Health Sector Response to Gender Based Violence Protocol for Health Care Providers

Health Economics Unit
Health Services Division
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

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September 2017

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Minister
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MESSAGE

At the inception of the countrywide reform activities after independence, Bangladesh government recognized gender fairness and equality as constitutional obligation under article 28. Government is committed to attain SDG 5 of gender equality and empowerment by implementing CEDAW and Beijing platform for action. Through Vision 2021 and 2041, a momentum has been created to remove gender discrimination to ensure rights across all social spheres.

A viable safety net for women is key to grow to their full potentials towards building a gender balanced society. We must create an environment for every woman free from discrimination, harassment and more particularly Gender Based Violence. Gender equality and equity remains a dream without eliminating GBV at all levels.

I appreciate the initiative of Gender, NGO and Stakeholder Participation Unit (GNSPU) to publish the protocol for health care provider to serve survivors of Gender Based Violence (GBV). The protocol is a reflection of government's commitments to curb gender disparity in health sector.

1 am immensely pleased to see the valuable and much needed court verdict on widespread application and strict adherence to this protocol has further strengthened the campaign to ensure protection for women against all forms of violence.

I am also thankful for the coordinated efforts of the Government, Non-government Organisations and Development Partners who were involved in the development and publication of this protocol.

1 believe it will be an effective instrument for all of us to achieve our goal.

Joy Bangla, Joy Bangabandhu

Long live Bangladesh

Zahid Maleque, MP

Secretary
Health Services Division
Ministry of Health & Family Welfare
Government of the People's Republic of Bangladesh

MESSAGE

"Health Sector Response to Gender Based Violence: Protocol for Health Care Providers" is a comprehensive document with updated information on different policies and practices essential for rendering an integrated service to the GBV survivors.

A gender balanced society is central to achieve the targets of health-related Sustainable Development Goals (SDGs) by 2030. All directorates and departments, under the stewardship and oversight of the Ministry of Health & Family Welfare, are working relentlessly to optimize equitable access to health care.

Our country population has a unique phenomenon of having almost equal ratio for men and women. Our society cannot move forward without active cooperation of the other half of the population. We must create an environment for every woman free from discrimination, harassment and more particularly Gender Based Violence. The Government's Vision 2021 affirms its commitment to address GBV and uplifting dignity of women.

The GBV Protocol, a maiden document of this kind, has been long awaited for a much priority area of Gender equality in health sector.

1 would like to extend my special appreciation to all staff at Gender, NGO and Stakeholder Participation unit of Health Economics Unit for this noteworthy achievement in paving the way forward.

I also gratefully acknowledge the support of other departments of the Government and Development Partners specially for their support and contribution in developing this project.

I hope that concerned professionals and care givers will be fully oriented with the protocol and use it in their services provisions.

Md. Ashadul Islam

Director General
Directorate General of Health Services
Government of the People's Republic of Bangladesh

MESSAGE

It is indeed a matter of immense pleasure for me to know that the Gender, NGO and Stakeholder Participation Unit (GNSPU) is going to publish 'Health Sector Response to Gender Based Violence: protocol for health care providers", the first ever protocol for the service providers. It is a crucial and essential source of information and directives on the various aspects of GBV services involving various departments under DGHS.

Ending all forms of discrimination against women and girls is not only a basic human right, but it is also crucial to accelerating sustainable development. The world has observed, time and again, that empowerment of women and girls has multiple synergistic effect towards economic growth and development across the border.

Gender Based Violence remains a critical barrier towards having a society free from all discrimination regardless of wealth and social status. The government has a strong commitment to stand against all sorts of gender disparity in all aspects. GNSPU being the front-liner in taking the MOHFW visions towards gender equity, has successfully developed Gender Equity Strategy 2014 and Gender Equity Action Plan 2014-2024. The GBV protocol is the most recent addition to its accomplishments.

I expect all health care professionals to strictly follow the standard policies and practices described in this protocol to ensure service and justice for the GBV survivors. I also understand an optimized compliance to this protocol will enable all stakeholders to identify further areas of enhancement and set future priorities in approaches towards gender equity.

I am also thankful to those who contributed for the publication of this guideline including the Development Partners.

Professor Dr Abul Kalam Azad

Director General
Directorate General of Family Planning
Government of the People's Republic of Bangladesh

MESSAGE

I am delighted to see the Gender Based Violence (GBV) protocol for health care providers is finally going to add to the glory of health care systems of Bangladesh. It is not only a regular publication like many other documents, but also it envisions a designated, focused and streamlined multisectoral service to ensure health and justice for the survivors.

Directorate General of Family Planning combines with Directorate General of Health Services to deliver a quality and comprehensive service when it comes to sexual and reproductive health and rights. The service package for GBV survivors largely involves and demands synchronization of departments within and beyond MoHFW. The protocol paves the way to bring all related service provisions under one integrated umbrella to ensure quality and comprehensiveness of the services for GBV survivor.

I offer my sincere appreciation to the Gender, NGO and Stakeholder Participation Unit (GNSPU) of Health Economics Unit for their hard work, dedication to prepare the protocol.

Quazi A. K. M Mohiul Islam

UNFPA Representative
Bangladesh

MESSAGE

Gender-based violence (GBV) is a pervasive human rights violation. It is relentless and ruthless and slow to change in the whole world. Gender-based violence is inextricably linked to existing gender norms rooted in inequitable and unequal power relations prevalent in the society. Worldwide, and in Bangladesh too, GBV causes not only physical injury and death, and deep psychological trauma; it also has serious negative economic and social costs, both for individual women and for society as a whole, producing a multifaceted public health problem.

Because of the serious and complex nature of GBV, a multi-sectoral approach is required to provide comprehensive response and support women who experience gender-based violence. The health sector is uniquely placed to assist survivors of GBV, as individual women can be expected to interact with the health system. It can identify, treat, care and refer women and girls experiencing violence. This said, mainstreaming health sector response to GBV is critical in preventing and managing GBV.

The United Nations Population Fund (UNFPA) advocates against gender-based violence as a human rights violation and a public health priority according to the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) which guides our work. As the lead UN agency on sexual and reproductive health, UNFPA is honored and proud to play a pivotal role in supporting programmes aimed at strengthening the health sector response to GBV worldwide.

UNFPA provides a holistic approach, bringing gender issues to the forefront, promotes legal and policy reforms, health sector response to GBV and gender-sensitive data collection, and supports the government to empower women socially, politically and economically. We want women to be safe and well everywhere, all the time.

Towards this end, UNFPA has been privileged to support the development of the National protocol on ‘Health Sector Response to Gender-Based Violence’, under the leadership of the Health Economics Unit of the Ministry of Health and Family Welfare. Indeed, we are confident that training the health care providers based on this protocol will enhance their capacity to provide quality services to all GBV survivors in Bangladesh.

UNFPA expresses sincere gratitude to all stakeholders involved in the process of developing this protocol and particularly to the technical team and policy leaders in the Gender, NGO and Stakeholders Participation Unit (GNSPU) for their instrumental work in developing the resource package.

UNFPA would like to reaffirm its continued commitment to support the Government of Bangladesh in ending all forms of GBV and in providing adequate support to survivors of GBV everywhere.

Dr. Asa Torkelsson

Director General
Health Economics Unit
Health Services Division
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PREFACE

Indeed it has been a great accomplishment of Gender, NGO & Stakeholder Participation Unit to deliver the protocol to move one step forward from "encouragement to enforcement". It is a much needed document to strengthen the ongoing programs and activities towards a sustainable gender balanced society in Bangladesh.

The GBV protocol has clear directives for providers in health care delivery to prevent violence against women as well as manage GBV survivors. I believe strict adherence to this protocol will curb GBV prevalence and improve quality of life for the survivors. I am grateful to Hon'ble Minister of the Ministry of Health and Family Welfare for his cooperation in all of our activities.

The GBV services remain a multisectoral response. The protocol has defined a clear directives on synchronization of services across various departments and sectors. I believe this protocol will enable us to create and maintain a safe, harmonious and congenial environment for GBV survivors in the years ahead. This is a vital guide for all GBV service providers to know and work in a multisectoral approach.

I am obliged to Secretary of Health Services Division for his dynamic oversight and keen mentorship to deliver such a long awaited document.

I am thankful to UNFPA, Bangladesh for sharing their experience and expertise in preparing this useful document.

I would also like to express thanks to the working group for their relentless efforts to produce the first ever document of this kind in Bangladesh. I wish this document will be extensively used by all relevant stakeholders.

Dr. Mohd. Shahadt Hossain Mahmud

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Abbreviations

ANC	Antenatal Care
BDHS	Bangladesh Demographic and Health Survey
CBO	Community Based Organization
CRHCC	Comprehensive Reproductive Health Care Center
CSO	Civil Society Organization
EC	Emergency Contraceptive
ESP	Essential Service Package
GBV	Gender Based Violence
GNSPU	Gender, NGO & Stakeholder Participation Unit
GoB	Government of Bangladesh
HBV	Hepatitis B virus
HDRC	Human Development Research Center
HEU	Health Economics Unit
HF	Health Facility
HMC	Hospital Management Committee
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
IUD	Intra Uterine Device
MOE	Ministry of Education
MOHA	Ministry of Home Affairs
MOHFW	Ministry of Health and Family Welfare
MOLJPA	Ministry of Law, Justice & Parliamentary Affairs
MO (MCH-FP)	Medical Officer (Maternal Child Health-Family Planning)
MOSW	Ministry of Social Welfare
MOWCA	Ministry of Women & Child Affairs
MOY&S	Ministry of Youth & Sports
OCC	One Stop Crisis Center
OCc	One Stop Crisis Cell
PHCC	Primary Health Care Center
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother-to-Child Transmission
PTSD	Post-Traumatic Stress Disorder
PV	Per Vaginal
STI	Sexually Transmitted Infections
TG	Transgender
TOT	Training of the Trainers
UHC	Upazila Health Complex
UN	United Nations
UNFPA	United Nations Population Fund
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

Chapter 1: Preface

1.1 Preamble

Gender Based Violence (GBV) exists as a social problem. It especially affects women and children in their physical, as well as psychological health, sexuality, security, social life and ability to acquire justice including overall development. As it is crucial to develop a system to provide emergency services to the survivors of GBV, this protocol for health care providers has been developed as per the Gender Equity Strategy 2014 and the Gender Equity Action Plan 2014 – 2024 of Ministry of Health and Family Welfare.

1.2 Background

GBV is a grave social and human rights concern affecting virtually all societies. The U.N. Convention for the Elimination of All Forms of Discrimination against Women (1992) defined it as "violence that is directed against a woman because she is a woman, or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty" (General Recommendation No. 19).[1] It is inextricably linked to the gender norms and unequal power relations present in the society, and violence against women and girls is one of the manifestations of these inequities. Thus, it is rooted in women's subordination in the society relative to men. It constitutes a breach of the fundamental right to life, liberty, security, dignity and equality between women and men, non-discrimination and physical and mental integrity. GBV and violence against women are often used interchangeably as most GBV is inflicted by men on women and girls. However, there is increasing recognition that men and boys and gender minorities can also experience violence based on gender, for example when they do not conform to the traditional norms of masculinity.

Globally, it is estimated that 35% of women have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Worldwide, almost one-third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. Globally, as many as 38% of all murders of women are committed by intimate partners; women who have been physically or sexually abused by their partners report

[1] In 1993, the U.N. Declaration on the Elimination of Violence against Women would stipulate that the violence against women referred to in the declaration was "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (Article 1). Subsequently, this definition became widely used as the definition for gender-based violence. In more recent years, the term has been used by others to include other forms of violence that might be directed toward men and boys, particularly in the case of sexual violence in conflict situations and violence against sexual minorities.

higher rates of a number of important health problems. For example, they are 16% more likely to have a low birth weight baby. They are more than twice as likely to have an abortion, almost twice as likely to experience depression, and, in some regions, are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence. Additionally, 7% of women have been sexually assaulted by someone other than a partner[2].

In Bangladesh, over two third (72.6%) of ever married women experienced one or more such forms of violence by their husband at least once in their lifetime, and 54.7% experienced violence during last 12 months.

Of lifetime experiences, controlling behavior was most common, reported by more than half of ever-married women (55.4%). This was followed by physical violence (49.6%), emotional violence (28.7%), sexual violence (27.3%) and economic violence (11.4%).The experiences of one or more incidents of intimate partner violence during the last 12 months were also measured. The most common form was controlling behavior, experienced by more than one third (38.8%) of ever-married women, followed by emotional violence (24.2%), physical violence (20.8%), sexual violence (13.3%) and economic violence (6.7%). Partner violence were highest in rural areas (74.8% of ever-married women) and lowest in city corporation areas (54.4%)[3].

Along with adults, a large number of children and adolescents also experience gender based violence in Bangladesh. Bangladesh has the highest rate of child marriage and adolescent fertility in South East Asia. According to BDHS 2014, 59 percent of women aged 20-24 years were married before the age of 18 and the median age at first marriage is 17.2 years. The adolescent fertility rate is 113 live births per 1000 women aged 15-19 years. According to the BDHS (2014), 31 percent of adolescents aged 15-19 years have begun child bearing, about 1 in 4 has given birth, and another 6 percent were pregnant with their first child.

Violence against Women Survey 2015 highlighted that 42.8 percent and 28.4 percent ever married adolescents aged 15-19 years reported physical or sexual violence during their lifetime and in the last 12 months respectively. Adolescent boys are also not excluded from experiencing gender based violence. A study conducted in four districts of Bangladesh revealed that 9.8 percent of school going adolescent boys reported experiencing sexual violence and for a majority of them, the perpetrators were other boys from school (HDRC 2015).

The Convention on the Elimination of all Form of Discrimination against Women (CEDAW)[4] have been instrumental in identifying it as violation of women's human right and not a private matter to be condoned without redress. Violence can occur throughout women's lives during the

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2 Global and Divisional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. World Health Organization, 2013.

3 Violence Against Women Survey, 2015, BBS

4 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly, is often described as an international bill of rights for women. Consisting of a preamble and 30 articles, it defines what constitutes discrimination against women and sets up an agenda for national action to end such discrimination.

course of the lifecycle, irrespective of class, caste/ethnicity, social status, race, nationality or any other defining features[5]. The impacts of violence against women and girls as a public health problem with legal, social, cultural, economic and psychological dimensions have increasingly been articulated[6].

1.3 Objectives of the Protocol

GBV survivors often come to the health facilities to seek health care. Although female survivors do not disclose the associated violence or abuse to others, they often express the violence against them to the service providers, who can provide appropriate support and information to the survivors.

So the role of the service providers and managers to identify the violence, provide care and make appropriate referral is very important. This Protocol has been developed with the objective to provide quality services as well as enhance the capacity of the health workers involved in providing health care service to all GBV survivors. It would also improve coordination between health and multisectoral stakeholders at the national and local levels. The main objective of this manual is to establish a standardized and homogenous guideline for the health care providers for both identification as well as management of cases and their follow up.

a) The eventual purpose is providing the healthcare personnel with guideline for achieving comprehensive physical, psychological and social care to survivors enduring gender based violence who resort to a health care center.

b) To make health care personnel aware of the GBV and its consequences so that they consider it as a serious public health concern.

Although this protocol deals with sexual, physical and psychological violence including emotional abuse against women, men and children, its primary focus is on violence against women, the most common form of GBV.

1.4 Users of the Protocol

This Protocol is intended for Health managers, Doctors, Nurses, Midwives, Sub-Assistant Community Medical Officer (SACMO), Medical Assistants (MA), Family Welfare Visitors (FWV), Community Health Care Providers (CHCP), Health Assistants (HA), Family Welfare Assistant (FWA), and support service health workers at facility and the field.

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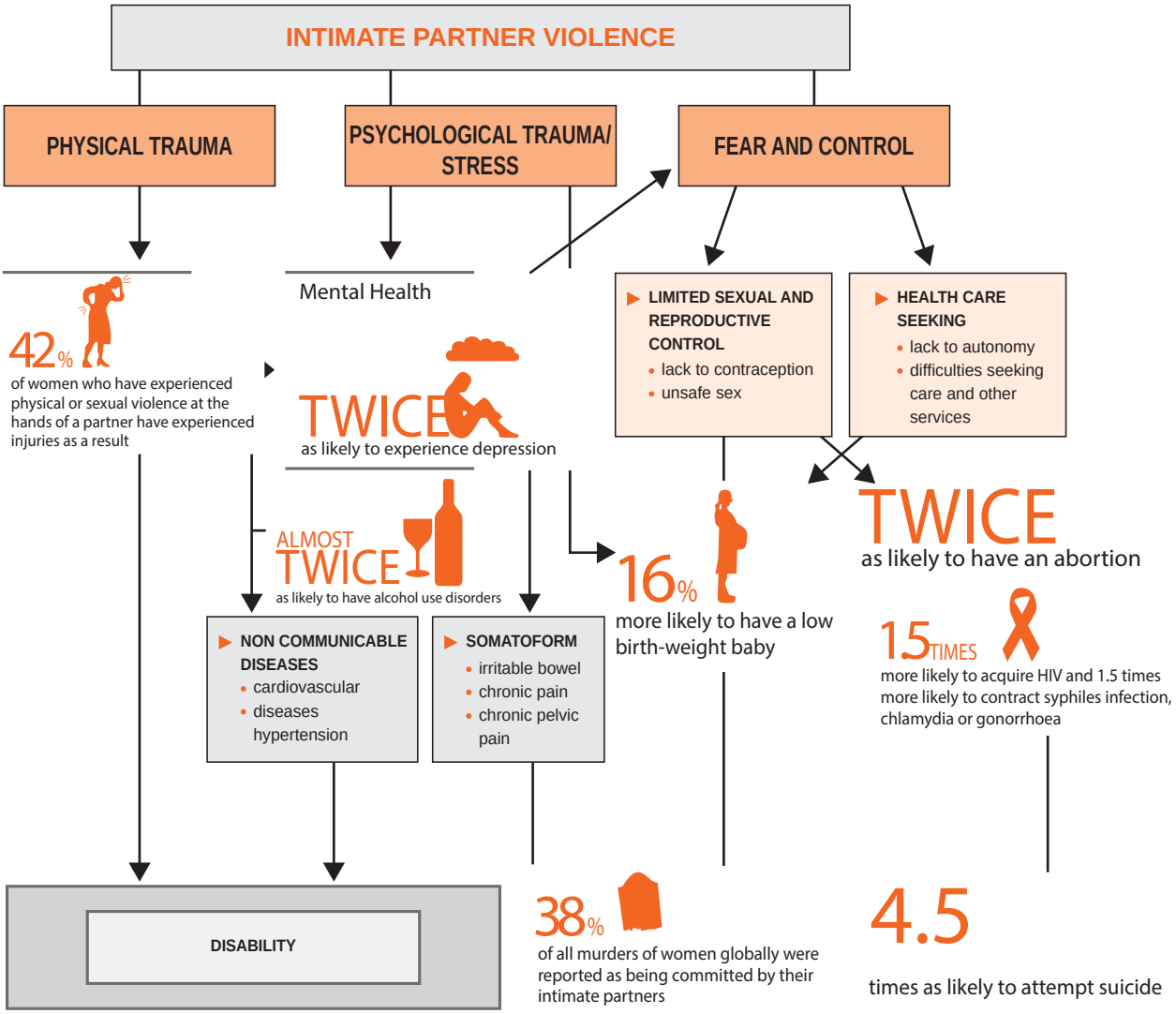
[5] CRDC (2002). Impact of Gender-Based Violence on the Health of Women.

[6] Addressing Violence Against Women and Girls in Sexual and Reproductive Health Services: A Review of Knowledge Assets, UNFPA 2010

1.5 Consequences of GBV

GBV can cause serious health problems that undermine women's energy, compromise physical and mental health, and erode self-esteem. Although GBV affects women primarily, its consequences extend beyond the survivor to the children, the family and the society as a whole. Therefore, they are unable to perform to the best of their ability, must take time off, become sick and are unable to make a significant contribution to the society. Girls may have curtailed education, reduced employment and economic opportunities and a reduced quality of life. GBV threatens the family structure, children who witness GBV suffer emotional damage. Families may break up, leaving the new female-headed household to struggle against increased poverty and negative social consequences.

Figure 1: Pathways and Health effects of IPV



According to the WHO (2013), there are multiple pathways through which intimate partner violence can lead to adverse health outcomes. They are more than twice as likely to have an abortion, almost twice as likely to experience depression, and 1.5 times more likely to acquire Human Immuno-deficiency Virus (HIV), as compared to women who have not experienced GBV. Physical trauma may lead to soft tissue and musculoskeletal injury and lead to disability or death. Similarly psychological trauma and stress may lead to mental health problems such as anxiety, depression, sleep and eating disorders, post-traumatic stress disorder (PTSD) and even suicide. The fear and control, which are integral to violence, may limit autonomy, health care seeking and limited sexual and reproductive control, lack of contraception and unprotected sex leading to unwanted pregnancy, abortion, Sexually Transmitted Infections (STIs) and HIV infection[7].

