pool of qualified health care providers and social welfare officers with competencies in providing quality comprehensive services to GBV and VAC survivors.

Prof. Muhammad Bakari Kambi
Chief Medical Officer
ACKNOWLEDGMENTS

The revision of these Job Aids were made possible through the cooperation and expertise of many government institutions, nongovernmental organizations, development partners, civil society organizations, and individuals, as well as by the generous support of the American people through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) with the U.S. Agency for International Development (USAID).

The MOHCDGEC expresses appreciation to the Government of the United States of America through the USAID/Tanzania and AIDSFree Project for their technical and financial support in reviewing and updating these Job Aids and all the related materials.

The ministry extends its appreciation to Dr. Grace Mallya, Coordinator for Gender Reproductive Health Program, and Dr. Beati Mboya, Chief of Party of AIDSFree Tanzania, for their overall leadership, guidance, and coordination in the entire process.

Special gratitude goes to all members of the task force listed below whose work and commitment produced this revised version of these Job Aids.

Last but not least, the ministry extends its special appreciation to Dr. Mangi J. Ezekiel, AIDSFree Technical Specialist, and Ms. Zuki Mihyo, AIDSFree GBV and HIV Specialist, for facilitating the review and updates of these Job Aids.

Dr. Neema Rusibamayila
Director of Preventive Services
A. OBTAINING CONSENT FROM GBV AND VAC SURVIVORS

Introduce yourself and explain your role in assisting the survivor and the importance of documenting the medical examination for the survivor’s records.

Provide information on the medical consequences related to GBV or VAC, including the risk of sexually transmitted infections (STIs), HIV, and pregnancy.

Inform the survivor (and family if appropriate) on the rights that correspond to GBV or VAC.

Explain the procedures for gathering forensic samples/evidence and that any evidence gathered may be used in court.

Strive to help the survivor understand your explanation.  
*Note that in some cases the survivor may be in a state that makes it difficult for him/her to comprehend.*

Obtain verbal consent from the survivor before performing every examination step.

Obtain written consent from the survivor using the consent form for:
- Conducting medical examinations (including genital and anal exams)
- Collecting forensic sample/evidence (body fluid, hair, scrapings, etc.)
- Providing forensic sample/evidence and information to the police/legal system
Children younger than 9 years have the right to give their informed opinion and be heard.

The social welfare officer shall seek alternative consent for the examination and any necessary treatment of the child.

- Consent may be provided by the child, where he or she is of sufficient maturity to understand why a medical examination and any necessary treatment should be undertaken.

- The determination of whether the child is of sufficient maturity shall lie with the doctor undertaking the examination. In any case where emergency treatment is required to prevent loss of the child’s life or to prevent permanent damage to the child, the doctor may proceed without the consent of either a parent or the child.

- In all other cases, where consent is not forthcoming, the social welfare officer may seek an order from the juvenile court under section 95(3)(a), permitting the medical examination to take place. Any such application shall be heard on the day that the application is made.

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

- Children between ages 14 and 16 are presumed to be mature enough to make a major contribution. Children between ages 9 and 14 can meaningfully participate in the decision-making procedure, but maturity must be assessed on an individual basis.

- Children younger than age 9 have the right to give their informed opinion and be heard. Views of the child should be weighed and decisions taken on a case-by-case basis, depending on his/her age, level of maturity, developmental stage, and cultural, traditional, and environmental factors.
**B. PROCEDURE FOR RECEIVING AND HANDLING GBV AND VAC SURVIVORS**