The persistent stress of a violent relationship affects the immune system leading to gastrointestinal disorders, chronic pain, hypertension and cardiovascular disease and the development of insulin-dependent diabetes[8]. Stress during pregnancy leads to constriction of the blood vessels, limiting blood flow to the uterus; survivors are 16% more likely to have a low birth weight baby. Furthermore, the hypothalamic pituitary adrenal response can trigger premature labor and premature birth, through contractions of the smooth muscle tissue in the uterus[9].

In addition to the biological stress response, there are behavioral and other risk factors. Some women try to manage the negative consequences of abuse through the use of alcohol, prescription medication, tobacco or other drugs[10].

The controlling behavior of a male partner limits the behavior and social interactions of their female partners (e.g., limiting social and family interactions, insisting on knowing where she is at all times, being suspicious of unfaithfulness, getting angry if she speaks with another man, expecting his permission for seeking health care).

Emerging evidence suggests that abusive partners who exhibit these behaviors can limit women's ability to control their sexual and reproductive decision-making, their access to health care, or their adherence to medications, which can have adverse health effects.

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[7] Campbell, R. et al. 2002. "Health Consequences of Intimate Partner Violence." Lancet 359(9314): A1331–1337. Abuse during pregnancy in industrialized and non-industrialized countries.

[8] Miller AH. Neuroendocrine and immune system interactions in stress and depression. Psychiatric Clinics of North America, 1998, 21(2):443–463.

[9] Altarac M, Strobino D. Abuse during pregnancy and stress because of abuse during pregnancy and birthweight. Journal of the American Medical Women's Association, 2002, 57(4):208–214. Wadhwa PD, Entinger S, Buss C, Lu MC. The contribution of maternal stress to preterm birth: issues and considerations. Clinical Perinatology, 2011, 39:351–384.

[10] a. Campbell JC. Health consequences of intimate partner violence. The Lancet, 2002, 359(9314):1331–1336.

b. Ellsberg M et al. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. The Lancet, 2008, 371(9619):1165–1172.

Chapter 2: Institutional Framework for Gender Based Violence

2.1 Organizational Framework of MOHFW for Prevention and Management of GBV

The roles of Ministry of Health & Family Welfare (MOHFW) and different divisions, centers and departments within the health system are very important to provide appropriate responses towards GBV and in providing health and other necessary services to GBV survivors. The roles and responsibilities of different sectors of MOHFW are described below:

Table 1: Roles and Responsibilities of MOHFW and its different administrative level

Office	Roles & Responsibilities
MOHFW (Policy Level)	• Formulate national policies and strategies. • Identify the focal unit to address GBV services. • Coordinate and collaborate with relevant ministries and stakeholders (CSO, NGOs and Development Partners) for budget allocation, advocacy and implementation of laws pertaining to GBV. • Mentor the multisectoral stakeholders on their roles and responsibilities related to GBV. • Review and update national guidelines and protocols, including referral guidelines to enable quality service provision. • Ensure system of supportive supervision and monitoring on the functioning of service delivery at primary, secondary and tertiary level health facility. • Guide evidence generation and relevant research on GBV; collect, compile, analyze and disseminate GBV service data from health facilities.
DGHS/DGFP (Implementation Level)	• Ensure service provision. • Ensure availability of resources including physical facilities for GBV services. • Orientation of stakeholders on prevention and management of GBV. • Prioritize budget allocation and programming for GBV. • Mentor, monitor progress and supervise GBV service at all level. • Coordinate with relevant stakeholders.

Office	Roles & Responsibilities
	● Integrate GBV services with other Essential Service Packages (ESP). ● Integrate GBV awareness creation in community outreach programs. ● Establish appropriate recording and reporting system. ● Create awareness at the community level to promote health education and awareness against GBV and the service availability. ● Ensure quality TOT, training to the different level service providers ● Use mass media to raise awareness about GBV. ● Design and disseminate appropriate IEC materials. ● Development of capacity of health workers for providing services to GBV survivors.
Division: ● Director Office, DGHS ● Director Office, DGFP	● Coordinate among the districts where services are being provided for referral and follow-up. ● Coordinate with divisional level stakeholders. ● Monitor and supervise the GBV service delivery at the divisional level.
District: ● Civil Surgeon Office ● DDFP Office	● Ensure enabling environment through availability of human resources, systems and training. ● Coordinate with Hospital Management Committee (HMC) and Community Based Organizations (CBOs) ● Coordinate with local level authorities of MOWCA, MOSW, MOHA and MOLJPA, MOE, MOY&S, LGED and community groups etc. to create network and enabling environment for service provision. ● Ensure monitoring and supervise the service providers in the health facilities. ● Ensure the services are offered through the network of health facilities (District Hospitals, UHC, FWC, Union Sub-Centers and Community Clinics). ● Conceptualize and conduct district level program orientation to relevant stakeholders with a mentorship role of MO (MCH-FP).

Office	Roles & Responsibilities
	● Ensure availability of commodities at peripheral facilities. ● Create awareness and increase access to GBV services in the community level through promotional activities.
Upazila: ● UH&FPO ● UFPO/MO MCH-FP	● Ensure enabling environment through availability of human resources, systems and training. ● Coordinate with Hospital Management Committee (HMC) and Community Based Organizations (CBOs) ● Coordinate with upazila level authorities of MOWCA, MOSW, MOHA and MOLJPA, MOE, MOY&S etc.to create network and enabling environment for service provision. ● Mentor, monitor and supportive supervision. ● Ensure the services are offered through the network of health facilities (UHC, FWC, Union sub-centers and Community Clinics). ● Conceptualize and conduct upazila level program orientation to relevant stakeholders with a mentorship role of MOMCH-FP. ● Ensure availability of commodities at Upazila Health Complexes (UHCs). ● Create awareness and increase access to GBV services in the community level through promotional activities.

Each health facility has different capacity and resources to meet the requirements of the protocols, which must be recognized. Likewise, not all health workers will be expected to carry out the full range of services in the protocol. Some services require specialized expertise. The table below outlines roles to be filled by various health provider profiles.

The following two tables describe the roles and responsibilities by the level of health facility (Table 2) and by the level of health workers (Table 3).

Table 2: Roles and Responsibilities of Health Providers by Level of Health Facility[11]

	Community		Union	Upazila	District			Urban	
Roles & Responsibilities	SC/OR	CC	UH&FWC /USC	UHC	DH	MCWC	Medical College Hospital	CRHCC	PHCC
Medical Service									
Survivor Identification	√	√	√	√	√	√	√	√	√
History Taking, Clinical Examination, Routine Investigation	x	x	x	√	√	√	√	√	√
First Point Counseling	√	√	√	√	√	√	√	√	√
Prevention of pregnancy: Emergency Contraception	√	√	√	√	√	√	√	√	√
Manage minor injuries	x	√	√	√	√	√	√	√	√
Manage major injuries	x	x	x	√	√	√	√	√	x
Prophylaxis for STI	x	x	√	√	√	√	√	√	√
Post-Exposure Prophylaxis (PEP)-HIV	x	x	x	√	√	√	√	√	x
Psychosocial Services									
Provide basic psychosocial support	√	√	√	√	√	√	√	√	√
Identification of anxiety and other trauma	x	x	x	√	√	√	√	√	√
Provide specialized psychosocial counselling	x	x	x	x	√*	x	√	√*	x
Link survivor with other GBV services	√	√	√	√	√	√	√	√	√
Follow up with the survivor	√	√	√	√	√	√	√	√	√

Note:

OR-Outreach Center, SC-Satellite Clinic, CC-Community Clinic, UH&FWC-Union Health & Family Welfare Center, USC-Union Sub-Center, UHC-Upazila Health Complex, DH-District Hospital, MCWC-Maternal and Child Welfare Center, CRHCC-Comprehensive Reproductive Health Care Center, PHCC-Primary Health Care Center.

[11] Bangladesh Essential Health Service Package (ESP), 2016

	Community		Union	Upazila	District		Medical College Hospital	Urban	
Roles & Responsibilities	SC/OR	CC	UH&FWC /USC	UHC	DH	MCWC		CRHCC	PHCC
Medicolegal Services									
Documentation of history	x	x	x	√	√	x	√	√	x
Documentation of findings of physical examination	x	x	x	√	√	x	√	√	x
Collect samples for forensic-related investigations	x	x	x	√	√	x	√	√	x
Reporting of findings	x	x	x	√	√	x	√	√	x
Completed chain of evidence and other forms	x	x	x	√	√	x	√	√	x
Serve as expert witness in court	x	x	x	√	√	x	√	√	x

√ Service to be performed.

* Services to be performed if facilities and a mental health specialist/trauma counselor are available.

** Routine investigations include blood tests, urine analysis, radiological and any other test required as per need and services are available at the facilities.

N.B. All procedures should be performed by qualified/trained medical personnel.

Note:

SC	Satellite Clinic
OR	Outreach Center
CC	Community Clinic
UHC	Upazila Health Complex
USC	Union Sub-center
UH&FWC	Union Health & Family Welfare Center
DH	District Hospital
MCWC	Maternal & Child Welfare Center
CRHCC	Comprehensive Reproductive Health Care Center
PHCC	Primary Health Care Center

Table 3: Roles and Responsibilities by Level of Health Care Provider

Roles & Responsibilities	HCP, HA, FWA	Nurse, FWV, MA, SACMO, Midwives	MO/ RMO	Specialists: Forensic / Gynecological /Psychologist / Psychiatrist**
Medical Service				
Survivor identification	x	√	√	√
Informed consent	x	x	√	√
History Taking, clinical examination	√	√	√	√
First Point counseling	√	√	√	√
Prevention of pregnancy: Emergency Contraception	√	√	√	√
Manage minor injuries	√	√	√	√
Manage major injuries	x	x	√	√
Prophylaxis for STI	√	√	√	√
Post-Exposure Prophylaxis (PEP)-HIV	x	x	√	√
Psychosocial Services				
Identification of anxiety and other trauma as needed	x	x	x	x
Provide survivor with basic psychosocial support	√	√	√	√
Provide survivor with specialized counseling	x	x	x	√
Link survivor with other GBV services	√	√	√	√
Follow up with the survivor	√	√	√	√
Medicolegal Services				
Documentation of history	x	x	√	√
Documentation of findings of physical examination	x	x	√	√
Collect samples for forensic-related investigations	x	x	√	√
Reporting of findings	x	x	√	√
Completed chain of evidence and other forms	x	x	√	√
Serve as expert witness in court	x	x	√	√

** Specialist comprises of Forensic Medicine, Gynecologist, Psychologist, Psychiatrist and Medicine Experts.

N.B. All personnel should be trained regarding significance of documentation, maintenance of chain of commands, understanding the principle of survivor centered approach including maintenance of confidentiality.

N.B. All personnel should be trained in the procedure of history taking examination and documentation in cases of GBV.

Gender Based Violence Logistics for collection of forensic evidence should include:

- Speculum (disposable, all size from adult to child)
- Xylocaine gel
- Normal saline/sterile water
- Comb for collecting foreign materials in hair including pubic hair
- Syringes/needles (butterfly for children), tubes for collecting blood
- Glass slides for preparing wet and dry mounts for sperm
- Cotton tipped swabs/applicators for collecting samples & test tubes
- Laboratory containers for transporting swabs
- Tape for measuring the size of bruises, lacerations, wounds, etc.
- Supplies for universal precautions (gloves, gown, goggles, chlorine solution, box for safe disposal of contaminated and sharp materials, soap, towel, bucket, etc.)
- Paper sheet for collecting debris as the survivor undress
- Zip lock plastic bag and paper bag for collection of evidence
- Paper tape for sealing and labeling containers
- Sterile medical equipment to repair tears/injuries/wound
- Pregnancy test kit
- Emergency Contraceptive Pills (ECP)
- Color coded waste disposal bucket (as per health care waste management guideline)
- Autoclave or sterilizer to sterilize equipment
- Refrigerator
- White bed sheets, gown, cloth to cover the survivor during the examination
- Information, Education and Communication (IEC) / Behavior Change Communication (BCC) materials
- Weighing scale and height chart
- Blood pressure machine
- Stethoscope
- Tongue depressor

Table 4: Roles and Responsibilities for Gender Based Violence of Different Sectors

Organization	Roles & Responsibilities
Ministry of Health & Family Welfare (MOHFW)	• Play a leading role in medical management of GBV at health facilities. • Operate the health facilities along with allocating budget for issues related to GBV activities. • Provide training and orientation to health service providers and other concerned staff on management of GBV survivors. • Create awareness at the community level to promote health education and awareness against GBV. • Advocacy through national media using IEC materials to raise awareness. • Prepare necessary protocols and guidelines, including referral to provide health and counselling services. • Provide feedback on the functioning and service delivery of the GBV management through the community health facility. • Maintain records and prepare reports about GBVservices.
Ministry of Women & Children Affairs (MOWCA)	• Operate regional service centers (One Stop Crisis Center and One Stop Crisis Cells) with essential resources and facilities for survivors of GBV and allocate annual budget for their management and functioning. • Allocate budget to conduct different community level activities related to GBV and also for the smooth operation of Service Centers and Children Centers. • Provide orientation on GBV issues to the staff employed in Women and Children Office. • Design, development and dissemination of materials related to GBV at community level to combat GBV. • Engage central and local level VAW committee effectively.
Ministry of Home Affairs (MOHA)	• Management of efficient human resources, means and methods to ensure the social and economic protection of survivors. • Manage Victim Support Centres. • Coordinate and cooperate with different security institutions and concerned agencies.

Organization	Roles & Responsibilities
Ministry of Law, Justice& Parliamentarian Affairs (MOLJPA)	• Arrange free Legal Aid services to GBV survivors through local legal aid office and other agencies providing legal services.
Ministry of Social Welfare (MOSW)	• Provide necessary support to the GBV survivors. • Establish and manage shelter homes for child survivors.
Ministry of Local Government and Rural Development (MOLGRD)	• Mobilize and motivate City Corporation and Municipality to support the activities conducted at the local level for survivors of GBV. • Provide medical care to the GBV survivors and link/coordinate with nearby One Stop Crisis Center (OCC)/ One Stop Crisis Cell (OCc). • Provide financial and technical support for GBV activities conducted at the local level. • Provide orientation on GBV to the staff working at the local level under the MOLGRD. • Develop and disseminate the information to create awareness against GBV during the district level planning and programs.
Non-Governmental Organizations & Community Based Organizations (NGO & CBO)	• Create social awareness against GBV through mobilization of community organizations. • Provide information about the OCC/GBV management at community health facilities and its services to the targeted groups. • Conduct regular follow-up and monitoring of rehabilitated persons to be aware of their status. • Provide physical, financial and humanitarian support to survivors so that they can be independent, and assist them to rehabilitate into the family/society. • Coordinate to the district and Upazila level GBV prevention committee performs the above-mentioned tasks/activities.

2.2 National Policies, Strategies and Guidelines supporting Health Sector Response (HSR) to Gender Based Violence (GBV)

a) National Health Policy 2011

b) 7th Five year Action Plan 2016-2020

c) National Women Development Policy 2011 and National Action Plan 2013

d) National Children Policy 2011

e) National Action Plan to Prevent Violence against Women and Children 2013-2025

f) Gender Equity Strategy 2014

g) Gender Equity action Plan 2014-2024

h) 4th Health Population Nutrition Sector Programme 2017-2022

2.3 Legal Environment for GBV in Bangladesh

It is important for the health worker to know the basic information about the laws in relation to GBV, the rights of the survivor, their own legal obligations as health care providers, the procedures for seeking redress, and the best ways to help clients avoid being re-traumatized. The health care providers also need basic legal information to adequately handle the cases of Gender Based Violence.

The Constitution of the People's Republic of Bangladesh

- All citizens are equal before law and are entitled to equal protection of law (Article 27).
- Women shall have equal rights with men in all spheres of the State and of public life (Article 28.2).
- Nothing in this article shall prevent the State from making special provision in favor of women or children or for the advancement of any backward section of citizens (Article 28.4).
- To enjoy the protection of the law, and to be treated in accordance with law, and only in accordance with law, is the inalienable right of every citizen, wherever he may be, and of every other person for the time being within Bangladesh (Article 31).
- The State shall adopt effective measures to prevent prostitution and gambling (Article 18.2).

Note:

Relevant sections regarding GBV from the Bangladesh Law is enclosed in **Annex 18**. (Relevant Section from Bangladesh Law.)

Chapter 3: Facility Readiness

Facility readiness is important for health service response to GBV. Adequacy of infrastructure, enabling environment for service provision with management systems, access to guidelines and protocols, staff orientation and training, availability of commodities and supplies, community network and support mechanism for the survivors are all important for quality service provision.

3.1 Infrastructure

Adequacy of infrastructure is important for ensuring the availability of confidential space for the survivor to disclose her/his experiences to the health workers without fear or shame. Therefore, facility upgradation for privacy and safety of clients may be warranted as follows (**Annex 2.** Minimum requirements of facility readiness for GBV Survivors). Separate room at the health facility with visual as well as auditory privacy for talking, examination and counseling of survivors.

a) Access to toilet and bathroom/wash room.

b) Access to laboratory facilities /microscope (where applicable).

3.2 Management

3.2.1 Guidelines and Protocols

The facility should have access to the "*Health Sector Response to Gender Based Violence Protocol for Health Care Providers.*" In addition, the health facility should also have relevant recording and reporting forms and formats as per protocol. These must be adhered to quality service provision.

3.2.2 Capacity Building of Health Care Providers

As GBV is often not adequately addressed in pre-service training, to ensure quality of care provided to survivor who experience GBV, health facilities should ensure that health workers, managers and support staff are trained/oriented as per need. Short orientation of GBV for all categories of staff followed by in-depth training to clinical service providers should be done prior to service provision. New staff who have not previously received training in prevention and management of GBV should receive training.

a) Staff Orientation

It is important for the facility to orient all staff on GBV, as it will allow staff members to be prepared if they are at some point approached by a survivor. All staff (including members of HMC, support staff and service providers) at the peripheral health facility can benefit from the orientation. If they feel competent to discuss GBV, this communicates to clients that there is openness here, and they no longer need to be silent about their experience of violence. The staff must be able to handle cases compassionately, without judgment, and in a private, and confidential manner.

GBV Topics for All Staff Orientation

- Introduction to gender and GBV
- Concept of GBV: cause and consequences
- Magnitude of the problem
- Myths about GBV
- The laws to address GBV in the country
- Rationale for integrating GBV in health services
- Role of health facility in service provision and referral
- Roles of the staff in responding to GBV
- Challenges in implementation of GBV Services

b) Training of Clinical Staff

Ensure that all clinical staff receive the competency-based training. Training should cover the following minimum packages of health services in addition to the content of the orientation listed above:

- Informed consent, including informed consent of parents/guardian in case of minor
- Immediate medical management (including history taking and physical examination)
- Treatment for injuries that the facility has the capacity to treat
- Training for collection, preservation of forensic evidence
- Preparing and appearing in the court as expert witness (those who are trained and eligible)
- Post Exposure Prophylaxis (PEP) for HIV and STI treatment/prophylaxis
- Other associated conditions like unwanted pregnancy, medical conditions, etc.
- Psycho-social assessment and counseling that the facility or health worker is able to provide
- Referral of survivors to higher level facilities and linkages with other services (legal, shelter, etc.) where feasible
- Follow-up care

3.2.3 Essential Commodities

a) Supplies

A survivor kit for collection of forensic evidence should include:

- Speculum (disposable, adult size)
- Xylocaine gel

- Normal Saline/sterile water
- Comb for collecting foreign matter in pubic hair
- Syringes/needles (butterfly for children) tubes for collecting blood
- Glass slides for preparing wet and or dry mounts (for sperm)
- Cotton tipped swabs/ applicators/gauze compresses for collecting samples
- Laboratory containers for transporting swabs
- Tape measure for measuring the size of bruises, lacerations, wounds, etc.
- Supplies for universal precautions (gloves, gown, goggles, chlorine solution, box for safe disposal of contaminated and sharp materials, soap, towel, bucket, etc.)
- Paper sheet for collecting debris as the survivor undresses
- Paper bags for collection of evidence
- Paper tape for sealing and labeling containers
- Sterile medical equipment to repair tears
- Pregnancy test kit
- Emergency contraceptive pills
- Color coded waste disposal bucket (as per health care waste management guideline)
- Autoclave to sterilize equipment
- Refrigerator
- White bed sheets, gown, cloth to cover the survivor during the examination
- Information, Education and Communication / Behavior change communication materials
- Weighing scale and height chart
- Blood Pressure machine
- Tongue depressor

b) Drugs

- For pain relief (e.g. paracetamol)
- Local anesthetic for suturing
- Antibiotics for wound care
- Emergency contraceptive pills and /or intrauterine contraceptive device
- Prophylaxis for Sexually Transmitted Infections (STIs) as per national protocol
- Post Exposure Prophylaxis (PEP) for HIV

c) Administrative Supplies

- Register
- Consent forms
- Medical examination forms (Female & Male)
- Injury form
- Reporting forms
- Referral forms
- Information pamphlets for post rape care (for survivor)
- Safe locked filing space to keep confidential records

d) Furniture

- Examination table
- Light, preferably fixed (a torch may be threatening for children)
- Chair
- Cupboard
- Handwashing basin

Chapter 4: Guiding Principles in Managing Survivors

Key guiding principles for survivor centered care are:

a) Ensure the physical safety of the survivor and those who help the survivor.

b) Guarantee confidentiality.

c) Respect wishes, rights and dignity of the survivor and in case of children be guided by the best interest of the child.

d) Ensure non-discrimination.

All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Governments have a legal obligation to take all appropriate measures to prevent sexual violence and to ensure that quality health services equipped to respond to sexual violence are available and accessible to all.

Health care providers should respect the human rights of people to provide survivor-centered care.

4.1 Right to health

Survivors of rape and other forms of sexual abuse have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way 'revictimize' rape survivors.

4.2 Right to human dignity

Persons who have been raped should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.

4.3 Right to non-discrimination

Laws, policies, and practices related to access to services should not discriminate against a person who has been raped on any grounds, including race, sex, colour, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.

4.4 Right to self-determination

Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment are personal ones that can only be made by the survivors. In this context, it is essential that the survivor receives appropriate information to allow them to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.

4.5 Right to information

Information should be provided to each client in an individualized way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. MR, keeping the child, adoption). The full range of choices must be presented regardless of the individual believes of the health provider, so that the survivor is able to make an informed choice.

4.6 Right to privacy

Conditions should be created to ensure privacy for people who has been sexually abused. Other than an individual accompanying the survivor, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment.

4.7 Right to confidentiality

All medical information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor. In cases where a charge has been laid with the court, the relevant information from the examination will need to be conveyed.

Chapter 5: Health Response to Gender Based Violence

Medical management of GBV survivors involves evaluation of the survivor regarding treating injuries, infections and other consequences that occur as a result of the GBV as well as documentation of medico-legal evidence. The management of medical emergencies should be a priority, but at the same time, the time-dependent preventive treatments should be provided[12].

Sexual assault is a traumatic experience, both emotionally and physically. Survivors may have been sexually assaulted by one or several people, in different circumstances, once or repeatedly over a period of time. Therefore, it is very important that an examiner understands that the survivors may react in different ways. The manner in which they react may be affected by the way in which they are received and treated by the health care providers and law enforcement officers. Hence, it is important to conduct these examinations in an empathetic, understanding, ethical and non-judgmental manner, which would give them confidence and reassurance. This approach helps the health worker establish a rapport with the survivor, which leads to a higher quality medico-legal examination and management.

A medical officer, when approached by a survivor, must 'quickly' perform the medical examination, furnish a certificate to the survivor and notify the police station of the commission of the offence. **This means that there is no mandatory requirement to record an FIR before a medical examination is conducted.**

> Once an incident of rape takes place, any person may make a report of it to the Officerin- Charge (OC) of the police station, and this report will be recorded in a "First Information Report" (FIR). In some cases, women put in an application to the police in writing and the contents of the application may then be recorded as an FIR.

Once an incident of rape takes place, any person may make a report of it to the Officer-in-Charge (OC) of the police station, and this report will be recorded in a "First Information Report" (FIR). In some cases, women put in an application to the police in writing and the contents of the application may then be recorded as an FIR.

This provision further provides that the failure to conduct medical examinations within reasonable time is deemed to be inefficiency/ misconduct, punishable with appropriate penalties and sanctions set out in the provision[13].

The responsibility of the examiner is to follow the national guidelines and protocol for providing the survivor with appropriate care; documenting the findings, and finally sending a comprehensive report with an opinion to a court of law to help in the administration of justice, as needed and requested by the survivor.

Health service providers should follow the following steps outlined in the algorithm (Figure-2) while providing services to GBV survivors, including survivors of sexual assault.

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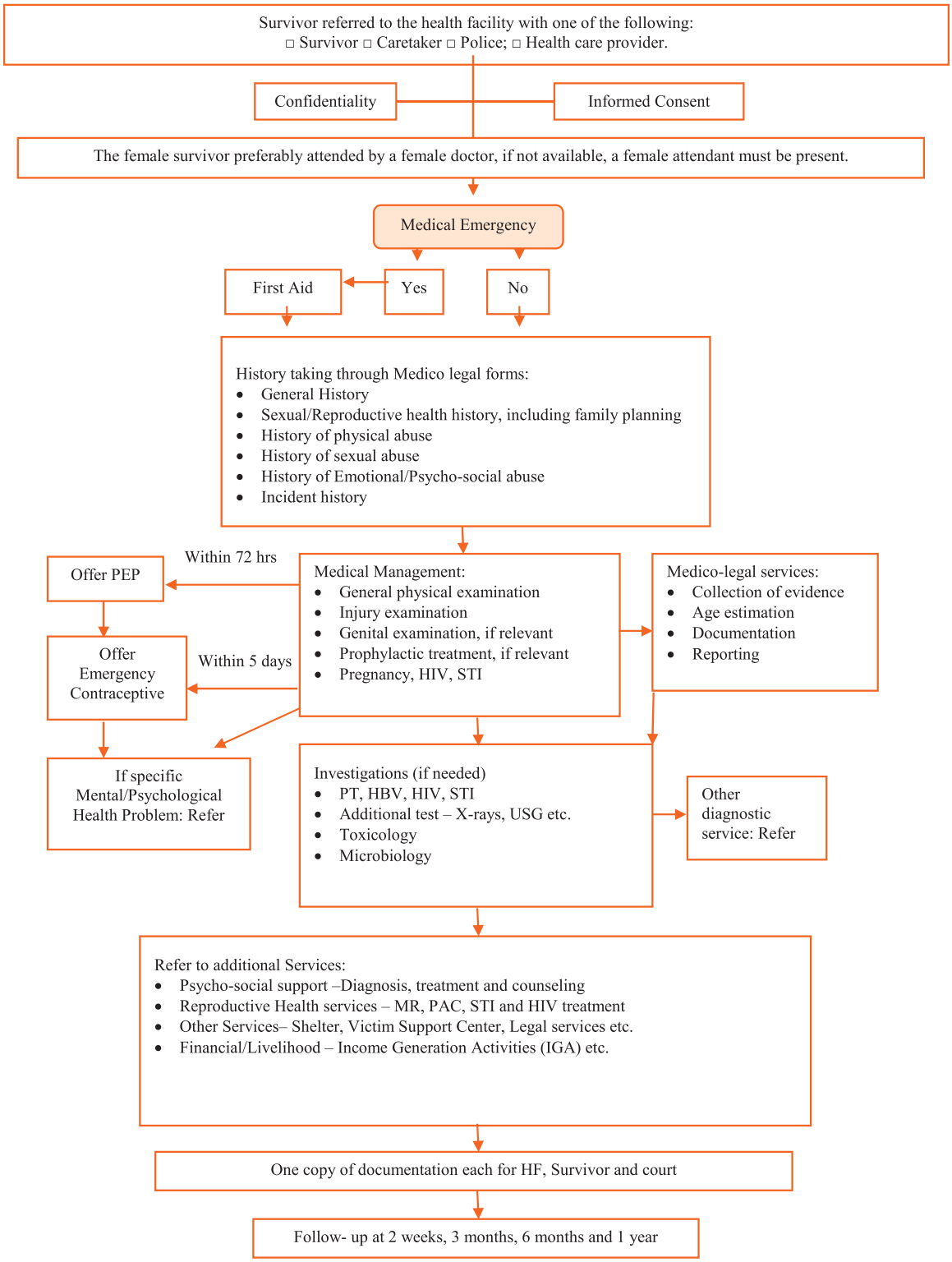
[12] National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV), The United Republic of Tanzania, Ministry of Health and Social Welfare, Sept 2011

[13] Section 32 Nari O Shishu Nirjaton Domon Ain

Figure 2: Health Response to GBV[14]



[14] Clinical protocol of Gender Based Violence, Government of Nepal, MOHP, Population Division, 2015.

5.1 Care for Adult Survivors

5.1.1 Identifying the Survivor[15]

One may be identified as a GBV survivor and reach the health facility in various ways, for example, referral or accompanied by the police, a caretaker or other community groups. She may also disclose an experience of abuse herself. However, evidence shows that the majority of survivors do not report or disclose their experience of GBV. WHO does not recommend universal screening for violence of women attending healthcare. WHO does encourage health care providers to raise the topic with women who have injuries or conditions that they suspect may be related to violence. According to the Violence Against Women survey 2015 Bangladesh, few (1.1%) women seek help from Police, (2.1%) seek help from community leaders and 72% do not report at all. Many women experiencing GBV may seek health services for many other reasons without reporting abuse. Thus, it is critical that health providers are aware to the signs that one has been subjected to violence.

A health provider may suspect that one has been subjected to violence if she has any of the following:

- Symptoms of depression, anxiety, Post Traumatic Stressed Disorder (PTSD), sleep disorders
- Suicidal tendency or self-harm
- Alcohol and other substance abuse
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and STIs
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system- headaches, cognitive problems, hearing loss
- Chronic pain (Repeated health consultations with no clear diagnosis)

[15] Guidelines for medico-legal care for victims of sexual violence, World Health Organization 2003

The health worker should be aware about individuals who are at higher risk of violence. These could be unaccompanied women, lone female heads of household, children and young adults, children in foster care, physically and mentally disabled men and women, individuals in prison or held in detention, individuals with a past history of rape or sexual abuse, individuals in an abusive intimate or dependent relationship, victims of war or armed conflict situations and the homeless or impoverished. Considering the above conditions, the examiner should follow the following procedures.

- Open the discussion about GBV by giving examples of other women who survived violence by husband /in-laws/ other relatives/ employers/ neighbors/ others.
- Ask direct questions to explore if she has experienced such kind of violence as given below:
    - "Are you afraid of your husband (or partner)?"
    - "Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?"
    - "Does your husband (or partner) or someone at home bully you or insult you?
    - "Does your husband (or partner) try to control you, for example, not letting you have money or go out of the house?"
    - "Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?"
    - "Has your husband (or partner) threatened to kill you?"

You may also suspect abuse if the accompanying guardian or partner is intrusive during consultations or the suspected survivor and/or the children have emotional and behavioral problems.

5.1.2 Determine if Medical Emergency

The health of the individual is the first priority. In cases where the clinician suspects physical or mental injuries that require acute management, the medico-legal evaluation should only be performed after emergency care.

5.1.3 Confidentiality and Informed Consent

As per the protocol in the previous chapter, the health provider should make sure that the survivor's confidentiality is ensured. This includes conducting the examination in a private space, ensuring others cannot hear, and assigning a unique code name in the register and reporting forms. In addition, the provider should obtain informed expressed consent for medico-legal examination/treatment and collection of medico-legal samples, to take a photograph and sharing non-identifiable information for reporting purposes using the annexed consent form **Annex 3.** (Consent form for GBV Services.)

5.1.4 Accompanying Person

The examiner should enquire whether the survivor would like to have a companion during the consultation or examination. It will be important to keep in mind that the companion could be the perpetrator, and therefore, the examiner should ensure that it is solely the choice of the survivor to decide whether the companion is present. It is to be noted, a female survivor preferably be examined by a female doctor, if not available, then a female attendant must be present during consultation or examination.

5.1.5 History Taking

History taking, examination, and documentation provide the crucial links among the occurrence, the survivor, and the health care and criminal justice systems. **Any documentation** brought by the survivor, companion or referrer shall be reviewed before taking the history.

Procedures for History Taking

The following are the steps for taking the history of the survivor:

1. Introduce one-self to the survivor.
2. Limit the number of people allowed in the room during the examination; if others are present, explain their roles and ask permission from the survivor to have them present.
3. Explain that the survivor is in control of the place, timing, and components of the examination.
4. Reassure the survivor that the examination findings will be kept confidential; ask her if she has any questions.
5. Explain what is going to happen during each step of the examination and the importance of the examination.
6. Provide relevant information on legal provisions and other services for GBV and the need for medico-legal documentation.
7. Explain the provisions in the consent form; ask if she agrees to them; and if so, have the survivor sign the consent form.
8. After the survivor has signed the consent form, undertake the examinations as soon as possible.
9. Throughout the process, ensure that confidentiality is maintained.

Main Elements of History Taking

Details of information to be collected are contained in the five GBV medical examination forms found in the annexes. Generally, the following information should be collected:

1. General Information

- Name, code number, address, residence, telephone number, sex, date of birth (or age in years), ethnicity, marital status, parity, education.
- Date and time of the examination and the name (s) of any staff or support persons present.
- Incident information (types of violence, which time of day incident took place, incident location, time between incident and date of interview, if incident was a harmful traditional practice, if previous incidents of GBV perpetrated against the person).
- Perpetrator Information (number of primary perpetrators, age, sex, perpetrator-survivor relationship, perpetrator occupation).
- Information related to referral mechanism (incidents referred from other service providers to you, services provided by your organization and survivors referred to other service providers).

2. Description of the Incident

- Describe what happened and note the date, time, and place.
- Obtain information about the perpetrator, per medical forms.
- Every information should be written in the own word of the Survivor.

It is important that the health care provider understands the details of exactly what happened to check for possible injuries. For example: When did the assault take place? Whether perpetrator abused only physically or sexually?

If sexually abused, ask questions according to the Medical Examination Form (**Annex 4.A.** Medical Report & Examination Form for Female Survivor; **Annex 4.B.** Medical Report & Examination Form for Male Survivor)

If physically abused, ask according to the Medical Examination Form (**Annex 5.** Injury Examination Report). These details may provide direction for the collection of forensic evidence.

Gynecological & Obstetric History

- Obtain the first date 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 had STIs before and if she was treated.
- Determine if the survivor has ever been tested for HIV before and what is her HIV status.
- 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, since when, and the compliance, when relevant.

- Vaginal or anal pain, bleeding and/or discharge following the event.
- Blood stained discharge from vagina or anus.
- Any difficulty of pain with voiding or defecating.
- Any urinary or fecal incontinence.

Mental Health Status

- Obtain a mental health history using the format on Mental Health Examination listed in **Annex 7.** Report of Psychological Examination (Psychiatrist only) if a psychiatrist is available in the facility. Salient points include previous and current psychiatric diagnoses, prior hospitalization, previous and current medication, drug use, domestic violence and family history of mental illness.
- Survivors that display any of the symptoms listed below in the mental health assessment should be referred to a psychosocial counselor or medical doctor experienced in managing clients in need of mental health services.

Table 5: Components of the Mental Health Assessment

1) Appearance and behavior	• Does s/he take care of his/her appearance? Are his/her clothing and hair cared for or in disarray? • Is s/he distracted or agitated? Is s/he restless, or is s/he calm? • Are there any signs of intoxication or misuse of drugs?
2) Mood, both what you observe and what she reports	• Is s/he calm or crying or angry or anxious or very sad or without expression?
3) Speech	• Is s/he silent? • How does s/he speak (clearly or with difficulty)? Too fast/ too slow? • Is s/he confused?
4) Thoughts	• Does s/he have thoughts about hurting herself? • Are there bad thoughts or memories that keep coming back?

You can also gather information by asking general questions:

- "How do you feel?"
- "How have things changed for you?"
- "Are you having any problems?"
- "Are you having any difficulties coping with daily life?"

If your general assessment identifies problems with mood, thoughts or behavior, and the survivor is unable to function in daily life, s/he may have more severe mental health problems.

Past Medical and Surgical History

Ask about:

- Possible medical conditions, allergies, vaccination
- Use of alcohol/drugs
- HIV/HBsAg status
- Previous surgery

In Alleged Sexual GBV

- Type of sexual GBV: oral / inter-crural intercourse / inter-labial / vaginal / anal / penetration, etc. as perceived by the victim.
- Issues in relation to obtaining consent for sexual activity:
    - Perpetrator used: threats/ intimidation/threat of death / physical pain / detention / enticement (e.g. pornographic literature)
    - Victim: was of unsound mind/ intoxicated (alcohol/drug)/under 16 years of age.
- Effects that are perceived by the victim at the time of incident: bleeding per vagina (PV), bleeding per rectal (PR), soreness, pain on walking, dysuria, pain on defecation, discharge per vagina or anus, pruritus (anus, vulva), others (specify).
- Force/injuries inflicted by the perpetrator on the victim during the incident as perceived by the examinee:
    - Bites, beating, pinch, scratch, pricks, pulling hair, use of weapon-blunt/ sharp force, etc. inflicted by the examinee on the perpetrator.
- Use of contraceptives type and method (emergency, short term, long term, permanent)
- In a case of a male examinee ask about the history of vasectomy, where relevant.

Relevant Acts Following the Incident

Ask the survivor to describe relevant acts following the incident such as-

- Washing of genital/anal area, bathing, urination, defecation, brushing teeth, rinsing mouth, changing/washing clothes, use of tampon/pad, vomiting etc.

5.1.6 Examination[16]

Examination should be performed in the presence of an attendant of the same sex of the examinee. Examination should be conducted on a clean white bed sheet/paper/cloth in standing position in case of medico-legal cases and other situation examination should be performed in a confidential and comfortable environment.

Purpose of Medical and Forensic Examination

The purpose of the medical and forensic examination of the survivor is to establish the following:

- Whether a sexual act has been attempted or completed. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen. Sexual acts include genital, anal or oral penetration by the penis, fingers, or other objects as well as any form of non-consensual sexual touching.
- Whether such a sexual act is recent.
- Whether such an act was forceful. Signs of resistance to the assault are documented through examination. The history of resistance and/or evidence of struggle and injuries inflicted on the survivor by the accused and the survivor on the accused provide evidence that the act was against her will. However, the absence of signs of struggle does not imply consent.
- If validity of consent is questionable. Verifying the age of the patient in case of pre-pubertal/adolescent girls/boys.
- Ascertaining influence of alcohol or drugs administered to the survivor.
- Providing treatment for sequelae of the assault and appropriate referrals for the patient.

Source: CEHAT Manual for Medical Examination of Sexual Assault 2010

a) Observations

- A complete and thorough examination should be performed by observation and examining the entire body.
- The examinee is asked to remove clothing from upper half of the body and the upper half is to be examined. After completion of examination and documentation of findings in upper half of the body, the upper half should be covered (clothed).
- The examinee is then asked to remove clothing from the lower half of the body and examined. The examinee should not be completely naked at any time during the examination.

[16] National Guidelines on Examination, Reporting and Management of Sexually Abused Survivors for Medico-Legal Purposes– Compiled by the College of Forensic Pathologists of Sri Lanka, First edition, 2014.

b) General Physical Examination

A systematic, "top-to-toe" physical examination of the patient should be conducted in the following step-wise manner[17].

Step 1

First note the patient's general appearance and demeanor. Start with the patient's hands; this will reassure the patient. Take the vital signs (i.e., pulse, blood pressure, respiration and temperature). Inspect both sides of both hands for injuries. Observe the wrists for signs of ligature marks. Trace evidence may need to be collected.

Step 2

Inspect the forearms for defense injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body. Defensive injuries include bruising, abrasions, lacerations or incised wounds. In dark skinned people, bruising can be difficult to see, and thus tenderness and swelling is of great significance. Any intravenous puncture sites should be noted.

Step 3

The inner surfaces of the upper arms and the armpit or axilla need to be carefully observed for signs of bruising. Victims who have been restrained by hands often display fingertip bruising on the upper arms. Similarly, when clothing has been pulled, red linear petechial bruising can sometimes be seen.

Step 4

Inspect the face. Black eyes can be subtle. Look in the nose for signs of bleeding. Gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising. The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa. The hard/soft palate may indicate penetration. Check for a torn frenulum and broken teeth. Collect an oral swab, if indicated.

Step 5

Inspect the ears, not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp.

Step 6

Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of hematomas. Hair loss due to hair pulling during the assault may cause large amount of loose hair to be collected in the gloved hands of the examiner.

[17] WHO. Guidelines for medico-legal care for victims of sexual violence. 2003.

Step 7

The neck area is of great forensic interest. Bruising on the neck can indicate a life-threatening assault. Imprint bruising may be seen from necklaces and other items of jewelry on the ears and on the neck. Suction-type bruising from bites should be noted and swabbed for saliva before being touched.