**B.1. RECEIVING AND HANDLING AN ADULT SURVIVOR**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Receive and conduct triage.</td>
</tr>
<tr>
<td>2.</td>
<td>Greet and welcome.</td>
</tr>
<tr>
<td>3.</td>
<td>Introduce yourself and establish rapport.</td>
</tr>
<tr>
<td>4.</td>
<td>Build up a supportive relationship with the survivor.</td>
</tr>
<tr>
<td>5.</td>
<td>Use polite and familiar language.</td>
</tr>
<tr>
<td>6.</td>
<td>Respect norms, customs, and values of the survivor.</td>
</tr>
<tr>
<td>7.</td>
<td>Seek the survivor’s consent in every step of engagement.</td>
</tr>
<tr>
<td>8.</td>
<td>Consider the safety and privacy of the survivor.</td>
</tr>
<tr>
<td>9.</td>
<td>Ask survivor for a brief explanation of his/her health issues.</td>
</tr>
<tr>
<td>10.</td>
<td>Show sensitivity, understanding, and willingness to listen to the survivor’s concerns.</td>
</tr>
<tr>
<td>11.</td>
<td>Take detailed history from the survivor and/or other informants, and establish facts.</td>
</tr>
<tr>
<td>12.</td>
<td>Examine the survivor in a safe and private area.</td>
</tr>
<tr>
<td>13.</td>
<td>Collect samples for medical and forensic purposes.</td>
</tr>
<tr>
<td>15.</td>
<td>Discuss the findings with the survivor.</td>
</tr>
<tr>
<td>16.</td>
<td>Provide medical and psychosocial care and support.</td>
</tr>
<tr>
<td>17.</td>
<td>Link the survivor to appropriate services available.</td>
</tr>
<tr>
<td>18.</td>
<td>Provide evidence to police if required for investigation.</td>
</tr>
<tr>
<td>19.</td>
<td>Provide referrals to other services if desired.</td>
</tr>
<tr>
<td>20.</td>
<td>Keep the survivor’s information confidential.</td>
</tr>
<tr>
<td>21.</td>
<td>Thank the survivor.</td>
</tr>
</tbody>
</table>
### B.2. PROCEDURE FOR RECEIVING AND HANDLING A CHILD SURVIVOR

1. Ensure survivor’s privacy.

2. Approach all children with extreme sensitivity and recognize their vulnerability.

3. Establish a neutral environment and rapport with the child before beginning the interview.

4. Establish the child’s developmental level in order to understand any limitations as well as appropriate interactions.

5. Stop the examination if the child indicates discomfort or withdraws permission to continue.

6. Prepare the child by explaining the examination and showing equipment.

7. Encourage the child to ask questions about the examination.

8. If the child is old enough, and it is deemed appropriate, ask whom s/he would like in the room for support during the examination.

9. Some older children may choose a trusted adult to be present.

10. Establish ground rules for the interview, including permission for the child to say s/he doesn’t know, to correct the interviewer, and the difference between truths and lies.

11. Ask the child to describe what happened, or is happening, to her/him in their own words.

12. Use open-ended questions and avoid leading questions.

13. Consider interviewing the child with the caretaker present and/or absent.

14. Examine the child survivor in a safe and private area.

15. Collect samples/evidence for medical and forensic purposes.


17. Provide medical and psychosocial care and support.

18. Link the child survivor and family to appropriate services available.

19. Provide evidence to police if required for investigation.

20. Provide referral to other services.

C. DEVELOPING THE SAFETY PLAN

• The safety plan is a guide for a survivors that should be developed in partnership with service providers to help ensure safety.

• The questions are meant as a guide or prompt so a plan can be put in place. Remember that it might not be safe for survivors to fill in safety plans and take copies home.

SAFETY IN THE RELATIONSHIP

• Avoid places with potential weapons (such as the kitchen) when abuse starts.
• Develop a list of people the survivor can turn to for help and inform if s/he is in danger.
• Ask neighbors or friends to call for help or police if they hear anything to suggest abuse.
• Identify places to hide important phone numbers, such as help line numbers.
• Plan for how to keep children safe when abuse starts.
• Teach children to find safety or get help, perhaps from neighbors or social welfare officers.
• Keep important documents in one place to take if a survivor needs to leave suddenly.
• Let someone know about the abuse so that it can be recorded (important for court cases).

SAFETY WHEN THE RELATIONSHIP IS OVER

Keep contact details for professionals who can provide support.

• Change phone numbers and door locks.
• Develop a plan to keep the survivor’s location secret from the perpetrator.
• Obtain non-molestation, exclusion, or restraining order.
• Talk to any children about the importance of staying safe.
• Ask the survivor’s employer for help ensuring safety while at work.

LEAVING IN AN EMERGENCY

• Pack an emergency bag and hide it in a safe place in case the survivor leaves in an emergency.
• Plan for whom to call and where to go (such as a temporary shelter or a relative’s home).
• Remember to take documents, medication, keys, and a photo of the abuser if available.
• Ensure access to a phone.
• Save as much money as possible in a safe location, even if just enough to pay for transport.
• Develop a transport plan.
• Take proof of the abuse, such as photos, notes, or details of people who know about it.
D. ADHERENCE COUNSELING TIPS

Provide information on GBV and HIV, covering all aspects, and provide medical information to the survivor in an age-appropriate manner.

Educate on the need to prevent HIV and other illnesses by adhering to treatment.

Discuss the benefits of adherence and consequences of nonadherence.

Discuss current methods used to enhance treatment adherence (medication diary, reminders, alarm, buddy).

Discuss the importance of using a family system during the treatment process to help ensure adherence.

Discuss the importance of all family members getting involved and helping with a child’s treatment, particularly with taking medications at home.
E. HIV TESTING SERVICES

E.1. PRE-TEST SESSION

The health care worker prepares the client for the test by providing pertinent information on HIV and AIDS and assesses his/her readiness to take the test. This

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

To ensure a proper risk assessment in addition to the client’s own perception of risk, it is important that the health care provider assesses the actual level of risk by asking explicit questions about the client’s behaviour, 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 procedures.
E.2. POST-TEST COUNSELING

The counselor will prepare client to receive the HIV test result and provide the result to the client.

If HIV-negative, post-exposure prophylaxis (PEP) is recommended as well as two follow-up HIV tests, at four weeks and three months. Counsel the client on HIV prevention.

If HIV-positive, refer the client/patient for regular management.
F. EMERGENCY CONTRACEPTION FOR SURVIVORS OF SEXUAL VIOLENCE

F.1. ATTENDING THE SURVIVOR

1. Ask the survivor about her last normal menstrual period and current contraception use.

2. Perform a pregnancy test as needed.

3. Offer counselling on emergency contraception (EC) so the survivor can make an informed decision.

4. If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian, who can help her take the regimen as required.

5. Offer emergency contraception to non-pregnant female GBV survivors of childbearing age and adolescents in the case of sexual violence within 120 hours.

6. Perform another pregnancy test six weeks after the incident at the follow-up visit, whether or not the survivor took EC after the rape.
### F.2 EMERGENCY CONTRACEPTION REGIMENS AND DOSES

<table>
<thead>
<tr>
<th>REGIMEN</th>
<th>DOSE</th>
</tr>
</thead>
</table>
| **Progestin-only pill (POP)**         | • Progestin only pills; Postinor 2® (Levonogestrel) 1 tab twice daily (or 2 tabs stat)  
                                         |     OR                                                                |
|                                      | • Progestin only pills; POP (Levonorgestrel/Norgestrel) 20 every 12 hours (total 40 tabs per day) for 1 day         |
| **Combined oral contraceptive (COC) pills** | Combined oral contraceptive pills with high dose of estrogen (50 μg); Ovral® 2 tabs every 12 hours (total 4 tabs per day) for 1 day |
|                                      | OR                                                                  |
|                                      | Combined oral contraceptive pills with high dose of estrogen (30 μg); Nordette® 4 tabs every 12 hours (total 8 tabs per day) for 1 day |
G. COLLECTING FORENSIC SAMPLES/EVIDENCE FROM GBV AND VAC SURVIVORS

G.1. GENERAL GUIDELINES

- The primary aim of a forensic examination is to collect samples/evidence that may link a suspected perpetrator with a crime.
- Collection of forensic samples/evidence should be combined with physical examination, to reduce repetition of procedures.
- When collecting specimens for forensic analysis, the following principles should be strictly adhered to.