Step 8

The breasts and trunk should be examined with as much dignity and privacy as can be afforded. It is generally most convenient to start with the back. It is possible to expose only that area that is being examined; for example, the gown may be taken aside on the right side of the back and then the left side of the back. The shoulders should be separately viewed. Subtle bruising and more obvious bruising may be seen in a variety of places on the back. If the patient is able to sit up on the couch, the gown can be taken down to the upper breast level just exposing the upper chest on the right and left and then each breast can be examined in turn. Breasts are frequently a target of assault and are often bitten and so may reveal evidence of suction bruises or blunt trauma.

Step 9

The patient can then be reclined for an abdominal examination (i.e., an inspection for bruising, abrasions, lacerations and trace evidence). Abdominal palpation should be performed to exclude any internal trauma or to detect pregnancy.

Step 10

With the patient still in a reclined position, the legs can be examined in turn, commencing with the front of the legs. Inner thighs are often the target of fingertip bruising or blunt trauma (caused by knees). The pattern of bruising on the inner thighs is often symmetrical. There may be abrasions to the knee (as a consequence of the patient being forced to the ground); similarly, the feet may show evidence of abrasions or lacerations. It is important to inspect the ankles (and wrists) very closely for signs of restraint with ligatures. The soles of the feet should also be examined.

Step 11

It is advisable, if possible, to ask the patient to stand for the inspection of the back of the legs. An inspection of the buttocks is also best achieved with the patient standing. Alternatively, the patient may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock. Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibers, grass, soil etc.).

As a general rule, the **presence of any tattoos should be documented in the examination record,** together with a brief description of their size and shape, as these may become a means of **assessing the accuracy of the observations of the examining practitioner in court.** Similarly, obvious physical deformities should be noted.

c) Examination of Injuries and Scars

- Describe the appearance of injuries (recent, healing, scar) include nature, site, size, shape, direction, associated injuries, and any other foreign material. See **Annex 6.** Estimation of Time since Injury.
- Examine the mouth for injuries, other findings, and foreign materials.
- Signs and symptoms of dento-facial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum and jaw and facial bone fractures. They should be referred for dental or maxillo-facial care when needed.
- In head trauma cases: Examine carefully for evidence for scalp trauma. Record any bruises, areas of scalp swelling or hair loss. Examine earlobes carefully for any bruising or petechiae.
- In suspected bite marks, serial photographs should be taken with a scale in different angles and with the least delay. Where expertise is available, the examinee should be referred to the dentist/forensic odontologist as soon as possible for bite mark investigations.

d) Systemic Examination

- In addition to the positive findings as mentioned above, review the systems (CNS, CVS, and Respiratory System, etc.) and record findings for exclusionary purpose.

e) Genital and Para Genital Examination

- A standard positioning and technique must always be used in external and internal examination of genitalia and rectum. The technique used must not cause undue pain, physical and mental discomfort to the examinee and the examiner must always select an "examinee-friendly" technique. Position and the technique employed must be recorded.
- Assess development of secondary sexual characteristics (development of breast, hair distribution in genital organ) and evidence of pregnancy/delivery.

(i) Female Genital Examination

Survivor should be kept in a supine position on examination table. The external areas of the genital region should be examined, as well as any markings on the thighs and buttocks. Inspect the mons pubis. The vaginal vestibule should be examined paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum. **A swab of the external genitalia should be taken before any digital exploration or speculum examination is attempted.** A gentle stretch at the posterior fourchette area may reveal abrasions that are otherwise difficult to see, particularly if they are hidden within slight swelling or within the folds of the mucosal tissue. Gently pulling the labia (towards the examiner) will improve visualization of the hymen. Asking the patient to bear down may assist the visualizing of the introitus.

In most cases, a speculum examination should be performed as a matter of course. It is particularly relevant if there is significant vaginal or uterine pain post assault, vaginal bleeding or suspicion of a foreign body in the vagina. Furthermore, **in assaults that occurred more than 24 hours but less than 96 hours (approximately) prior to the physical examination, a speculum examination should be performed in order to collect an endocervical canal swab (for semen). If a speculum examination is not conducted (e.g. because of patient refusal) it may still be possible to collect a blind vaginal swab.**

- Note appearance of public hair for secondary sexual characteristics and other observations. Look for loose and matted pubic hair.
- Note the appearance of labia majora, labia minora, posterior fourchette, and fossa navicularis.
- Observe for the presence of bleeding, discharge, presence of foreign materials, etc.
- Record the presence of recent injuries, such as abrasions, contusions and lacerations, according to the position of the clock. Observe for signs of swelling, tenderness and redness to indicate a fresh injury or whether injury is healing or is completely healed. Please mark on the pictogram provided in **Annex 4.A.** Medical Report & Examination Form for Female Survivor; **Annex 5.** Injury Examination Report; **Annex 6.** Estimation of Time since Injury.
- When describing hymenal injuries, specify timing of the injury going through the features like redness, swelling, bleeds on touch scarified.
- Note the presence of injuries in the vaginal wall (where relevant) and changes to the cervix (where relevant), urethral meatus and perineum.
- Look for evidence of STI like profuse offensive discharge/purulent discharge/warty growth and document.
- In case of inability to arrive at a conclusion at the end of the examination, contact the nearest specialist in forensic medicine.

(ii) Male Genital Examination

- Note the pubic hair, shaft, prepuce, corona, glans and urethral meatus, scrotum, testes/ epididymis/cords.
- Describe the injuries and scars including vasectomy scar, presence of discharge or any other abnormalities or diseases.
- Perform anal and peri-anal examination.

f) Anal Examination

- Record the appearance of peri-anal area, anal opening and anal canal. Look for injuries (recent, healing, scars), reflex and dilatation, lubricant, blood, seminal stain, any other foreign materials, fecal soiling.

5.1.7 Medicolegal services

(a) Collection of Material for Evidence

- Details about types of sample to be collected and its purposes are included in **Annex 10.** Types of Samples to Be Collected.
- Relevant significant materials should be collected and documented at the time of examination.
- Dry materials (foreign materials, stained clothing, hair, etc.) should be collected and packed in a paper envelope. If the material is wet or damp, the material evidence should be dried naturally, at room temperature, in shade and then packed in a paper envelope.
- Fingernail (nail scrapping or broken part): Use the tooth pick to collect material under the nails or nails can be cut and the clippings collected in a sterile container.
- Swabs of area of bite mark, after wetting the swab with normal saline or distilled water, should be dried naturally, at room temperature, in shade and packed in a paper envelope.
- Swabs of the genitalia should be obtained in all cases with history of contact with the examinee's genitalia irrespective of whether penetration has occurred or not. This should include a perineal swab, low-vaginal, mid-vaginal and high-vaginal swabs as well as a peri-anal swab. The swab should be used to create smears at the same time of collection. The swabs and smears should be labeled and left to dry naturally, at room temperature, in shade and should be packed in a paper envelope after it has dried.
- Low vaginal swab – A low vaginal swab, obtained by passing the swab into the vagina under direct vision avoiding contact with the external genitalia.
- High vaginal swab – With a speculum in place two high vaginal swab (HVS) should be taken from the vaginal fornices above the speculum avoiding contact with the side or the top of the instrument.
- Endocervical swab – If more than 48 hours have passed since the alleged incident, in special situation one or two endocervical swabs should be taken in addition to the HVS as spermatozoa remain longer in that area.

(b) How to collect vaginal swab:

- Counsel survivor regarding each steps
- Take informed written consent
- She should be in dorsal position
- Place a sheet over her body
- Ensure proper exposure at the time of the examination.
- Introduce the speculum lubricated only with water and check the condition of hymen
- A sterile cotton swab introduced within the vaginal canal

- Secretion will be collected from posterior fornix
- Properly label the test-tube with cotton swab, send to lab

- If facility for cytological analysis for presence of semen is available, the smear samples should be processed and analyzed at the hospital laboratory. In instances of non-availability, the samples and evidences should be given to the police following sealing and after maintaining "chain of custody."
- Urine should be collected for pregnancy test in cases where there is history of sexual contact. This test should be carried out immediately at the same facility.
- Blood should be collected for testing for presence of HIV, hepatitis B virus (HBV), VDRL for syphilis and other STIs as well as for toxicological analysis to detect presence of common drugs of abuse including alcohol. Blood should be collected in 2 (two) vials or tubes (one for diagnostic tests and other for toxicological and other medico-legal analysis) and preserved by adding NaF (sodium fluoride) and EDTA (ethylene-diamine-tetra acetic acid). If facilities are available, diagnostic tests for STIs should be performed at the same center. If facilities are not available, the samples should be sent to referral centers after sealing and maintain 'chain of custody.' DNA tests are done in National Forensic DNA Profiling Laboratory and survivors who are supported by One Stop Crisis Center (OCC), DNA tests are done free for them.
- In case of stains present over the clothing, a swab should be collected after wetting the swab with normal saline or distilled water. In case the examinee has not brought a second set of clothing, the swab should be collected and clothing can be returned to the examinee. In case a second set of clothing is available, the clothing in addition to the swab should be collected. The swab and clothing should be dried naturally, at room temperature, in shade and should be packed in a paper envelope.

  All samples should be labeled with the following information:

  - Name/registration number of survivor
  - Date of collection
  - Time of collection
  - Nature and description of sample
  - Purpose of collection/examination/analysis
- Different samples should be packed in separate containers/bags.
- Seal the samples after collection.
- Maintain 'chain of custody' which must include:
  - Name of receiver
  - Designation of receiver

- Organization
- Date and time of receipt
- Signature

- The analyzed specimen and remaining part of the sample (e.g. glass slides, blood, etc.) should be stored at the same center in safe custody and maintaining confidentiality for a minimum of three months.

(c) Examination of Clothing

- List the clothing worn by the victim at the time of examination
- Record whether they were the clothing worn by the victim at the time of incident. If the clothing worn by the victim at the time of incident is available, list, and describe (tears, stains etc.)
- If the clothing worn at the time of the incident is not available, record the reason for it. Where possible, make attempts to obtain those clothes, examine them and give them to police.
- Make arrangements to have another set of clothing if the clothing that was worn is taken as a sample.
- Observe for presence of stains, tears, or other anomalies.

(d) Documentation

- The clinician shall fill in the Medical Report & Examination Form **Annex 4-9** in three copies (one copy for health facility, one for the survivor and another for legal action).
- The health care provider is responsible for safe keeping of the records.
- The health care provider is responsible for providing essential document as per requirement.

5.1.8 Laboratory Test

Do a pregnancy test, if indicated and laboratory facilities are available. Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination. If laboratory facilities are available, samples may be taken from the vagina or anus for STI screening for treatment purposes. Screening might cover:

- Rapid Plasma Reagin (RPR) test for syphilis or any point of care rapid test
- Gram stain and culture for gonorrhea
- Culture or enzyme-linked immunosorbent assay (ELISA) for Chlamydia or any point of care rapid test
- Wet mount for trichomoniasis
- HIV test (only on a voluntary basis and after counseling)

5.1.9 Treatment and care of GBV Survivors

Treatment of the survivor of gender based violence will depend on how soon the victim presents to health service after the incident. It can be described in two parts:

I. Survivor who presents within 72 hours of the incident

II. Survivor who presents after 72 hours of the incident

Male survivors require same treatment & vaccination as female survivors. Care provided to GBV survivors can broadly be grouped under five main headings:

a) Treat Physical injuries or refer

Immediately refer patients with life-threatening or severe conditions for emergency treatment. Complications that may require urgent hospitalization:

- Extensive injury (to genital region, head, chest or abdomen)
- Neurological deficits (for example, cannot speak, problems walking)
- Respiratory distress
- Swelling of joints on one side of the body (septic arthritis).

Patients with less severe injuries – for example, superficial wounds – can usually be treated on site. Clean and treat any wounds as necessary.

The following medications may be indicated:

- Antibiotics to prevent wound infection
- Medications for relief of pain
- Medication for insomnia if needed

Tetanus prophylaxis

- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
- If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.
- Advice survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months, forth dose at 1 year & fifth dose 1 year later).

Dose for Tetanus Immunization in Cases of Wounds

History of tetanus immunization (number of doses)	If wounds are clean and < 6 hours old or minor wounds		All other wounds	
	TT*	TIG	TT	TIG
Uncertain or <3	Yes	No	Yes	Yes
3 or more	No, unless last dose >10 years ago	No	No, unless last dose >5 years ago	No

Source: Control of Communicable Diseases Manual, 20th Edition, Washington DC, American Public health Association.

b) Provide emergency contraception to prevent unwanted pregnancy

If emergency contraception (EC) is used soon after sexual assault, it can help a woman to avoid pregnancy. Offer EC to any woman who has been sexually assaulted along with counselling so that she can make an informed decision.

Facts about emergency contraception pills (Annex-12)

- Any woman can take ECP. No need to screen for health conditions or test for pregnancy.
- A woman can take ECP, antibiotics for STIs and PEP for HIV prevention at the same time without harm. ECP and antibiotics can be taken at different times and along with food to reduce nausea.
- If the survivor is already pregnant, EC pills will not harm the pregnancy. However, a pregnancy test may identify if she is pregnant already, and she can have one if she wishes.

Instructions

- Survivor should take ECP as soon as possible preferably within 72 hours of unprotected sex. She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes.
- She should return if her next menstrual period is more than 1 week late. Menstrual Regulation should be offered within 12 weeks of missed period according to existing law.

c) Prevent sexually transmitted infections

Survivors of sexual violence may contact a number of infections like chlamydia, gonorrhea, syphilis and trichomoniasis, for which treatment is available. They are also at risk of contacting viruses like human papillomavirus (HPV), herpes simplex virus type 2 (HSV-2), HIV, and HBV.

- Offer STI treatment on your first meeting with the woman.
- There is no need to test for STIs before treating.
- Give presumptive treatment for STIs common in the area (for example, chlamydia).
- Give the shortest courses available in the national protocol, as these are easiest to take. For further information see **Annex 13.** STI Management.

Hepatitis B

The hepatitis B virus can be sexually transmitted. Therefore, women subjected to sexual violence should be offered immunization for hepatitis B within 14 days of incidence. In Bangladesh immunization programs now routinely use hepatitis B vaccine for the children; a survivor may already have been fully vaccinated. If the vaccination record card confirms this, no additional doses of hepatitis B vaccine need to be given.

Immunization status	Treatment guidelines
No, never vaccinated for hepatitis B	1st dose: at first visit 2nd dose: 1 month after the first dose 3rd dose: 6 months after the second dose
Started but has not yet completed the course	Complete the course as scheduled
Yes, completed	No need to revaccinate

d) Prevent HIV

All survivors should be offered voluntary counselling and HIV testing. **HIV testing is not mandatory. Survivors who cannot or do not want to undergo HIV testing and who are not already known to be HIV positive, should be offered Post Exposure Prophylaxis (PEP) if indicated.** Administration of PEP must never be made conditional on the person agreeing to have an HIV test. Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible within 72 hours of possible exposure to HIV. **Annex 14.** Post Exposure Prophylaxis (PEP) for Sexual GBV Survivor.

When should PEP be considered?

Situation/Risk factor	Suggested procedure
Perpetrator is HIV infected or of unknown HIV status.	Give PEP
Survivor's HIV status is unknown.	Offer HIV testing and counselling
Survivor's HIV status is unknown and is NOT willing to test.	Give PEP and make follow-up appointment
Survivor is HIV-positive.	Do NOT give PEP
Survivor has been exposed to blood or semen through vaginal, anal or oral intercourse or through wounds or other mucous membranes).	Give PEP
Survivor was unconscious and cannot remember what happened.	Give PEP
Survivor was gang-raped.	Give PEP

Communicate

Taking PEP is the survivor's decision. Discuss the following points to help s/he decide.

- Does s/he know if the perpetrator is HIV-positive?
- PEP can lower chances of getting HIV, but it is not 100% effective.
- S/he will need to take the medicine for 28 days, either once or twice daily depending on the regimen used.

- About half of people who take PEP have side-effects, such as nausea, tiredness, and headaches (For most people side-effects decrease in a few days).
- Start the regimen as soon as possible and in any case no later than 72 hours after the assault.
- The choice of PEP drugs should be based on national guidelines.
- Offer HIV testing at the initial consultation.
- In the case of a positive test result, refer for HIV treatment and care.
- Ensure follow-up at regular intervals. Retest at 3 or 6 months or both.

PEP adherence counselling

Adherence is an important element of delivering PEP. Discuss the following points with the woman:

- It is important to remember to take each dose, and so it is helpful to take it at the same time every day, such as at breakfast and dinner.
- If she forgets to take her medicine on time, she should still take it, if it is less than 12 hours late.
- If it is more than 12 hours late, she should wait and take the next dose at the regular time.
- She should not take 2 doses at the same time.
- She should return to the clinic if side-effects do not go away in a few days, if she is unable to take the drugs as prescribed, or if she has any other problems.

e) Psychosocial Care and Support

Many women who are subjected to intimate partner violence or sexual violence will have emotional or mental health problems. There are specific ways you can offer help and techniques you can teach to reduce women's stress and help them heal. Some women, however, will suffer more severely than others. It is important to be able to recognize these women and to help them obtain care. If such help is not available, there are things that first line health care providers can do to reduce their suffering.

Common Psychological Reactions to GBV

Physiological effects of GBV vary considerably from person to person. Survivors may present with:

- Low energy, fatigue, sleep problems
- Multiple physical symptoms with no clear cause (for example, aches and pains)
- Persistent sadness or depressed mood; anxiety
- Little interest in or pleasure from activities
- Sexual difficulty

- Eating disorders
- Emotional lability (crying, smiling, indifferent response)
- Guilt and anger

There are provisions of two types of psychosocial services in this protocol:

1. Basic psychosocial support and
2. Specialized psychosocial management.

Basic psychosocial support can be provided in health facilities starting from grass root level. Specialized psychosocial management is available at the tertiary or specialized health facilities or in facilities where psychiatrists are available.

Basic psychosocial support:

Basic psychosocial support for GBV includes:

- Address the basic needs (Hunger, thirst, sleep)
- Actively listening to, validating and consoling the survivor.
- Help strengthen her positive coping methods (see below.)
- Explore the availability of social support, psychological counseling, legal suport.
- Explain / offer choices to survivor: Immediate access to

  a) Safe accommodation

  b) Emergency health care service

  c) Option to recontact the service if needed

Strengthening Positive Coping Methods

After a violent event, a woman may find it difficult to return to her normal routine.

- Encourage her to take small and simple steps.
- Talk to her about her life and activities.
- Discuss and plan together.
- Let her know that things will likely get better over time and encourage her to do the following.
    - Build on her strengths and abilities. Ask what is going well currently and how she has coped with difficult situations in the past.
    - Continue normal activities, especially ones that used to be interesting or pleasurable.
    - Engage in relaxing activities to reduce anxiety and tension.
    - Keep a regular sleep schedule and avoid sleeping too much.

- Engage in regular physical activity.
- Avoid using self prescribed medications, alcohol or illegal drugs to try to feel better.
- Recognize thoughts of self harm or suicide and tell her to come back as soon as possible for help if they occur.
- Encourage her to return if these suggestions are not helping.

Referral for specialized psychosocial management:

- Repeated thoughts of suicide or death or suicide attempts
- Major depressive disorder: If more than five symptoms (Insomnia or hypersomnia, depressed mood or loss of interest or pleasure, feeling of worthlessness, fatigue, diminished ability to think or make decisions, change of weight, psychomotor retardation or irritation, preoccupation with death or hopelessness) persist over two weeks then it will be considered as major depressive disorder
- If any psychiatric disorder develops or survivor does not improve after two weeks of treatment

Organizations which provide psychological management

- National Institute of Mental Health (NIMH), Sher-e-Bangla Nagar, Dhaka
- Mental Hospital, Pabna
- Psychiatric department of Bangabandhu Sheikh Mujib Medical University (BSMMU), Dhaka
- National Trauma Counselling Center (NTCC), Department of Women Affairs Building, Eskaton Garden, Dhaka
- One Stop Crisis Center (OCC) present in Medical College Hospitals.
- Psychiatric department of all Medical College Hospitals.

Communication DOs and DON'Ts While Handling Survivors of GBV

Table 6: Communication DOs and DON'Ts while handling survivors of GBV[18]

Do	Don't
DO ensure and respect confidentiality. ● If a survivor says s/he needs help, try to have the conversation in a place that makes her comfortable. This may be a private place or s/he may prefer a public place to avoid stigmatization. Confidentiality is essential to building trust and ensuring the survivor's safety.	DON'T force the survivor to tell the details of what happened to her. ● Never insist on telling the story on revealing details about what happened when a survivor does not feel ready to talk about this.
DO believe and validate the survivor's experience. ● Listen to the survivor and believe her. ● Acknowledge the survivor's feelings and needs and let the survivor know that she is not alone and you will try to get her help.	DON'T trivialize or minimize the violence. ● Not taking a survivor's story seriously is a violation of her trust and can serve as a barrier for a survivor seeking help. Not taking a survivor seriously is re-victimizing.
DO make referrals and promote access to community services. ● Advise survivors to seek out medical care as soon as possible and provide referrals.	DON'T refer survivors to services that will not provide confidential, respectful care. ● Community groups should work together to ensure that they refer survivors to agencies that provide compassionate and confidential care.
DO help the survivor to plan for safety. ● Whenever possible, ensure the survivor is not in immediate danger of re-victimization. If the perpetrator of the violence is in the survivor's home, help find the survivor an alternative place to stay. This may prove difficult in conflict situations, but efforts should be made to improve the survivor's safety.	DON'T ignore the survivor's need for safety. ● Do not instruct the survivor to return to a home or a village that she knows to be unsafe, or where her perpetrator continues to threaten her.

[18] Source: IRC_CCSAS Psychosocial Toolkit, 2014

Do	Don't
DO acknowledge the injustice. ● Sexual violence is NOT the survivor's fault, and ensures that the survivor understands this.	DON'T blame the survivor. ● Do not ask questions like "why didn't you run?" ● Or "what did you do to make him hurt you?" Sexual violence is NEVER the survivor's fault.
DO provide information to the survivor. ● Inform the survivor about who you are, what you can do for her and what the options are to seek help.	DON'T tell a survivor what to do. ● You may suggest options for assistance to the survivor, and help a survivor to make a choice, but you should never decide for a survivor what to do.

5.1.9 Follow-Up Care

Follow-up visits are recommended at 2 weeks, 1 month, 3 months and 6 months post-assault to check for injury, STIs, pregnancy, mental health and planning, as per **Annex 15.** Follow Up of the GBV survivors.

5.2 Care for the child and adolescent GBV survivors

The capacity of children and adolescents to understand information about the nature of the clinical care, its benefits and consequences, and to make voluntary and informed decisions, evolves with their age and developmental stage.

- Provide information that is appropriate to age as well as to other considerations (e.g. sex, race, ethnicity, religion, sexual orientation, gender identity, and disability and socioeconomic status). The information should be offered and delivered (e.g. in choice of words or language: use of visual aids) according to the child's or adolescent's age and developmental stage, including their cognitive, behavioral and emotional maturity to understand the information.
- Seek informed consent as appropriate, where the child or adolescent is below the legal age of consent, it may still be in their best interests to seek informed consent. In some settings, older adolescents are able to provide informed consent in addition to, their parents or legal guardians. They have the right to access confidential counseling or advice and information without the consent of their parents or legal guardians. In situations where the adolescents are in need of care, health-care providers may consider whether to involve the parents or legal guardians.
- Respect the autonomy of children or adolescents (e.g. not forcing them to give information or be examined) while balancing this with the need to protect their best interests (e.g. protect and promote their safety). In cases where a child's or adolescent´s wishes cannot be prioritized, the reasons should be explained to the child or adolescent before further steps are taken.
- Offer choices in the course of the medical care, as appropriate.

5.2.1 Identifying a Child or adolescent as Survivor of GBV

The consequences of violence against children include both the immediate personal impacts and the damage that they carry forward into later childhood, adolescence and adult life. Despite its devastating consequences on child's physical, psychological, behavioral and economic life, these experiences often remain unnoticed and under-reported at home or at health facility unless in extreme conditions.

The potential for damage to the child increases with increasing frequency and severity of victimization over time. Therefore, it is important to identify violence as early as possible and intervene to stop it. Health professionals have an important role in child protection because, except in very remote rural areas, infants and small children are usually taken to the health center on a routine basis. Health workers should be aware of the following mental health signs to watch for in children to identify survivors of GBV[19].

Table 7: Physical and Behavioral Indicators of Child Sexual GBV[20]

Physical Indicators	Behavioral Indicators
1. Unexplained genital injury 2. Recurrent vulvo-vaginitis 3. Vaginal or penile discharge 4. Bed wetting and fecal soiling beyond the usual age 5. Anal complaints (e.g., fissures, pain, bleeding) 6. Pain on urination 7. Urinary tract infection 8. STIs 9. Pregnancy	1. Regression in behavior, or attaining developmental milestones 2. Problems at school - academic deterioration, school refusal / avoidance 3. Isolation 4. Restlessness, irritability and aggressive behavior 5. Acute traumatic response such as clingy behavior and irritability in young children 6. Sleep disturbances 7. Eating disorders 8. Depression 9. Poor self-esteem 10. Inappropriate sexualized behaviors 11. Suicidal/ homicidal thoughts

[19] UNICEF. World Report on Violence against Children. http://www.unicef.org/violencestudy/ World Report on Violence against Children.

[20] The United Republic of Tanzania, Ministry of Health and Social Welfare, National Management Guidelines for the Health Sector – Response to and Prevention of GBV, September 2011.

5.2.2 Create a Safe Environment[21]

The following steps should be followed for creating safe environment:

- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that he or she is not in any trouble.
- Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favorite activities.

5.2.3 History Taking of Child or adolescent Survivors

- Begin the interview by asking open-ended questions, such as "Why are you here today?" or "What were you told about coming here?"
- Avoid asking leading or suggestive questions.
- Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.
- Assure the child it is okay to respond to any questions with "I don't know."
- Be patient; go at the child's pace; do not interrupt his or her train of thought.
- For girls, depending on age, ask about menstrual history, they may be at risk of pregnancy.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation (has the child a secure place to go?);
- How the rape/abuse was discovered;
- Who did it, and whether he or she is still a threat;
- If this has happened before, how many times and the date of the last incident;
- Whether there have been any physical complaints (e.g., bleeding, dysuria, discharge, difficulty walking, etc.); and
- Whether any other siblings are at risk.

5.2.4 Examination of the Child or adolescent Survivors

a) Preparation

- As for adult examinations, there should be a support person or trained health worker whom the child trusts in the examination room with you.

[21] Clinical Management of Rape Survivors – Developing Protocols for use with refugees and internally displaced persons. (Revised edition).

- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- With adequate preparation, most children will be able to relax and participate in the examination.
- It is possible that the child cannot relax because s/he has pain. If this is a possibility, give paracetamol or other simple pain killers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination.

b) Examination

The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the child will have to be admitted to hospital.

Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:

- Note the child's weight, height, and pubertal stage.
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do not carry out a digital examination.
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimen can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury.
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a pre-pubertal child is usually done under general anesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs, if indicated.
- All children, boys and girls, should have an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it.
- Record the findings in the pictogram.

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

5.2.5 Laboratory Testing

Blood tests for STIs, HBsAg and HIV should be done in survivors with history of contact.

5.2.6 Treatment

Guiding principle for management of violence case should include medical management, psychosocial management and prevention of future GBV.

a) Medical Care

Regarding STIs, HIV, HBV, and tetanus, children have the same prevention and treatment needs as adults, but may require different doses. Special protocols for children should be followed for all vaccinations and drug regimens.

Recommended dosages for PEP to prevent HIV transmission in children are given in **Annex 14**.

b) Psychosocial Care

The GBV survivor undergoes psychological distress, some immediately, while others may suffer in the short-or long-term. The counselor should apply the survivor-centered approach and professional ethical conduct to counseling. This approach focuses on "Doing good and not doing harm" when counseling survivors. Health care providers should be able to provide basic counseling and refer for special counseling services.

5.2.7 Follow-up

Follow-up care is the same as for adults. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse.

5.3 Care for survivors with disabilities

The two key issues we must consider in implementation are:

(i) Communication:

In most cases, survivors with disabilities can communicate directly with GBV practitioners with no adaptations, or relatively small adaptations, such as identifying someone who can interpret their form of sign language or by using simplified language in discussions. In other cases, it may be less clear what the best way to communicate with a survivor is, and additional steps may be required to determine this.

(ii) Caregiver involvement:

Family members and caregivers can be critical partners in helping us in effective communication and participation with persons with disabilities. The relationship between the survivor and the caregiver is sometimes an enduring relationship. We can focus on supporting and strengthening positive features of this relationship throughout the case management process.

Guidance on communicating with persons with disabilities

Use respectful language:

The Convention on the Rights of Persons with Disabilities is translated into many languages and can be a useful guide to using terms about disability that are both sensitive and appropriate.

Table 8: Communication DOs and DON'Ts while handling survivors with disability

DON'T	DO
Emphasizing a person's impairment or condition For example: Disabled person	Focus on the person first, not their disability For example: Person with disabilities
Negative language about disability	Instead use neutral language
For example:	For example:
"suffers" from polio	"has polio"
"in danger of" becoming blind	"may become blind"
"confined to" a wheelchair	"uses a wheel chair"
"crippled"	"has a disability"
Referring to persons without disabilities as "normal" or "healthy"	Try using "persons without disabilities"

5.3.1 Working with people with different impairments

Survivors with physical impairments:

- Move at their speed; do not walk ahead of them if they are moving slower than you.
- When offering assistance, always ask first what they require. Follow their instructions, and not what you think is best.
- Do not lean on or move someone's wheelchair or assistive device without their permission.
- Discuss transportation options for activities and events. Consider what is going to be safest, most affordable and the least amount of effort for the individual and family.
- Check that physical facilities are accessible (including toilet facilities, etc.) and have sufficient space for people with mobility aids to move around the room.

Survivors with deafness or hearing impairment:

- Find out how the person prefers to communicate. People with hearing impairments may use a combination of writing, lip reading and/or sign language. This can be determined by observing their interactions with others or by using simple gestures to suggest communication options.
- Get the person's attention before speaking, by raising your hand or waving politely.

- Face and talk directly to a person who is deaf, not to the interpreter (as they are only facilitating the communication).
- Speak clearly — don't shout or exaggerate words as this will make it more difficult to lip read.
- Try not to sit or stand with your back to the light — this can put your face in the dark and make it difficult to lip read. Do not cover your mouth or eat while talking. This will make it difficult to lip read.
- Allow the person who is deaf or hearing impaired to choose the best place to sit at a meeting to be able to see people clearly and communicate more easily.
- In meetings, ensure the interpreter can hear the presenter and the rest of the group. They should also be visible to the individual for whom they are interpreting.

A note about sign language

Like spoken languages, sign languages are different in different countries and regions. Some people also use unofficial sign language, and in these cases a family member or friend may need to interpret. Ask them to teach you some simple signs (e.g. good, bad and thank you) and try to include these in your discussion with a person who is deaf or hearing impaired.

Survivors with vision impairments:

- Always introduce yourself and any other people in the group by name.
- Tell the person if you are moving or leaving their space -don't just walk away.
- If the person has arrived at a new place, tell them who is in the room or group, and offer to describe the environment.
- Avoid vague language, such as "that way" or "over there" when directing or describing a location.
- Always ask the person first if they would like assistance to get from one place to another. Ask for instructions on how they would like to be assisted and where they would like to go. Some people prefer verbal guidance, whereas others may prefer for you to physically guide them.
- If you are asked to physically guide someone with vision impairment, they may want to hold your arm just above the elbow. This will allow them to walk slightly behind you, following you as you turn or step up or down onto steps.
- Ask persons with vision impairments if they would like documents in alternative formats, such as Braille or large print. In some contexts where people have access to computers, persons with vision impairments may prefer electronic documents that are accessible through screen reader software (e.g. word documents).

Survivors with intellectual impairments:

People with intellectual impairments may experience difficulty in understanding, learning and remembering, as well as applying information to new situations.

- Communicate in short sentences that convey one point at a time.
- Use real life examples to explain and illustrate points. For example, if discussing an upcoming medical visit, talk the person through the steps they are likely to go through both before and during the appointment.
- Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, then repeat it once. If this doesn't work, then try again using different words.

Allow time for Survivors with intellectual impairments to ask questions.

- Make sure that only one person is speaking at any given time, and that the person with an intellectual impairment is not being rushed to answer.
- Persons with intellectual impairments may want some more time to think about decisions or to discuss their options with someone they trust.
- Identify quiet environments to have conversations in order to reduce distractions.
- Pictures can also be used to communicate messages to people with intellectual impairments — these are sometimes called "Easy to Read" documents.

Survivors with speech impairments:

- Plan more time for communicating with people with speech impairments.
- It is okay to say "I don't understand." Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly.
- Don't attempt to finish a person's sentences — let them speak for themselves.
- Try to ask questions that require short answers or yes/no gestures.
- If you have tried several ways to understand a person without success, ask if it is okay to communicate in a different way, such as through writing or drawing.

5.4 Referral

To facilitate the referral process to outside organizations, health workers need to be aware of the available services in their communities. For example, there may be an One stop Crisis Cell that can provide linkage to a specialised service such as shelter, legal aid, psychosocial support, and police protection.

Coordination with relevant stakeholders such as local committees, Community Groups, Community Support Groups, VAW committee at Union, Upazila and District level, women desk at police station, district legal aid office, district legal aid committee, civil society organizations, etc. should be established for receiving survivors. This will assist providers in helping survivors decide where to seek the necessary services according to the need and type of service offered.

5.4.1 Requirements for establishing referral system

Building networks and identifying organization that work on GBV related issues are important. The survivors may have many needs that go beyond health care, including the need for legal advice, police protection, shelter, economic support and other social services. These needs may be more important than their health care needs, and no organization can single-handedly address the range of services that survivors may need. Therefore a health facility should have a contact list of medical, psychological, social and legal aid organizations, local committees/ groups as well as local police and shelter home contacts.

a) Steps to Develop Referral Directory

i) Explore the existing Civil Society Organisations, legal, security or other coordinating bodies who may respond to the needs of the survivor in the given setting.

ii) Make a referral directory containing list of organizations with the following information:

- Name and contact address/hotlines
- Services available
- Hours of operation
- Service charges

iii) Make a directory with the collected information and make it available at the health facility and update the directory on regular basis.

iv) Get regular feedback from service providers and users about how well the directory is working.

v) Update directory with the agreement of multi sector agencies to coordinate and provide referral support on regular basis

b) Steps to Develop Referral System

- Reach out to potential partners/stakeholders identified in the referral directory for collaborative work.
- Develop a system of referral and counter-referral among organizations, including referral papers, where appropriate.
- Plan regular meeting with service providers to improve co-ordination
- Make sure that partner organizations make survivors aware of the importance of accessing health services within 72 hours for prevention of HIV and five days for prevention of unintended pregnancy, in the case of sexual violence.

- Display posters about sexual violence and where to go for help in the health facilities (having information displayed may make victims feel more comfortable in disclosing and talking about the sexual violence in their lives)[22].
- Place pamphlets and brochures regarding sexual violence in examination rooms, waiting rooms and women's toilets so that patients can take them away with them or read the information in private.
- Develop a list of useful telephone numbers and addresses and develop a system of regular update.
- Refer to higher level facilities/OCC/multisector agencies as appropriate.

[22] Guidelines for medico-legal care for victims of sexual violence, World Health Organization 2003.

Chapter 6: Prevention of GBV

Risk Assessment & safety planning

Before going to develop a safety plan for the survivor a danger assessment or evaluation of multiple risk factors should be done.

- Assess the survivor's level of risk by asking questions to assess the danger felt by the survivor about her health, evidence about GBV and information about the perpetrators if she knows. Some sample questions are shown in the box below, "Sample Danger Assessment Questions" for intimate partner violence.
- If the survivor responds 'yes' to any of the questions, discuss with her that these responses indicate that she may be at grave risk for extreme physical harm or that her life may even be at risk.
- Once she understands these risks, refer her to police, district women and children office, shelter home or other resources that can protect her from the grave violent situation. These referrals shall be based on the necessity and availability of services. Discuss and plan with her other practical strategies that may help her mitigate risk for violence.
- If danger is not imminent, ask the survivor to explore his/her needs. Provide counseling and legal advice as relevant. If the case is criminal then the health staff has to inform to police.

6.1 Risk assessment questionnaire[23]

DANGER ASSESSMENT

Jacquelyn C. Campbell, PhD, RN, FAAN

Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex-partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up", severe contusions, burns, broken bones, miscarriage
4. Threat to use weapon; head injury, internal injury, permanent injury, miscarriage
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

[23] Adapted from the Danger Assessment Tool developed by Jacquelyn C. Campbell, copyright 1998. Additional information on Campbell's original Danger Assessment tool can be found at the Johns Hopkins University, School of Nursinghttp://www.stopvaw.org/uploads/danger_assessment_form_-_resource.pdf

Mark "Yes" or "No" for each of the following.

("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

	Yes	No	
1.	—	—	Has the physical violence increased in severity or frequency over the past year?
2.	—	—	Does he own a weapon/gun?
3.	—	—	Have you left him after living together during the past year?
4.	—	—	Is he unemployed?
5.	—	—	Has he ever used a weapon against you or threatened you with a lethal weapon? i. (If yes, was the weapon a gun? _____)
6.	—	—	Does he threaten to kill you?
7.	—	—	Has he avoided being arrested for domestic violence?
8.	—	—	Do you have a child that is not his?
9.	—	—	Has he ever forced you to have sex when you did not wish to do so?
10.	—	—	Does he ever try to choke you?
11.	—	—	Does he use illegal drugs?
12.	—	—	Is he an alcoholic or problem drinker?
13.	—	—	Does he control most or all of your daily activities? (For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car?) (If he tries, but you do not let him, check here: _____)
14.	—	—	Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
15.	—	—	Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: _____)
16.	—	—	Has he ever threatened or tried to commit suicide?
17.	—	—	Does he threaten to harm your children?
18.	—	—	Do you believe he is capable of killing you?
19.	—	—	Does he follow or spy on you, leave threatening notes or messages, destroy your property, or call you when you don't want him to?
20.	—	—	Have you ever threatened or tried to commit suicide?
	———		Total "Yes" Answers.

Table 9: Safety Planning for Intimate Partner Violence[24]

Elements of Safety Plan	Questions to Ask Oneself for Making Safety Plan
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you?	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbor you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

6.2 Preventive care at the Community

Health care providers can and should liaise with other services and community stakeholders to promote uptake of services and prevent on-going violence by:

- Creating awareness about the availability of services that could be accessed that the health facility and elsewhere is important. This can be done by displaying leaflets, posters or sign boards sharing GBV services both at the facility and elsewhere in the community.
- Having information about GBV prominently displayed to make the survivor feel more comfortable to talk and disclose about violence in their lives.
- Conducting outreach in the community to raise awareness about availability of services.
- Working with community people, CG/CSG, religious leaders, health workers, social service providers, police, the judiciary, the media, and/or other service providers to make them aware of services and encourage them to refer survivors to health facilities.
- To ensure the functionality of the referral system, the health facility should, where possible, assign community health worker responsible for ongoing communication and coordination with other GBV service providers to monitor and facilitate flow of information and referral processes.

[24] WHO Clinical Handbook (Field-testing version), 2014.

- Mobilizing/supporting community health volunteers, HMCs, CG/CSG to raise awareness of GBV health services and refer GBV survivors to health facilities.
- Engage men and adolescent clubs in the community for raising GBV awareness.
- Coordinating with local level stakeholders to identify, understand and address causes and consequences of GBV.

6.3 Advocacy and Education

The health sector also has an important role to play in raising awareness about GBV and its health consequences and mitigating the culture of acceptance of GBV. Display posters and leaflets and other information, education and communication on domestic violence, rape and sexual abuse on the walls of health facility to educate clients about the unacceptability of GBV, inform women about their rights, and encourage safety planning. Health workers and providers should educate community members about GBV and its health and legal consequences during community outreach.

Chapter 7: Self-Care and preparation of the Health Care Provider as expert witness

Self-care is a critical issue for health providers dealing with the issue of violence. Without concern for self-care, health providers can quickly burnout or experience secondary trauma and depression as a result of hearing and dealing with cases of GBV. Listening to hours of stories of suffering and abuse, health providers may also come to think that violence is so common and thus, begin to live in fear of violence, resulting in loss of faith in human beings. This constant feeling of fear and hyper-alertness has physical and emotional consequences.

A first step in self-care is to reflect on the manifestations of violence in one's own personal life, either constant or as isolated incidents, as well as the violence that one may have exerted against others. It will be important to carefully consider one's own experience of violence and how it may affect attention to survivors of violence.

7.1 Recognizing Burnout

Beyond reflecting one's own experience with violence, critical steps in self-care are to listen to one's body and feelings to recognize signs and symptoms of burnout resulting from over exposure to GBV cases and potentially, vicarious trauma.

Warning signs of fatigue, stress emotional exhaustion and vicarious trauma due to handling GBV cases are:

- Feelings of anxiousness
- Impatience with the GBVsurvivor
- Disassociation when listening to the survivor
- Suspect all people as perpetrator
- Feelings of sadness
- Extreme worry about safety
- Not wanting to go to work or inability to function
- Chronic fatigue
- Physical consequences: Muscular pain, rapid heartbeat, stomach pains, tightness in the chest, trembling, feeling tired all the time, headaches and other aches and pains
- Sleep problems
- Recurring physical illnesses
- Frustration, Irritation, Depression

Not recognizing and dealing with these signs of burnout can also be detrimental not only to the health worker but the survivors themselves. Frustration, pessimism, depression and emotional exhaustion by the health provider results in incapacity to give of oneself. Thus, without concern for self-care, health providers can result in limited capacity to serve survivors.