<table>
<thead>
<tr>
<th>Avoid contamination</th>
<th>Wear protective gear at all times and carefully collect samples.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect specimens early</td>
<td>Collect specimens within 24 hours of the assault; after 72 hours yields are reduced considerably.</td>
</tr>
<tr>
<td>Handle appropriately</td>
<td>Ensure that specimens are packed, stored, and transported correctly.</td>
</tr>
<tr>
<td></td>
<td>Fluids should be refrigerated; anything else should be kept dry.</td>
</tr>
<tr>
<td></td>
<td>Use paper bags/envelopes for dry specimens.</td>
</tr>
<tr>
<td></td>
<td>Use plastic bags or bottles for liquids and wet specimens.</td>
</tr>
<tr>
<td>Label accurately</td>
<td>All specimens must be clearly labeled with the survivor’s name and date of birth, facility name, health worker’s name, type of specimen, and date and time of collection.</td>
</tr>
<tr>
<td>Ensure security</td>
<td>Specimens should be packed to ensure that they are secure and tamper-proof.</td>
</tr>
<tr>
<td></td>
<td>Only authorized people should be entrusted with specimens.</td>
</tr>
<tr>
<td>Maintain continuity</td>
<td>Record all subsequent handling of specimens done by different individuals. Maintain proper chain-of-custody procedure.</td>
</tr>
<tr>
<td>Document collection</td>
<td>Compile an itemized list in the patient’s medical notes or reports of all specimens collected and details of when, and to whom, they were transferred.</td>
</tr>
</tbody>
</table>
## G.2. Collecting Specimens

<table>
<thead>
<tr>
<th>Site</th>
<th>Material</th>
<th>Equipment</th>
<th>Sampling Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anus (rectum)</td>
<td>Semen</td>
<td>Cotton swabs and microscope slides</td>
<td>Use swab and slides to collect and plate materials. NOTE: Lubricate instruments with water, not lubricant.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lubeant</td>
<td>Dry swab after collection.</td>
</tr>
<tr>
<td>Blood</td>
<td>Drugs</td>
<td>Appropriate tube</td>
<td>Collect 5 ml venous blood.</td>
</tr>
<tr>
<td></td>
<td>DNA (survivor)</td>
<td>Appropriate tube</td>
<td>Collect 5 ml venous blood.</td>
</tr>
<tr>
<td>Clothing</td>
<td>Adherent foreign material</td>
<td>Paper bags</td>
<td>Dry swab after collection.</td>
</tr>
<tr>
<td></td>
<td>(e.g., semen, blood, hair, fibers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia</td>
<td>Semen</td>
<td>Sterile swabs and microscope slides</td>
<td>Use separate swabs and slides to collect and plate material collected from the external genitalia, vaginal vault, and cervix; lubricate speculum with water, not lubricant, or collect a blind vaginal swab. Clothing should be placed in a paper bag.</td>
</tr>
<tr>
<td></td>
<td>Blood</td>
<td>Sterile swabs and microscope slides</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pubic hair</td>
<td>Paper bags</td>
<td></td>
</tr>
<tr>
<td>Scalp hair</td>
<td>Comparison to hair found at scene</td>
<td>Sterile container</td>
<td>Pull approximately 20 hairs and place hair in sterile container.</td>
</tr>
<tr>
<td>Mouth</td>
<td>Semen</td>
<td>Sterile swabs, sterile container (for oral washings) or dental flossing</td>
<td>Swab multiple sites in mouth with one or more swabs. To obtain a sample of oral washings, rinse mouth with 5 ml water and collect in sterile container.</td>
</tr>
<tr>
<td></td>
<td>Blood</td>
<td>Sterile toothpick or similar or nail scissors/clippers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DNA (survivor)</td>
<td>Sterile swab</td>
<td></td>
</tr>
<tr>
<td>Nails</td>
<td>Skin, blood, fibers, etc. (from perpetrator)</td>
<td>Sterile toothpick or similar or nail scissors/clippers</td>
<td>Use the toothpick to collect material from under the nails or the nail(s) can be cut and the clippings collected in a sterile container.</td>
</tr>
<tr>
<td>Sanitary pads/tampons</td>
<td>Foreign material (e.g., semen, blood, hair)</td>
<td>Sterile container</td>
<td>Collect if used during or after vaginal or oral penetration.</td>
</tr>
<tr>
<td>Skin</td>
<td>Semen</td>
<td>Cotton swab</td>
<td>Swab sites where semen may be present.</td>
</tr>
<tr>
<td></td>
<td>Saliva (e.g., at sites of kissing, biting or licking), blood</td>
<td>Cotton swab</td>
<td>Dry swab after collection.</td>
</tr>
<tr>
<td></td>
<td>Foreign material (e.g., vegetation, matted hair, or foreign hairs)</td>
<td>Sterile swab or tweezers</td>
<td>Place material in sterile container (e.g., envelope, bottle).</td>
</tr>
<tr>
<td></td>
<td>Injuries</td>
<td>Pictogram</td>
<td>Record when there is physical harm or injuries.</td>
</tr>
<tr>
<td></td>
<td>Photo</td>
<td>Photo</td>
<td>Consult police for official photograph.</td>
</tr>
<tr>
<td>Urine</td>
<td>Drugs</td>
<td>Sterile container</td>
<td>Collect 100 ml urine.</td>
</tr>
</tbody>
</table>
## I. PROVIDING REFERRAL TO GBV AND VAC SURVIVORS

Identify and list all possible needs of survivors that may require referral, such as:
- Security and protection needs
- Legal needs
- Psychological needs
- Physical needs
- Medical needs

Create a local directory of all services for each of the possible needs listed above, including the following details:
- Type of service and institution conducting the service
- Location and address of the service
- Contact details of person(s) responsible
- Hours and days of service

Identify the cause for which the survivor needs to be referred for further attention/help.

Explain to the survivor/ (his/her family) about the importance of the referral and where the service is available in your local setting.

Obtain verbal consent from the survivor for the particular referral you intend to offer.

Provide the required referral using the official form and arrange for a follow-up.
J. CONDUCTING FOLLOW-UP ON REFERRED GBV AND VAC SURVIVORS

J.1. FOLLOW-UP FLOW CHART

GBV service provider/GBV focal point

Liaises with/goes to the village development committee/ten-cell leader/community leader on referral status

- Social welfare officer
- Police
- Lawyer
- Prosecutor if the case goes to court
- Magistrate
Coordination facilitates collaboration among multisectoral service providers.

Service providers need to be aware of the GBV and VAC services, stakeholders, and key people involved in GBV and VAC prevention available in their area.

Coordination establishes a strong network to ensure available services are maximized in caring for GBV and VAC survivors, including men and boys.
J.3. GOALS OF GBV AND VAC PREVENTION AND COORDINATION

- Promoting multisectoral participation
- Identifying and filling gaps
- Advocating for action (at all levels)
- Prioritizing urgent needs of the most at-risk GBV and VAC survivors, including men and boys experiencing violence
- Assigning roles and responsibilities
Determine the period when the assault occurred

Note: For rape or sexual assault, obtain informed consent, perform medical and forensic examination and key tests (STI and pregnancy) and counsel patient on trauma.