7.2 Promoting Self-Care for the health providers

For self-preservation, a health worker may distance him/herself from the survivor or others that seek help. In this state, individuals begin to doubt their abilities and experience feelings of failure. Eventually, this can lead to one abandoning his/her work completely and needing professional therapy. Thus, the health provider has a responsibility to develop a self-care plan for him/herself. Daily or common exercises to promote self-care include:

- Exercising regularly
- Maintaining a well-balanced, healthy diet
- Practicing deep breathing exercises for a few minutes each morning in a private, peaceful room with closed eyes and in a comfortable position while imagining the suffering being exhaled
- Getting sufficient sleep and rest
- Changing patterns of thought and behavior
- Engaging in purification and relaxation activities, like watching movies
- Talking to others (co-workers, supervisors) about your experiences and your needs (without compromising confidentiality)
- Staying engaged in your community and seeking help if needed

If the health provider experiences any signs of burnout, she should immediately inform the manager and seek help from a counselor.

7.3 Management Responsibilities to Support Providers

It is important for health facility managers to maintain an ongoing dialogue with front line health workers to ensure that health workers are receiving the adequate support that they need to do their job and that they are not experiencing burnout. The feedback may be used to make the appropriate changes at the health facility. Ongoing feedback to the providers about the care and outcome of specific cases, especially referred cases may also be important. Dialogue between management and health workers can give health workers the opportunity to:

- Discuss what is working and what is not going well
- Address the challenges
- Discuss challenging cases in case review sessions
- Adopt and develop new skills

Management should also establish support groups for providers to facilitate communication about the challenges and stresses of responding to GBV.

7.4 Preparing for Court

Health care providers delivering GBV services may be called to give evidence in court. They should, as much as possible, follow the stated court procedures. While preparing for the court, health worker should use the chain of custody form listed in **Annex 11.** Chain of Custody Form.

Providing Evidence in a Court of Law as an Expert Witness

A medical professional who examines and documents the history of and findings regarding the survivor is considered as expert witness by law and practice.

The examiner must attend the court for testimony when there is a summon from the court.

Summon means a letter in the language of order from the court to examiner (expert) to attend court and follow the court procedures to provide an expert witness testimony. The medical doctor must go to court with a letter from the health facility. Medical doctors should know how to prepare and present their expertise in a court testimony.

Court procedures are:

a. Oath-taking
b. Chief examination
c. Cross-examination
d. Re-examination
e. Question by the judge

Oath-Taking

There will be no question and answer session while taking the oath. This step is just a formality to sign the statement that is written. I speak the truth, only the truth, and nothing but the truth.

Chief Examination

In this step, there will be questions posed by the government attorney or prosecution's lawyer. The questions are about the report, which was prepared and submitted by examiner (expert) immediately after examining the survivor. Questions are general and descriptive in type. For example, what are the findings on the body of the victim to result in such opinion about the causation of injuries or age of the injuries?

Cross-Examination

There is another lawyer from the side of the accused-the defense lawyer-who cross examines the expert by asking any number of questions and from various angles. The defense lawyer is seeking answers related to the facts in the report or is otherwise concerned with the case. Sometimes, this cross-examination may cause irritation for the expert, but the expert should not lose his or her patience.

Re-examination

This step is a repetition of the chief examination if there is some new version of a fact or to explore a new set of facts. The prosecution lawyer may pose additional questions about the new fact.

Questions from the judge

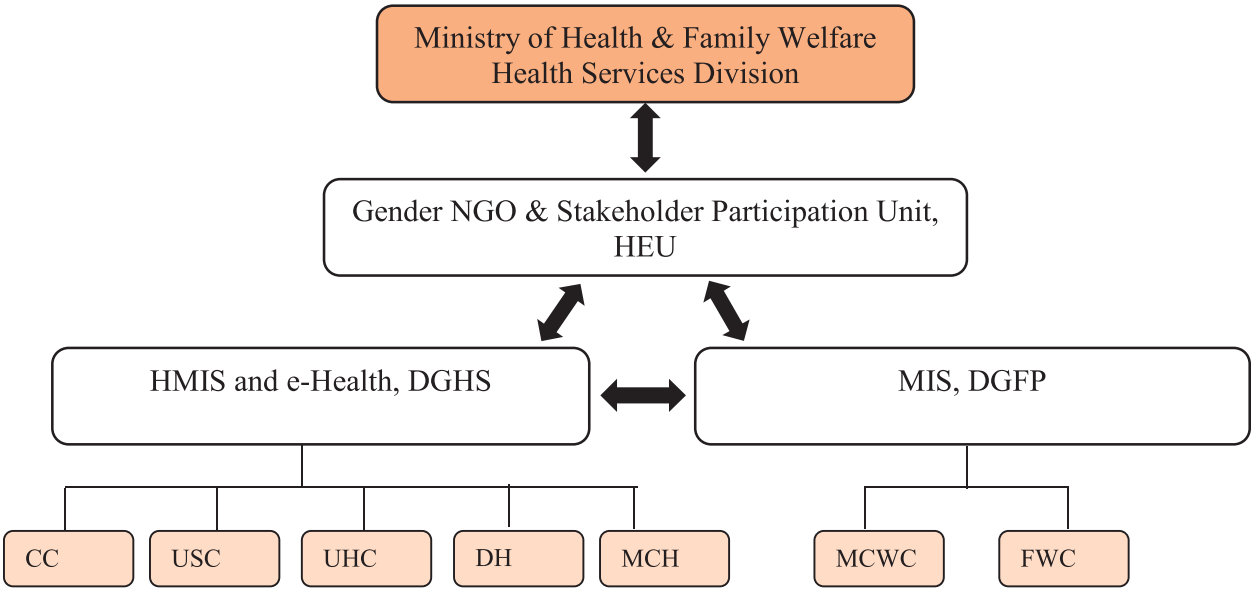
There may be questions from the judge who is observing and following the court testimonies. Lastly, the expert witness reads the written document from his/her procedure and signs it.

Chapter 8: Recording and Reporting

8.1 Introduction

This chapter provides a brief overview of the reporting system for GBV management by front line health workers.

Figure 3: A Diagrammatic Snapshot of the System for Monitoring



8.2 Recording and Reporting System

a) Daily Case Records of GBV Cases (Hard Copy) at Health Facility

A detailed examination of the GBV survivor will be done according to the *"Protocol for Health Care Providers on Health Sector Response to Gender Based Violence"* Each health facility will keep the following records for each reported case/incident of GBV.

- Report in medical examination in sexual offence for female subject (**Annex 4.A.** Medical Report & Examination Form for Female Survivor).
- Report in medical examination in sexual offence for male subject (**Annex 4.B.** Medical Report & Examination Form for Male Survivor).
- Injury examination report for physical GBV (**Annex 5.** Injury Examination Report).
- Report in medical examination of mental health (**Annex 7.** Report of Psychological Examination (Psychiatrist only).
- Report in medical examination-age estimation (**Annex 8.** Age Estimation, **Annex 9.** Age Estimation Form).
- Report in follow up after sexual assault (**Annex 15.** Follow Up of the GBV survivors).
- Chain of custody form (**Annex 11.** Chain of Custody Form)

These forms should be completed by health facility staff for each identified GBV survivor according to the requirement. **A completed consent form must be treated with strictest confidentiality and kept in separate lockers with access limited to designated health facility staff.** Other records must be kept separately from the consent forms under lock and key with access limited to designated health facility staff.

b) Monthly Reporting of GBV Data (Service statistics)

Every month, each health facility must send the completed table in **Annex 16** to the Civil Surgeon Office, DDFP office, MIS of DGHS and DGFP.

Furthermore, the monthly data summary table produced by the health facility for Civil Surgeon Office/ MIS, DGHS/DGFP should be shared with the Hospital Management Committee (HMC) during their monthly meeting. This opportunity should be used to get the feedback from staff about how well the system for providing GBV services is working. Sharing of GBV information during Hospital Management Committee meetings helps to:

- Raise community awareness and prevent GBV at the community.
- Facilitate GBV case management at the health facility.
- Improve coordination and collaboration with community level stakeholders.

However, **DHIS2** platform will be open and accessible to all facilities to share monthly service statistics from upazila and district level. This service statistics will be entered into the **DHIS2** platform like monthly EmOC data entered from each facility. This statistics will be analysed at the national and local level. GBV issues will be discussed for improvement of services in monthly coordination meeting at district and upazila level and also in Hospital Management Committee meeting at facility level. National level policy makers, Gender NGO & Stakeholder participation Unit and other stakeholders will also get the service statistics on GBV.

Annexure

Annex 1. Operational definitions for Classification of Gender-Based Violence

Gender and Violence

Gender Based Violence takes on many forms, including rape, sexual assault, physical assault, intimate partner violence, forced marriage, denial of resources, opportunities or services, and psychological/emotional abuse.

A. Gender and Sex

Sex refers to the biological characteristics that define human as female and male. It is physical attribute pertaining to a person's body contours, features, hormones, genes, chromosomes, and reproductive organs. Sex differences between females and males are natural and remain the same regardless of time and place.

Gender refers to attitudes, roles, behaviors and values assigned by cultures and society to women and men. These roles, attitudes, norms and values, which are culturally and socially determined, define the behavior of women and men and the relationship between them. Gender differences between women and men vary over time and between places.

Sex	Gender
Sex is a biological fact.	Gender is culturally and socially determined.
Sex is a natural attribute that a person is born with.	Gender is created, produced, reproduced and maintained by the social institutions such as families, communities, societies.
Sex remains static everywhere and all the time.	Gender varies from culture to culture and from one period to another because it is determined by the society.

B. Gender Equity and Equality

Gender Equity is the process of being fair to women and men. Gender equity calls for those who are in disadvantaged positions to have a fair share of the benefits of development as well as the substantive responsibilities in society. This means giving to those who have less on the basis of needs, and introducing special measures and interventions to compensate for the historical and social disadvantages that prevent women and men from operating on a level playing field. Equity leads to equality.

Gender Equality simply implies that the equal opportunity to reach their full potential as human beings in the development process should be equally accorded to both women and men. It refers to women and men having the equal:

- Rights: Social, economic, political and legal(e.g. right to own land, manage property, conduct business, travel);

- Resources: command over productive resources including education, land, information and financial resources
- Voice: power to influence allocation and investment decisions in the home, in the community and the national level.

C. Gender Analysis

Gender Analysis is a tool for examining the differences between the roles that women and men play; the different levels of power they hold; their differing needs, constraints and opportunities; and the impact of these differences on their lives.

> Amina was a 15 year old girl who suffered from obstructive labor for three days. She was attended only by a traditional birth attendant. Her mother-in-law did not allow her to be taken to the Upazila Health Complex (UHC) because a male doctor would perform the delivery of the child. When Amina was about to die, her father-in law and husband were convinced by the neighbors to take her to the UHC three kilometers away. On the way, Amina bled profusely, had a still-birth and died before reaching the hospital.

To analyze the situation from a gender perspective, the following issues can be considered:

- **Access to resources:** Neither Amina nor her mother-in law had access to information on the signs of unsafe delivery or to the medical resources of the health center. Appropriate transport for women in labor was not available
- **Control over resources:** Amina did not have the right to decide about her marriage-she was married at the age of 13 and became pregnant before her body reached sufficient maturity for safe delivery. Amina did not have the right to decide to consult a doctor on family planning, Pre-natal check or the delivery of her child.
- **Constraints and opportunities:** The family held traditional beliefs that prevented them from taking to hospital where she might be treated by a male doctor.
- **Practical needs:** Amina's practical need for safe child birth was not met due to her lack of access to resources.

D. Gender Discrimination

Gender discrimination refers to any distinction, exclusion or restriction made on the basis of socially constructed Gender roles and norms which prevent a person from enjoying full human rights. Socially constructed and sexual differences have been used to justify societies in which one sex or other has been relegated to significantly inferior and secondary roles.

E. Gender Based Violence

It is important to understand that GBV is rooted in unequal power relationship between women and men; women may have less access than men to resources, such as money or information, and they may not have the freedom to make decisions for themselves; women may be blamed and stigmatized for violence and may feel shame and low self-esteem.

Domestic violence

This refers to physical abuse, psychological abuse, sexual abuse or economic abuse against a woman or a child of a family by any other person of that family with whom the victim is or has been in family relationship.

Intimate partner violence

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner -a husband, boyfriend, either current or past. Women may suffer several types of violence by a male partner: physical violence, emotional/ psychological abuse, controlling behaviors, and sexual violence.

a. Physical Violence:

Physical abuse that is, any act conduct which is of such a nature as to cause bodily pain, harm, or danger to life, limb, or health or impair the health or development of the victim and includes assault, criminal intimidation and criminal force[25]. For Example: kicking, biting, slapping, burn, acid violence etc.

i. **Burn**: Violence by any burning object like, hot water, hot things, fire of burner, cigarette, kerosene oil, fire from lamp etc.

ii. **Acid Violence**: Acid means any kind of thick, fluid or mixed ingredients of sulphuric acid, hydrochloric acid, nitric acid, phosphoric acid, caustic potash, carbolic acid, battery fluid (acid), chromic acid and aqua regia and other corrosive items determined as acid by the government. Acid burn means the person who was physically affected by acid thrown or any kind of acid[26].

b. Sexual Violence:

Sexual abuse that is, any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of the victim.[27] Nature of sexual violence:

i. **Rape:** If any male person except in marriage tie, without the consent of the woman or by intimidation or by deceitful means cohabits with a woman aged above the age [sixteen years] or with a woman of below the age of [years] with consent or without consent cohabits then it shall be presumed that he has raped her[28].

ii. **Sexual Harassment**: Sexual Harassment includes (1) Undesirable sexual appeal (direct or gesture) which indicated to made sexual relationship; (2) For fulfilling the sexual urge to established sexual relation by using the administrative power; (3) Sexual appeal in facial expression; (4) Request or desire to sexual oath; (5) Exhibition of pornography; (6) Sign or gesture-posture of sexual appeal; (7) Unacceptable gesture, intending harassing language or word, sexually provoking jokes; (8) Intended writing word which is sexually provoking

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[25] Domestic Violence (Prevention and Protection) Act, 2010

[26] Acid Control Act, 2002

[27] Domestic Violence (Prevention and Protection) Act, 2010

[28] The Suppression of Violence against Women and Children Act, 2000

jokes in letters, telephone call, mobile call, SMS, posturing, notice, industry, classroom and public toilet; (9) Recording still and videos to fulfill the purpose of blackmailing or blaming the character; (10) Restricting or refusing the participation from sports, cultural and institutional programme, curricular activities for the cause of sexual harassment; (11) Proposal for affairs and providing pressure and provoking fear for refusal the proposal; (12) Trying to build the sexual relationship by pretending or false promising[29].

c. Psychological Violence:

Psychological abuse that includes but is not limited to: i) Verbal abuse including insults, ridicule, humiliation, insults or threats of any nature; (ii) Harassment; or (iii) Controlling behavior, such as restrictions on mobility, communication or self-expression[30].

d. Economic violence

Refers to refusal (by husband, intimate partner) to give enough money for household expenses, even though he (husband, intimate partner) has money for other things

e. Controlling behaviors

This includes, for example:

i. Not allowing a woman to go out of the home, or to see family or friends
ii. Insisting on knowing where she is at all times
iii. Often being suspicious that she is unfaithful
iv. Not allowing her to seek health care without permission
v. Leaving her without money to run the home.

f. Human Trafficking:

Human trafficking is defined as an act where the selling, buying, recruitment, receipt, transportation, transfer, or harboring of any person for the purpose of sexual-exploitation, labor-exploitation or any other form of exploitation whether in or outside of Bangladesh by means of (a) threat or use of force or other forms of coercion, or (b) abduction, fraud or deception, or of the abuse of any person's socio-economic, environmental or other types of vulnerability, or (c) of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person[31].

g. Child Marriage:

(a) Child means the person who, if a male, is under twenty-one years of age, and if a female, is under eighteen years of age.
(b) Child marriage means a marriage to which either of the contracting parties is child[32].

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[29] The Sexual Harassment Against Women And Children Writ Petition No: 8769/2010

[30] The Domestic Violence (Prevention and Protection) Act, 2010

[31] Human Trafficking (Deterrence and Suppression) Act, 2012 32The Child Marriage Restraint Act, 1929

[32] The Child Marriage Restraint Act, 1929

Annex 2. Minimum requirements of facility readiness for GBV Survivors

Checklist for supplies

1. Protocol	Available
# Written management protocol	
2. Personnel	**Available**
# Trained (local) health care professionals for 24 hours, 7 days	
# A "same language" trained female health worker or companion in the room during examination	
3. Physical Arrangement	**Available**
# Room (private, quiet, accessible, with access to a toilet or latrine)	
# Examination table	
# Light, preferably spot light (a torch may be threatening for children)	
# Access to toilet, water, hand washing facilities	
# Access to an autoclave or sterilizer to sterilize equipment	
4. Supplies	**Available**
# Logistics for collection of forensic evidence, including:	
-3 Speculum (small, medium and large size)	
-Measuring tape for measuring the size of bruises, lacerations, etc.	
# Supplies for universal precautions	
# Instruments for measuring height/weight	
# Sterile medical instruments for repair of tears, and suture material (gauge, needles, syringes)	
# Gown, cloth, or sheet to cover the survivor during the examination	
# Sanitary (pads)	
5. Drugs	**Available**
# For pain relief (e.g. paracetamol)	
# Antibiotics for wound care	
# Local anaesthetic for suturing	
# Emergency contraceptive pills and/or IUD	
# Antibiotics for treatment of STIs as per country protocol	
# Psychiatric drugs enlisted in Essential Service Package (ESP)	
6. Administrative supplies	**Available**
# Medical chart with pictograms	
# Consent forms, registars	
# Information pamphlets for post-rape care (for survivor), IEC maretials with positive information	
# Safe, locked filing space to keep confidential records	

Annex 3. Consent form for GBV Survivor

1 Name of the Hospital: _____

2. OPD No._____ Inpatient No: _____Survivor Reg. No:_____

3. Name: _____ D/o or S/o (where known): _____

4. Address: _____

5. Contact No _____

6. Age (as reported): _____ Date of Birth (if known): _____

7. Sex (M/F/TG): _____ Education: _____

8. Date and Time of arrival in the hospital: _____

9. Date and Time of commencement of examination: _____

10. Brought by: [Name (s) & signature(s)]: _____

11. Medico-legal Code No.: _____ Police Station: _____

12. Whether conscious, oriented in time and place and person: Yes □ No □

13. Any physical/intellectual/psychosocial disability (Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psycho social disability)

_____

_____

_____

Informed Consent/refusal: (All information will be collected for proper management and safety of the patient. These information would remain strictly confidential unless the patient is willing to reveal it for any purpose.)

I, d/o or s/o ……. here by give my consent for:

a) Medical examination for treatment Yes □ □ No

b) Medico legal examination Yes □ □ No

c) Sample collection for clinical & forensic examination Yes □ □ No

d) Sharing non identifiable information for reporting purposes Yes □ □ No

I would like the information released to the following for service provision (Tick all that apply and specify name of personnel and organization as applicable.)

a) Medical Services

b) Psychological services

c) Legal Aid

d) Interim support and Security services

e) Shelter services

f) Rehabilitation services

g) Economic (Livelihood) services

In cases, where medical personnel consider injuries to be classified as sexual violence, attempt to murder and life threatening/grievous injuries, it is the duty of the medical personnel to inform it to the police.

In other cases except mentioned above:

I want the information to be revealed to the police □ Yes □ No

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment and other referral services will not be affected by my refusal, has also been explained. Contents of the above have been explained to me in my own language (Bangla) with the help of a special educator/interpreter/support person (circle as appropriate).

a. If special **educator/interpreter/support person** has helped, then his/her name and signature:

b. **Name & signature of survivor** or parent/Guardian/person in whom the child reposes trust in case of child (<18 yrs.) **(Assent Form)**

With date

_____

_____

_____

c. **Name & signature/thumb impression of Witness**

With Date

_____

_____

_____

14. Marks of identification of survivor (Any scar/mole)

(1) _____ (2) _____

Thumb impression

Right	Left

Annex 4.A. Medical Report & Examination Form for Female Survivor

Attested photograph of the survivor

1. General Information

1.1. Survivor Registration No. : .....

1.2. Name of the hospital/office referred from (if any, with letter of reference No. and date) : .....

1.3. Name of the hospital / health facility : .....

1.4. Name and ID details of the accompanying police personnel : .....

2. Details about the survivor

2.1. Name (To be confidential) : .....

2.2. Age : ..... 2.3 Sex : ☐ Male ☐ Female ☐ Transgender 2.4 Education : .....

2.5. Address : .....

2.6. Current marital status : ☐ Unmarried ☐ Married ☐ Divorced/Separated ☐ Widowed

2.7. Religion/Ethnicity : .....

2.8. Guardian's name and relation (if < 18 years) : .....

2.9. Contact No of survivor (To be confidential) : .....

2.10. Date and time of examination : .....

2.11. Female attendant's name and address : .....

2.12. Marks of identification : a) ..... b) .....

3. History of incident

3.1. Brief history of the incident, as stated by survivor or guardian (how, when, where and what had happened?) If more space is required, please attach an additional sheet .....