- **Less than 72 hours**
  - Consent denied
    - Test NOT done
      - PEP NOT RECOMMENDED
  - Consent given
    - Test PERFORMED
      - HIV NEGATIVE
        - (Source positive, unknown or in window period)
        - PEP RECOMMENDED
      - Perform follow up HIV testing at 4 weeks and 3 months
        - HIV NEGATIVE
          - Counsel on how to stay negative
        - HIV POSITIVE
          - *If positive at 4 weeks, continue with PEP and refer immediately

- **More than 72 hours**
  - PEP NOT RECOMMENDED
  - HIV POSITIVE
    - Refer patient/client for regular management
L. PROVIDING TRAUMA COUNSELING

L.1. PURPOSE

• Helps survivors understand what they are experiencing and explore ways to cope
• Can prevent longer-term mental health problems by quickly returning survivors to pre disaster levels of functioning
• Normalizes, validates, and affirms survivor’s reactions
• Offers practical assistance

Start after assessing the survivor and provide emergency care.

L.2. STEPS

<table>
<thead>
<tr>
<th>STEP</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic alliance/relationship building</td>
<td>• Ensure safety and confidentiality, welcome, greet, and acknowledge</td>
</tr>
<tr>
<td>Storytelling, remembrance, and mourning</td>
<td>• Preferred questions:</td>
</tr>
<tr>
<td></td>
<td>• “Where would you like to start?” or “How are you?”</td>
</tr>
<tr>
<td></td>
<td>• Avoid questions like “What happened?”</td>
</tr>
<tr>
<td></td>
<td>• Encourage survivor to tell his/her story.</td>
</tr>
<tr>
<td></td>
<td>• Help survivor to transform his/her traumatic memories, focusing on other aspects of client’s symptoms.</td>
</tr>
<tr>
<td>Reconnection</td>
<td>• Reconnect the survivor with self, family, and community.</td>
</tr>
<tr>
<td></td>
<td>• Assess and focus on strengths, interests, and goals.</td>
</tr>
<tr>
<td></td>
<td>• Establish and develop positive coping strategies.</td>
</tr>
<tr>
<td></td>
<td>• Build confidence, self-worth, and self-esteem.</td>
</tr>
<tr>
<td></td>
<td>• Reestablish roles and responsibilities.</td>
</tr>
<tr>
<td></td>
<td>• Foster and maintain good knowledge of and relationships with services in community, building pathways to education, support networks, leisure facilities, voluntary work, employment.</td>
</tr>
</tbody>
</table>

Remember:
• Each survivor is affected by a traumatic event differently and processes trauma differently.

• This implies that the counselor has to be nondirective, probing, encouraging the survivor to express what is important to him/her in the order and way he/she feels is natural.

• Trauma counseling may not be completed in one session. The counselor may need to arrange for follow-up sessions.
## M. TECHNIQUES FOR STRESS MANAGEMENT

<table>
<thead>
<tr>
<th>COPING STRATEGY</th>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Writing</strong></td>
<td>• Help survivor to write things that bother her/him.</td>
</tr>
<tr>
<td></td>
<td>• Help survivor to list 10–15 stressful events s/he has encountered.</td>
</tr>
<tr>
<td></td>
<td>• Help survivor to write a few words about how s/he felt after the events.</td>
</tr>
<tr>
<td></td>
<td>• Help survivor to find out what was the cause.</td>
</tr>
<tr>
<td><strong>Helping survivor’s feelings to come out</strong></td>
<td>• Encourage survivor to talk, laugh, cry, express anger and emotion as a way to relieve stress.</td>
</tr>
<tr>
<td><strong>Helping survivors to do something they enjoy</strong></td>
<td>• Encourage survivor to perform his/her hobby such as gardening, creative activity such as writing or crafts, caring for animals, or voluntary work.</td>
</tr>
<tr>
<td><strong>Helping survivors to exercise</strong></td>
<td>• Encourage survivor to exercise; everyday activities such as housecleaning or yard work can also reduce stress.</td>
</tr>
<tr>
<td><strong>Breathing exercise</strong></td>
<td>• Encourage survivor to practice deep breathing.</td>
</tr>
<tr>
<td><strong>Progressive muscle relaxation</strong></td>
<td>• Encourage survivor to relax separate groups of muscles one at a time—this helps to reduces muscle tension.</td>
</tr>
</tbody>
</table>
## N. FILLING IN GBV REGISTER AND MEDICAL FORMS