.....

.....

.....

.....

3.2. Medical history (Medical and psychological history including past medical history) : If more space is required, please attach an additional sheet. .....

.....

3.3. Date of Incident :.....

Time of incident : ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ Unknown

3.4. Location of incident :

☐ Survivor's home ☐ Perpetrator's home ☐ Educational institute ☐ Workplace

☐ Hotel or guest house ☐ Public area (Field, Road side, Forest, etc.)

☐ Others (Please specify) : .....

3.5. Type of violence : ☐ Sexual violence ☐ Physical violence ☐ Psychological violence

3.6. Does the survivor has any previous history of GBV ? Was the incident reported ?

☐ No ☐ Yes, please specify : .....

3.7. Description of clothing/belongings : .....

3.7.1. Clothing changed? ☐ Yes ☐ No

3.7.2. Clothes washed ? ☐ Yes ☐ No

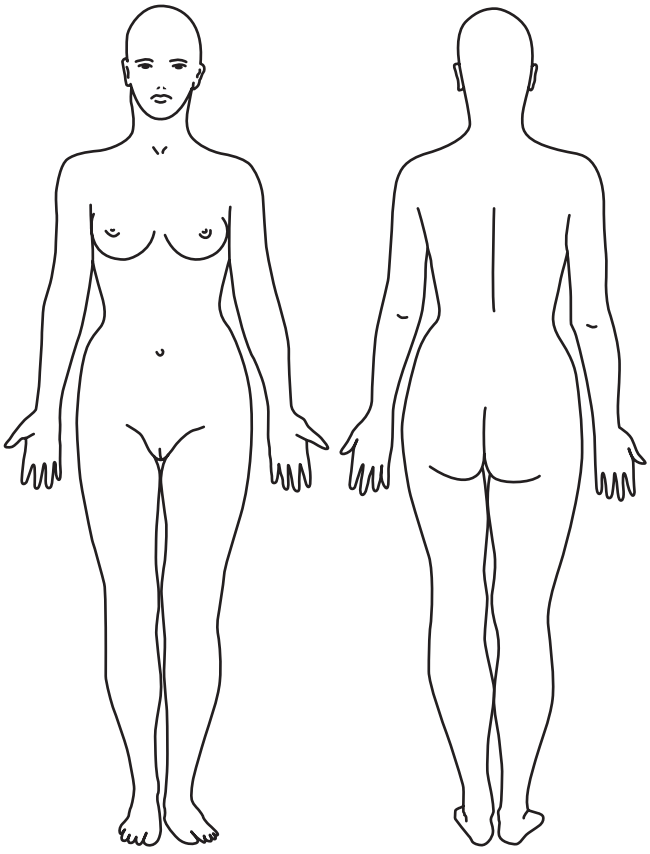
3.7.3. Findings on clothing ☐ Tears ☐ Scratches ☐ Stains ☐ Foreign materials

4. Information about the Perpetrator

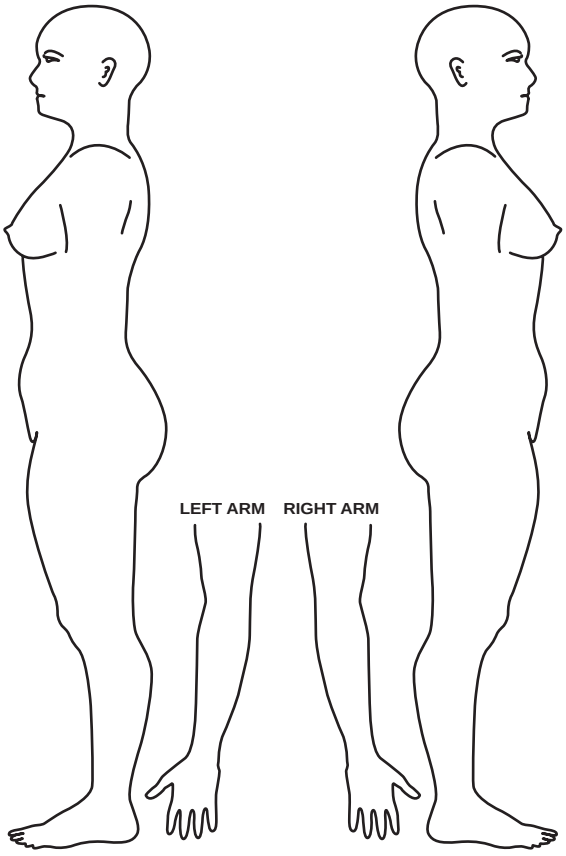
Number of alleged perpetrator(s)	Alleged perpetrator's sex	Age
☐ 1 ☐ 2 ☐ 3 ☐ More than 3 ☐ Unknown	☐ Male ☐ Female ☐ Transgender	☐ <18 years ☐ 18 years & older ☐ Unknown
Relationship with alleged perpetrator :		

Examiner's Signature : ..... Date :.....

Full body : Female - anterior and posterior views



Full body : Female - lateral view



5. Physical examination

5.1. General physique and vitals :

Height : ..... Weight : ..... Pulse :..... B.P: .....

Temperature : ..... Respiratory rate : ..... Any disability : .....

5.2. Injuries on the bodies (Type, size, site, color, surrounding area, signs of treatment, bleeding, sign of healings, any imprints etc.) Please use the pictogram to depict the injuries as best as possible : .....

.....

5.3. Bite marks : (enclose photos, taken with survivor's consent if possible) : .....

.....

5.4. Conditions of pubic hair (Matted, stained, any foreign hairs) : .....

5.5. Oral cavity : The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa petechae on the hard/soft palate may indicate penetration. Check for a torn frenulum or broken teeth, Collect an oral swab, if indicated. : .....

.....

5.6. Genital injuries (Name, size, site, color, surrounding area, sign of treatment, bleeding, sign of healings, imprints, any content, stain and discharge etc.) Please use the figure provided to depict the injuries as best as possible: (If more space is needed, please attach additional pages).

(a) Perineum : .....

(b) Vulva : .....

(c) Vagina : ..... (d) Hymen : .....

(e) Perianal area and anal orifice : .....

Note : Examination should be done immediately, even during menstruation and preferably by a female doctor. *If not available, a female attendant must be present.*

5.7. Specimen preserved for further analysis :

(a) Blood : ☐ Collected ☐ Not Collected, please explain why not : .....

Purpose of collection : (Alcohol/drugs/HIV/VDRL/HBsAg/TPHA/DNA Identification etc.) .....

(b) Urine : ☐ Collected ☐ Not collected, please explain why not: .....

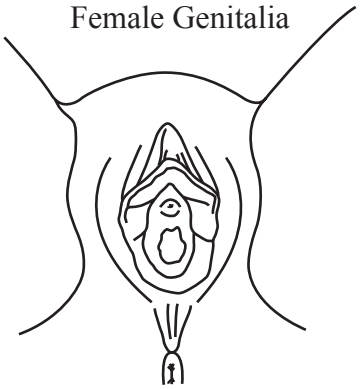
Purpose of collection (Intoxication/pregnancy) : .....

(c) Swab from stains : ☐ Collected ☐ Not collected, please explain why not : .....

Purpose of collection (identification of semen or any others) : .....

Examiner's Signature : ..... Date :.....

Female Genitalia



(d) Vaginal Swab : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection (semen analysis) : .....

(e) Foreign materials : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection (identification of material as evidence) : .....

(f) Hair from Survivor : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection (DNA Analysis) : .....

(g) Nail scrapings : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection : .....

(h) Others : .....

5.8. Specimen analyzed in the same hospital? ☐ Yes ☐ No, please specify : .....

5.9. Specimen sent to : .....

5.10. Investigation and reports : Please specify : (Blood, urine, X-ray, USG, DNA profiling and other required investigations) : .....

6. Treatment

6.1. Treatment of physical injuries or refer : .....
.....

6.2. Emergency contraception to prevent unwanted pregnancy : .....

6.3. Prophylaxis and treatment of Sexually Transmitted Infections (STIs) : .....
.....

6.4. Post Expore Prophylasix (PEP) for HIV : .....
.....

6.5. Phychological care and support : .....

7. Referral (where and why ?) : .....

8. Follow up visits suggested on : (2 weeks, 1 month, 3 month and 6 months)
.....
.....

9. Opinion

Opinion of the expert : (While framing opinion the examiner should consider her mental status, possible causation of injuries and their time of infliction, age estimation in case of minors or teenagers and general condition of the survior. If there are signs of alleged sexual activities matching with history also should be verified while framing opinion. In case of complete negative findings in survivor, the examiner cannot declare that the alleged incident did not take place. S/he should only note the findings during examination. Should not write "it seems to be or suggestive of .....".

.....

.....

.....

.....

(a) Opinion about mental status of the survivor : .....

(b) Opinion about the injuries on body : .....

(c) Opinion about the condition of genital organs : .....

Name of the Examiner : ..... Qualification : .....

Signature : ..... BMDC Reg. No. : .....

Name of Hospital/Health facility with seal ..... Date : .....

Note

- □ Report should be prepared by doctor who conducts the examination.
- □ The report should be clear and understandable and original copy of the report should be given to the survivor, one copy for legal action & another copy for hospital record.
- □ Separate sheet of paper should be used, if the space allocated for description in the form is inadequate.

Annex 4.B. Medical Report & Examination Form for Male Survivor

Attested photograph of the survivor

1. General Information

1.1. Survivor Registration No. : .....

1.2. Name of the hospital/office referred from (if any, with letter of reference No. and date) : .....

1.3. Name of the hospital / health facility : .....

1.4. Name and ID details of the accompanying police personnel : .....

2. Details about the survivor

2.1. Name (To be confidential) : .....

2.2. Age : ..... 2.3 Sex : ☐ Male ☐ Female ☐ Transgender 2.4 Education : .....

2.5. Address : .....

2.6. Current marital status : ☐ Unmarried ☐ Married ☐ Divorced/Separated ☐ Widowed

2.7. Religion/Ethnicity : .....

2.8. Guardian's name and relation (if < 18 years) : .....

2.9. Contact No of survivor (To be confidential) : .....

2.10. Date and time of examination : .....

2.11. Male attendant's name and address : .....

2.12. Marks of identification : a) ..... b) .....

3. History of incident

3.1. Brief history of the incident, as stated by survivor or guardian (how, when, where and what had happened?) If more space is required, please attach an additional sheet .....

.....

.....

.....

.....

3.2. Medical history (Medical and psychological history including past medical history) : If more space is required, please attach an additional sheet. .....

.....

3.3. Date of Incident :.....

Time of incident : ☐ Morning ☐ Afternoon ☐ Evening/Night ☐ Unknown

3.4. Location of incident :

☐ Survivor's home ☐ Perpetrator's home ☐ Educational institute ☐ Workplace

☐ Hotel or guest house ☐ Public area (Field, Road side, Forest, etc.)

☐ Others (Please specify) : .....

3.5. Type of violence : ☐ Sexual violence ☐ Physical violence ☐ Psychological violence

3.6. Does the survivor has any previous history of GBV ? Was the incident reported ?

☐ No ☐ Yes, please specify : .....

3.7. Description of clothing/belongings : .....

3.7.1. Clothing changed? ☐ Yes ☐ No

3.7.2. Clothes washed ? ☐ Yes ☐ No

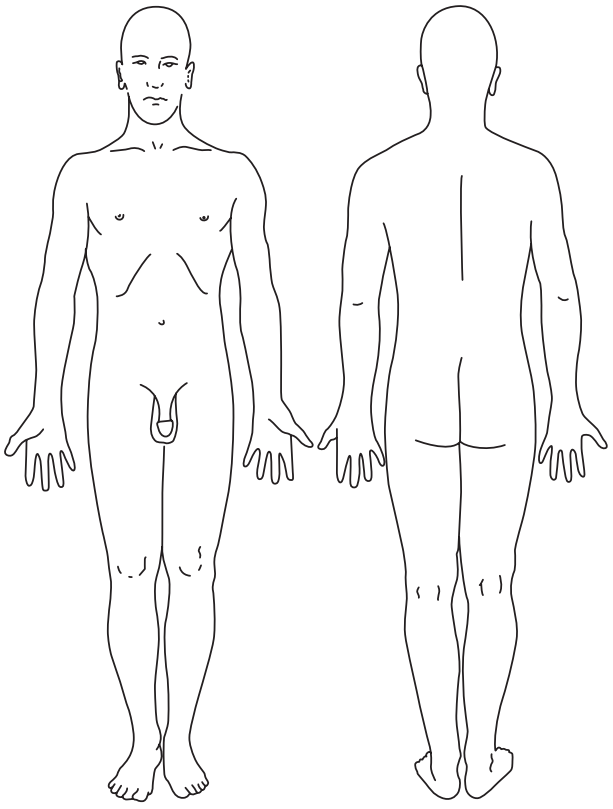
3.7.3. Findings on clothing ☐ Tears ☐ Scratches ☐ Stains ☐ Foreign materials

4. Information about the Perpetrator

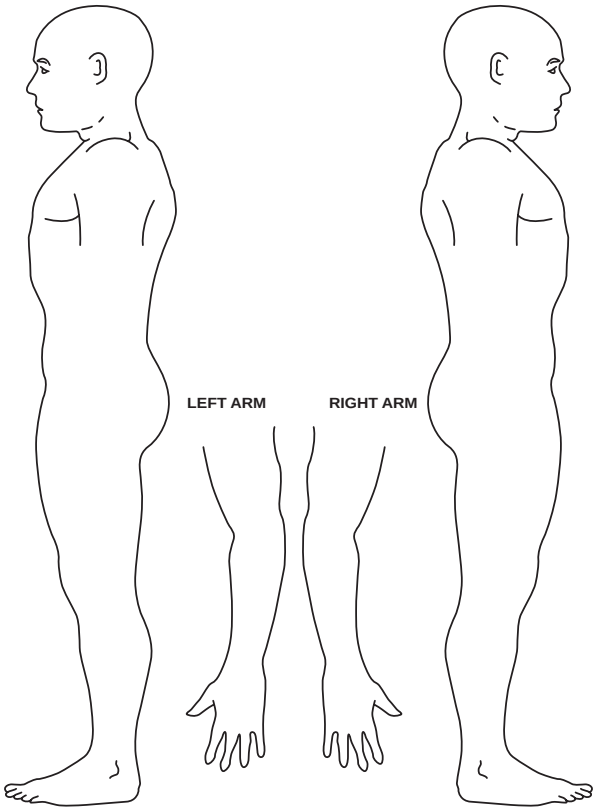
Number of alleged perpetrator(s)	Alleged perpetrator's sex	Age
☐ 1 ☐ 2 ☐ 3 ☐ More than 3 ☐ Unknown	☐ Male ☐ Female ☐ Transgender	☐ <18 years ☐ 18 years & older ☐ Unknown
Relationship with alleged perpetrator :		

Examiner's Signature : ..... Date :.....

Whole body : Male - anterior and posterior views



Whole body : Male - lateral view



5. Physical examination

5.1. General physique and vitals :

Height : ..... Weight : ..... Pulse :..... B.P: .....

Temperature : ..... Respiratory rate : ..... Any disability : .....

5.2. Injuries on the bodies (Type, size, site, color, surrounding area, signs of treatment, bleeding, sign of healings, any imprints etc.) Please use the pictogram to depict the injuries as best as possible : .....

.....

5.3. Bite marks : (enclose photos, taken with survivor's consent if possible) : .....

.....

5.4. Conditions of pubic hair (Matted, stained, any foreign hairs) : .....

5.5. Oral cavity : The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa petechae on the hard/soft palate may indicate penetration. Check for a torn frenulum or broken teeth, Collect an oral swab, if indicated. : .....

.....

5.6. Genital injuries (Name, size, site, color, surrounding area, sign of treatment, bleeding, sign of healings, imprints, any content, stain and discharge etc.) Please use the figure provided to depict the injuries as best as possible: (If more space is needed, please attach additional pages).

(a) Perineum : .....

(b) Penis : .....

(c) Scrotum : .....

(d) Perianal area and anal orifice : .....

5.7. Specimen preserved for further analysis :

(a) Blood : ☐ Collected ☐ Not Collected, please explain why not : .....

Purpose of collection : (Alcohol/drugs/HIV/VDRL/HBsAg/TPHA/DNA Identification etc.) .....

(b) Urine : ☐ Collected ☐ Not collected, please explain why not: .....

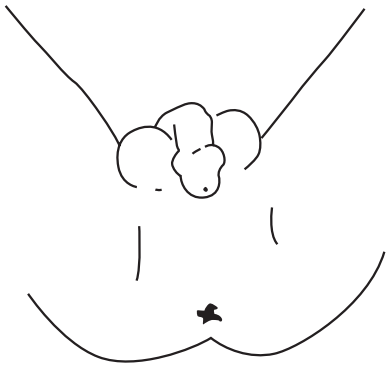
Purpose of collection (Intoxication/pregnancy) : .....

(c) Swab from stains : ☐ Collected ☐ Not collected, please explain why not : .....

Purpose of collection (identification of semen or any others) : .....

Examiner's Signature : ..... Date :.....

Male Genitalia



(d) Foreign materials : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection (identification of material as evidence) :.....

(e) Hair from Survivor : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection (DNA Analysis) : .....

(f) Nail scrapings : ☐ Collected ☐ Not collected, please explain why not : .....
Purpose of collection : .....

(g) Others : .....

5.8. Specimen sent to : .....

5.9. Specimen analyzed in the same hospital? ☐ Yes ☐ No, please specify :.....

5.10. Investigation and reports : Please specify : (Blood, urine, X-ray, USG, DNA profiling and other required investigations) : .....
.....
.....

6. Treatment

6.1. Treatment of physical injuries or refer : .....

6.2. Prophylaxis and treatment of Sexually Transmitted Infections (STIs) : .....

6.3. Post Expore Prophylasix (PEP) for HIV : .....

6.4. Phychological care and support : .....

7. Referral (where and why ?) : .....

8. Follow up visits suggested on : (2 weeks, 1 month, 3 month and 6 months)
.....
.....

9. Opinion

Opinion of the expert : (While framing opinion the examiner should consider his mental status, possible causation of injuries and their time of infliction, age estimation in case of minors or teenagers and general condition of the survior. If there are signs of alleged sexual activities matching with history also should be verified while framing opinion. In case of complete negative findings in survivor, the examiner cannot declare that the alleged incident did not take place. S/he should only note the findings during examination. Should not write "it seems to be or suggestive of .....".

.....

.....

.....

.....

(a) Opinion about mental status of the survivor : .....

(b) Opinion about the injuries on body : .....

(c) Opinion about the condition of genital organs : .....

Name of the Examiner : ..... Qualification : .....

Signature : ..... BMDC Reg. No. : .....

Name of Hospital/Health facility with seal ..... Date : .....

Note

- □ Report should be prepared by doctor who conducts the examination.
- □ The report should be clear and understandable and original copy of the report should be given to the survivor, one copy for legal action & another copy for hospital record.
- □ Separate sheet of paper should be used, if the space allocated for description in the form is inadequate.

Annex 5. Injury Examination Report Form for Survivor of Physical GBV

1. General Information

1.1 Survivor Registration No.: _____

1.2 Name of the office/hospital referred from (with letter of reference No. and Date):

1.3 Name of the hospital/facility:

1.4 Name and ID no of the accompanying Police Personnel:

2. Details about the examinee

2.1. Name (Maintain confidentiality): _____

2.2 Age: _____

2.3 Sex: □ Male □ Female □ Transgender □ Others (Specify)_____

2.4 Address: _____

2.5 Contact No: _____

2.6 Current marital status: □ Single □ Married □ Divorced/Separated □ Widowed

2.7 Religion/Ethnicity: _____

2.8 Guardian′s Name and relation (if < 18years): _____

2.9 Date and time of examination: _____

2.10 Attendant's name and address: _____

2.11 Marks of Identification: _____

3. History of incident

3.1 Brief History of the incident, as stated by survivor/patient or guardian (How, When, Where and what had happened?) If more space is required, please attach an additional sheet.

_____

_____

_____

_____

_____

_____

3.2 Medical history (Medical and Psychological history including past medical history): If more space is required, please attach an additional sheet.