### N.1. GBV MEDICAL FORM

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>DESCRIPTION OF HOW TO FILL IN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Number</td>
<td>Facility name/survivor number, e.g., AMANA /00001</td>
</tr>
<tr>
<td>Residence</td>
<td>District/village</td>
</tr>
<tr>
<td>Contact</td>
<td>Collect telephone number if applicable</td>
</tr>
<tr>
<td>Type of assault</td>
<td>Allow choosing more than one option when appropriate</td>
</tr>
</tbody>
</table>

### N.2. GBV REGISTER

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>DESCRIPTION OF HOW TO FILL IN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Age in years, if less than a year please specify; e.g., 9 months</td>
</tr>
<tr>
<td>Address</td>
<td>District/village</td>
</tr>
<tr>
<td>Type of violence</td>
<td>Allow choosing more than one option when appropriate</td>
</tr>
<tr>
<td>Type of treatment</td>
<td>Physical will include all surgical, medical, and psychosocial care</td>
</tr>
<tr>
<td>Referral</td>
<td>Service to which survivor has been referred; e.g., police, social welfare officer, HIV care and treatment center (CTC).</td>
</tr>
</tbody>
</table>
O. MANAGING GBV AND VAC SURVIVORS WITH SEXUALLY TRANSMITTED AND/OR REPRODUCTIVE TRACT INFECTIONS

Sexual violence established

Take history, examine, and document basic data

Evidence of intercourse

- NO
  - Counsel and reassure

- YES
  - Presumptive supervised treatment for STIs
    1. Benzathine penicillin 2.4 MU intramuscular, single dose (1.2 MU in each buttock)
    2. Ciprofloxacin 500 mg orally, single dose
    3. Metronidazole 2 g orally, single dose
    4. Azithromycin 1 g orally, single dose

- Occurrence < 72 hours
  - NO
  - Occurrence < 120 hours
    - YES
      - Counsel and test for HIV
        - HIV-positive
          - Link to HIV and AIDS CTC
        - HIV-negative
          - Give HIV PEP
            1. Tenofovir 300 mg orally, once per day+
            2. Lamivudine 300 mg orally, once per day
            3. Efavirenz 600 mg orally, once per day

- Provide emergency contraception
  - POP 1: Postinor-2® (levonogestrel) 1 tablet twice per day, immediately (or 2 tablets immediately) OR
  - POP 2: Levonogestrel/norgestere) 20 tablets every 12 hours (total 40 tablets per day) OR
  - COC 1: Ovral® 2 tabs every 12 hours (total 4 tablets per day) OR
  - COC 2: Nordette® 4 tabs every 12 hours (total 8 tabs per day)
P. MEDICAL PRACTITIONER’S CHECKLIST: CARING FOR CHILDREN WHO HAVE EXPERIENCED SEXUAL ASSAULT

TAKING FORENSIC HISTORY

- Assess developmental level.
- Do not attempt for children younger than five years.
- Ask open-ended questions (avoid “yes/no” questions).
  - Say, “Tell me about what happened”; you can say, “This is not your fault. I believe you.”
    - DO NOT pressure a child to speak.
    - Refer to the chart for rape details.
      - Do not ask questions that have already been asked and documented.
      - Avoid questions that suggest blame, such as: “What were you doing there alone?”
- Attempt to speak with the patient and caregiver separately and in private.
- Write the history in the patient’s (or caregiver’s) exact words when possible (use quotes).
- Get other important information:
  - When and where the sexual assault occurred
  - How many times sexual assault occurred
  - Type of penetration
  - Condom use?
  - Is the perpetrator a known person or stranger?
  - Is the perpetrator’s HIV status known?
- Explain what will happen during the examination.
- Offer the patient choices throughout the examination.
- Offer the patient support and encouragement throughout the examination.

Medical history

- Any pain, bleeding, discharge, or injuries
- Last menses
- Last intercourse
- Birth control method
- Gravida/para
- Other medical history or diagnoses
- Family and social history
MEDICAL FORENSIC EXAMINATION

Complete physical assessment
- Assess for overall health
- Assess for body surface injuries
- Assess maturation level (Tanner staging)
- Be aware that this may be the only physical exam the patient has for a long time.

Genital assessment
- Positioning
  - “Frog-leg” position
  - “Knee-chest” position (supine and prone)
- Separation and traction of labia
  - Allows full visualization of the hymen edges, fossa navicularis, and posterior fourchette
  - Hymen assessment
    - Estrogenized
      - Appears in newborns (estrogen remains from mother) until approximately four years of age (may vary)
      - Appears thicker, redundant
    - Unestrogenized
      - Appears in young children (from approximately four years) to onset of puberty
      - Appears thinner, translucent
      - Painful to touch
      - NEVER insert any digits, swabs, or instruments
    - Estrogenized
      - Appears with the onset of puberty
      - Appears thicker, redundant
      - Preparing the body for reproduction and childbirth
      - ALL hymens have an opening
      - If the hymen is completely closed off, this is a medical condition that warrants attention
- Speculum exams
  - Only done on post-menarcheal patients
  - Assess vagina and cervix (for injury and infection).

Anal assessment
- Assess on all patients (for injury and infection).
MEDICATION CONSIDERATIONS

STI prophylaxis
- Consider for all patients raped within a four-week time frame.

PEP prophylaxis
- Consider for ALL patients raped within 72 hours (with negative test results).
- Injury does not have to be present.
- Proof of rape does not have to be present.

Pregnancy prophylaxis
- Consider for all pubertal patients raped within 120 hours.
- Pregnancy testing should be done on all pubertal patients.

Immunizations
- Discuss status with patients and caregivers.
- Consider tetanus with injury.

DISCHARGE CONSIDERATIONS

Review examination findings
- Injury versus no injury (what does it mean)
- What we can and cannot tell from an exam
- Can tell if there is injury or infection
- Cannot tell if there was penetration and by what mechanism
- Cannot provide virgin checks
- Signs and symptoms to return for
- Medications.

Safety planning
- Where is the child going?
- Who will be there to protect the child?
Q. SOCIAL WELFARE OFFICER’S CHECKLIST: CARING FOR CHILDREN WHO HAVE EXPERIENCED SEXUAL ASSAULT

THERAPEUTIC COMMUNICATION IS KEY

Discussing the rape

• Assess developmental level.
• Do not ask children younger than five years questions about the rape.
• Allow the patient to lead the conversation (if s/he wishes to talk about it).
• Ask the patient if s/he wants to talk about it; if so:
  o Ask open-ended questions (avoid “yes/no” questions)
    ▪ Say, “Tell me about what happened.”
    ▪ Let the patient tell his or her story the way s/he wants to.
    ▪ DO NOT pressure a child to speak.
    ▪ Refer to the chart for rape details.
  o Do not ask questions that have already been asked and documented.
  o Avoid questions that suggest blame, for example:
    ▪ “What were you doing there alone?”
• Attempt to initially speak with the patient and caregiver separately and privately.
  o Speak to the patient and caregiver together if that is what is desired.
• Encourage and support the patient and caregiver; for example:
  o “I believe you.”
  o “I am proud of you for talking about this.”
  o “This is not your fault.”
  o “You did what you had to do to survive the rape.”
  o “You did nothing wrong.”
  o “No one deserves to be raped.”

DISCHARGE CONSIDERATIONS AND SAFETY PLANNING

Discuss possible trauma-related symptoms

• Feelings of guilt and shame
• Uncontrolled emotions such as fear, anger, and anxiety
• Nightmares
• Suicidal thoughts or attempts
• Numbness
• Substance abuse
• Sexual dysfunction
• Medically unexplained somatic symptoms

Safety planning

• Where is the child going?
• Who will be there to protect the child?