_____
_____
_____
_____
_____
_____

3.3 Date of incidence: _____

3.4 **Time of incident:** □ Morning □ Afternoon □ Evening/Night □ Unknown

□ Exact time (if known): _____

3.5 **Location of incident:** □ Survivor's home □ Perpetrator's home □ Educational Institute □ Workplace □ Hotel or guest house □ Public area (Field, Roadside, Forest etc.)

Others (please specify):_____ _____

3.6 Type of Violence:

□ Sexual violence □ Physical violence □ Psychological violence

□ Other (please specify) _____

3.7 Weapon/object used: □ No □ Yes, please specify_____

3.8 Has the survivor been subjected to previous incidents of GBV?

□ No □ Yes, please describe

3.9 Was the incident reported?

□ No □ Yes, please describe _____

_____

□ Foreign materials (Please describe the clothing with the findings in detail)

_____
_____
_____

3.10 Description of clothing/belongings:

3.10.1 Clothing changed? □ Yes □ No

3.10.2 Clothes washed? □ Yes □ No

3.10.3 Findings on Clothing □ Tears □ Stains □ Scratches

4. Information about the Perpetrator

Number of alleged perpetrator(s)

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ More than 3
- ☐ Unknown

Alleged perpetrator(s) sex

- ☐ Male
- ☐ Female
- ☐ Transgender

Alleged perpetrator's age

- ☐ 0 - 18 years
- ☐ 18 years & older
- ☐ Unknown
- ☐ Relationship (perpetrator's) with survivor _____

3. Physical examination

3.1 General physique and vitals:

Height: _____ Weight: _____ Pulse:_____

B.P:_____ Temperature:_____

Respiratory rate: _____ Any disability: _____

3.2 Patient is alert to time, place and person: □ No □ Yes, please describe:

3.3 Injuries on the bodies (Type, Size, Site, Color, Surrounding area, Signs of treatment, Bleeding, Sign of Healings, any Imprints etc.) Please use the figure provided to depict the injuries as best as possible:

3.3.1 Type of injury: □ Simple □ Grievous □ Others: (please specify)

3.3.2 Severity (Explain in terms of existing condition and possible complications):

5.3.3 Investigation and reports (for example blood, urine, X-ray, DNA analysis, USG etc.):

_____

_____

_____

5.3.4 Treatment provided (briefly):

_____
_____
_____

5.3.5 Referral (Where and Why?):

_____
_____
_____

5.3.6 Follow up (if necessary):

_____
_____
_____

5.3.7 Opinion: (Condition of examinee, severity of the injury, age of the injury and possible causative objects should be considered to frame opinion)

Examiner's initial: _____ Date: _____

Name of the Examiner: _____ Qualification: _____

Signature: _____ BMDC Reg. No.: _____

Office/Hospital/Health Centre: _____ Seal of the Hospital/Health Centre: _____

Date: _____

Note

- Report should be prepared by doctor/physician who conducts the examination.
- The report should be clear and understandable and original copy of the report should be submitted.
- Separate sheet of paper should be used, if the space allocated for description in the form is inadequate.

Annex 6. Estimation of Time since Injury

Abrasion

Duration	Features
Fresh	Bright red, oozing of serum and blood
12 – 24 hours	Exudation dries to form a reddish scab
2 – 3 days	Reddish-brown scab, less tender
4 – 5 days	Dark Brown scab
5 – 7 days	Scab starts breaking and falls
7 – 10 days	Scab dries, shrinks and falls off
2 – 3 weeks	Scar gradually disappears

Contusion

Time Since Injury	Color
Fresh	Bright red
Up to 3 days	Bluish (deoxygenated Hb)
3 – 4 days	Bluish black/brown (haemosederin)
5 – 6 days	Greenish (biliverdin)
7 – 12 days	Yellowish (bilirubin)
2 weeks	Normal

Estimation of Age of scar

Time Since Injury	Features
5 – 6 days	Firm union, reddish/bluish scar
½ – 2 months	Pale, soft and sensitive (tender)
2 – 6 months	Tough, brownish, glistening, wrinkled and little tenderness
≥ 6 months	Tough, white, glistening and non-tender

Note: This is only a reference chart. Various factors in the body as well as in the atmosphere contribute to the healing of injuries.

Annex 7. Psychological Examination Form (Psychiatrist only)

1. General Information

1.1 Survivor Registration No.:

1.2 Name of the Office referred for examination (with letter reference No. and Date):

_____

1.3 Name of the accompanying Police Personnel:

_____

2. Details about the examinee

2.1. Name (Maintain confidentiality): _____

2.2 Age _____ 2.3 Sex: □ Male □ Female □ Transgender

2.4 Education: _____

2.5 Address: _____

2.6 Current marital status:

□ Single □ Married/cohabitating □ Divorced/Separated □ Widowed

2.7 Ethnicity/Caste: _____

2.8 Guardian′s Name and relation (in case of minors or if the survivor has severe mental illness): _____

2.9 Date and time of examination: _____

2.10 Attendants, Name & address: _____

2.11 Marks of Identification:

a. _____

b. _____

3. History of incident

3.1 Brief history of (any condition responsible to induce psychiatric disorders like victims of sexual offences, torture, ill-treatment, domestic violence etc.). If more space is required, please attach an additional sheet.

_____

_____

_____

_____

_____

3.2 Medical history: If more space is required, please attach an additional sheet.

_____
_____
_____

3.3 Past Psychiatric history (including pre-incident conditions): If more space is required, please attach an additional sheet.

_____
_____
_____

3.4 Substance use and abuse history: If more space is required, please attach an additional sheet.

_____
_____
_____

3.5 Current psychological complaints: (affective, behavioral, cognitive, emotional symptoms) if more space is required, please attach an additional sheet.

_____
_____
_____

3.6 Family: family members, relationship among them, to whom is she mostly attached. If more space is required, please attach an additional sheet.

_____
_____
_____

3.7 Pre morbid personality (mood, characteristic trait, habit, interest): If more space is required, please attach an additional sheet.

_____
_____
_____

4. Mental state examination

Please describe in detail. If more space is required, please attach an additional sheet.

4. General appearance and behavior (built, age group, grooming, hygiene, dress, eye to eye contact, psychomotor activity, catatonic features and any other abnormal movements):

_____
_____
_____

4.2 Speech or talk (spontaneous or non-spontaneous, reaction time, tone, pitch, volume, content relevance):

_____
_____
_____

4.3 Mood (Subjective patient's vibration) and objective (examiner's assessment):

_____
_____
_____

4.4 Thought (Form, rate of production and contents of thought (delusion, obsession, phobia, suicidal and homicidal idea):

_____
_____
_____

4.5 Perception (Hallucination, Illusion, depersonalization, de-realization):

_____
_____
_____

4.6 Attention and Concentration (serial seven tests or serial three tests or counting till 20 and reverse):

_____
_____
_____

4.7 Memory (Immediate, Recent and Remote):

_____
_____
_____

4.8 Orientation (Time, Place and Person):

_____
_____
_____

4.9 Judgments (well-stamped envelope test or house-on fire test or facing-snake suddenly test):

_____
_____
_____

4.10 Grasp of General Knowledge (GGK) (name well known people e.g. prime minister, places, capital):

_____
_____
_____

4.11 Insight (absent, partial or present):

_____
_____
_____

4.12 Clinical diagnosis (according to ICD –10):

_____
_____
_____

4.13 Recommendations (further assessment such as neuropsychological testing, medical or psychiatric treatment, or a need for security or asylum):

_____
_____
_____

4.14 Treatment provided:

_____
_____
_____

4.15 Referral if necessary (where and why):

_____
_____
_____

4.16 Follow up, if necessary:

_____
_____
_____

4.17 Clinical impression (opinion regarding whether the psychological findings are consistent with the "alleged history"? Are the findings the expected outcome resulting from the alleged incident? Correlate the symptoms with the sequence of events. Are the any coexisting stressors?)

_____
_____
_____

Examiner's initial: _____ Date: _____

Name of the Examiner: _____ Qualification: _____

Signature: _____ BMDC Reg. No.: _____

Name of Office/Hospital/Health Centre: _____ Seal of the Hospital/Health Centre: _____

Date: _____

Note

- Report should be prepared by doctor/physician who conducts the examination.
- The report should be clear and understandable and original copy of the report should be submitted.
- Separate sheet of paper should be used, if the space allocated for description in the form is inadequate.

Annex 8. Age Estimation

Tanner's Stages for Development of Secondary Sexual Characters

Development of Male Genitalia

Stage	Description	Age		
Tanner I (Prepubertal)	Testicular volume less than 1.5 ml Penis length — less than 3 cm	< 9 years	I	
Tanner II	Testicular volume between 1.6 and 6 ml Skin on scrotum thins, reddens and enlarges Penis length —unchanged	9–11 years	II	
Tanner III	Testicular volume between 6 and 12 ml Scrotum enlarges further Penis length — less than 6 cm	11–12½ years	III	
Tanner IV	Testicular volume between 12 and 20 ml Scrotum enlarges further and darkens Penis increases in length (10 cm) and circumference	12½–14 years	IV	
Tanner V	Testicular volume greater than 20 ml Adult-type scrotum Penis length — 15 cm in length	>14 years	V	

Development of Breasts

Stage	Description	Age		
Tanner I (Prepubertal)	No glandular tissue Areola follows the skin contours of the chest	< 10 years	I	
Tanner II	Breast bud forms, with small glandular tissue Areola begins to widen	10–11½ years	II	
Tanner III	Breast begins to become more elevated, and extends beyond the borders of the areola Areola continues to widen but remains in contour with surrounding breast	11 ½–13 years	III	
Tanner IV	Increased breast size and elevation Areola and papilla form a secondary mound	13–15 years	IV	
Tanner V	Breast reaches final adult size areola returns to contour of the surrounding breast, with a projecting central papilla	>15 years	V	

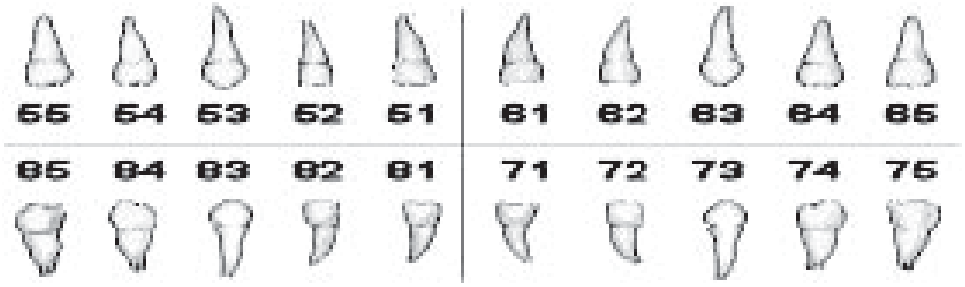
Development of Pubic Hair (Males and Females)

Stage	Description	Age		
Tanner I (Prepubertal)	No pubic hair at all	< 10 years	I	
Tanner II	Small amount of long, downy hair with slight pigmentation at the base of the penis an scrotum and on the labia majora	10–11½ years	II	
Tanner III	Hair becomes more coarse and curly, and begins to extend laterally	11 ½–13 years	III	
Tanner IV	Adult-like hair quality, extending across pubis but sparing medial thighs	13–15 years	IV	
Tanner V	hair extends to medial surface of the thighs	>15 years	V	

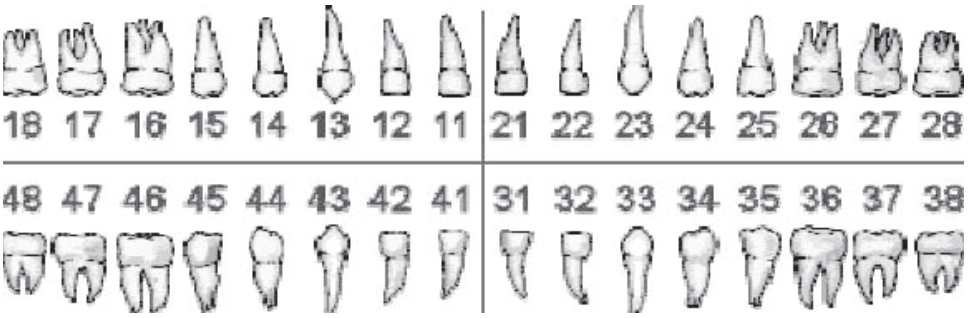
Age Estimation Based On Dentition

FDI Two-Digit Tooth Numbering System

Tooth Numbers for Primary Teeth



Tooth Numbers for Adult Teeth



Eruption of Teeth

Tooth	Lower/upper	Temporary	Permanent
Central incisor	Lower	06–08 months	07–08 years
	Upper	07–09 months	07–09 years
Lateral incisor	Lower	07–09 months	07–09 years
	Upper	10–12 months	08–09 years
Canine		18–20 months	11–12 years
First premolar		-	09–11 years
Second premolar		-	10–12 years
First molar		12–14 months	06–07 years
Second molar		20–30 months	12–14 years
Third molar		-	17–25 years

Difference between Deciduous and Permanent Teeth

Characteristics	Deciduous	Permanent
Size	Smaller	Larger
Colour	Porcelain white	Ivory white
Constriction at crown-root junction	More prominent	Less prominent
Edge	Sharp	Serrated
Cusp	Few and small	More in number Well

Radiological aging

Centers of bones	Appearance		Fusion
Humerus (Lower end)			
Medial epicondyle	5–6 years		Capitulum, trochlea & lateral epicondyle form conjoint tendon at 14 years, unites with shaft at 15 years Med. epicondyle unites at 16 years
Capitulum	1 year		
Trochlea	9–10 years		
Lateral epicondyle	10–12 (11) year		
Radius			
Upper end	5–6 years	15–16 years	
Lower end	1–2 years	18–19 years	
Ulna			
Upper end	8–9 years	16–17 years	
Lower end	5–6 years	18–19 years	
First metacarpal Head	2 years	15–17 years	
Other metacarpals	1.–2. years	15–19 years	
Hip bone			
Triradiate cartilage	11–13 years	14–15 years	
Iliac crest	14–15 years	18–20 years	
Ischial tuberosity	15–16 years	20–22 years	
Sacrum	8 months	IUL 25 years	
Femur (Upper end)			
Head	1 year	17–18 years	
Greater trochanter	4 years	17 years	
Lesser trochanter	14 years	15–17 years	
Femur (Lower end)	9 month IUL	17–18 years	
Tibia			
Upper end	9 month IUL	16–17 years	
Lower end	1 year	16 years	

Source: Handbook of P C Dikshi

Annex 9. Age Estimation Form

1. General Information

1.1 GBV Registration No.: _____

1.2 Name of the office/hospital referred from (with letter reference No. and Date):

_____

_____

_____

1.3 Name of the accompanying Police Personnel:

_____

2. Details about the examinee

2.1. Name (maintain confidentiality):

2.2 Age: _____ 2.3 Sex: □ Male □ Female □ Transgender

2.4 Education: _____

_____

2.5 Address: _____

_____

2.6 Current marital status: □ Single □ Married □ Divorced □ Separated □ Widowed

2.7 Ethnicity/Caste: _____

2.8 Guardian′s Name and relation (in case of minors): _____

2.9 Date and time of examination: _____

2.10 Attendant's Name & address: _____

2.11 Marks of Identification:

a. _____

b. _____

3. General configuration and development

3.1 Height: _____ 3.2Weight: _____

3.3 Voice: □ Adult-like □ Child-like

3.4 Adam's apple: □ Prominent □ Not Prominent

3.5 Scalp hair (Please describe color and length): _____

3.6 Moustache: □ Absent □ Present (describe color, length, distribution)

3.7 Beard: □ Absent □ Present (describe color, length, distribution)

3.8 Axillary hair: □ Absent □ Present (describe color, length, distribution)

3.9 Pubic hair: □ Absent □ Present (describe color, length, distribution)

3.10 Genitalia:

a) Male:

- Testis: □ Pendulous □ Non-Pendulous
- Penis: □ Adult-like □ Infantile

b) Female

- Breast: □ Globular □ Pendulous
- Areola: (describe color and diameter) _____

3.11 Any abnormality and disease? (describe in details)

_____

_____

_____

3.12 Alert to Time, Place and Person Yes □ No □

4. Dental examination

Using FDI charts as a reference, mark the appropriate teeth number as indicated -whether present, not erupted, missing etc.:

Deciduous:

$$\frac{55\ 54\ 53\ 52\ 51 / 61\ 62\ 63\ 64\ 65}{85\ 84\ 83\ 82\ 81 / 71\ 72\ 73\ 7475} = \_\_\_\_\_ \quad \text{(Total teeth)}$$

Permanent:

$$\frac{18\ 17\ 16\ 15\ 14\ 13\ 12\ 11 / 21\ 22\ 23\ 24\ 25\ 26\ 27\ 28}{48\ 47\ 46\ 45\ 44\ 43\ 42\ 41 / 31\ 32\ 33\ 34\ 35\ 36\ 3738} = \_\_\_\_\_ \quad \text{(Total teeth)}$$

□ Present ○ Not erupted x Missing

5. Radiological examination

5.1 X-ray examination advised

□ Wrist with hand – A/P □ Elbow A/P and lateral □ Pelvis – A/P

5.2 X-ray taken at _____ on _____ with number _____ in plates

5.3 X-ray Report

5.3.1. Right wrist with hand A/P view:

Lower end of radius

□ Not started □ Started □ Completing □ Recently completed □ Completed

Lower end of ulna

□ Not started □ Started □ Completing □ Recently completed □ Completed

Base of first metacarpals

□ Not started □ Started □ Completing □ Recently completed □ Completed

Heads of metacarpals

□ Not started □ Started □ Completing □ Recently completed □ Completed

Phalanges

□ Not started □ Started □ Completing □ Recently completed □ Completed

Pisiform

□ Not started □ Started □ Completing □ Recently completed □ Completed

5.3.2. Right elbow—A/P and Lateral views:

Lateral epicondyle

□ Not started □ Started □ Completing □ Recently completed □ Completed

Medial epicondyle

□ Not started □ Started □ Completing □ Recently completed □ Completed

Upper end of radius

□ Not started □ Started □ Completing □ Recently completed □ Completed

Trochlea

□ Not started □ Started □ Completing □ Recently completed □ Completed

Olecranon

□ Not started □ Started □ Completing □ Recently completed □ Completed

5.3.3. Pelvis A/P view:

Heads of femur

□ Not started □ Started □ Completing □ Recently completed □ Completed

Greater and lesser trochanters

□ Not started □ Started □ Completing □ Recently completed □ Completed

Tri-radiate cartilages

□ Not started □ Started □ Completing □ Recently completed □ Completed

Iliac crests

□ Not started □ Started □ Completing □ Recently completed □ Completed

Ischial tuberosities

□ Not started □ Started □ Completing □ Recently completed □ Completed

6. Opinion:

The age of the examinee is between _____ years and _____ years at the time of examination.

Name of the Examiner: _____ Qualification: _____

Signature: _____ BMDC Reg. No.: _____

Name of Office/Hospital/Health Centre: _____ Seal of the Hospital/Health Centre: _____

Date: _____

Examiner's initial: _____ Date: _____

Note

- Report should be prepared by doctor/physician who conducts the examination.
- The report should be clear and understandable and original copy of the report should be submitted.
- Separate sheet of paper should be used, if the space allocated for description in the form is inadequate.

Annex 10. Types of Samples to be Collected

Type of Evidence	Indication	Purpose	Investigation
Vaginal swabs and smears	● If there was genital contact ● Use of condom	● Semen/Sperm Detection ● Lubricant	Microbiological test for detection of spermatozoa/ detection of lubricant
Anal swabs	● If there was analgenital contact ● Use of condom	● Semen/Sperm Detection ● Lubricant	Microbiological test for detection of spermatozoa/ detection of lubricant
Oral swabs	If there was oralgenital contact	Semen/Sperm Detection	Microbiological test for detection of spermatozoa
Swabs from bites	If any bite injury/mark	Saliva	DNA Profiling
Hair	Collect a few strands of hair from the survivor as control	Identification	DNA Profiling
Nail scrapping	If any scraped skin of the perpetrator /soil/ foreign	Identification	DNA Profiling
Clothing or belongings	Any clothing worn at the time of the assault should ideally be bagged and dispatched for investigation	Identification	Microbiological test for detection of spermatozoa/ DNA Profiling

N.B: Please note that samples to be collected will depend on whether the survivor has bathed, has changed her clothing, washed her genitalia etc.

N.B.: Please note that swabs should be collected in all cases with history of contact, irrespective of history of ejaculation.

Annex 11. Chain of Custody Form

Chain of custody (CoC), in legal contexts, refers to the chronological documentation or paper trail that records the sequence of custody, control, transfer, analysis, and disposition of physical or electronic evidence. The chain of custody must account for the seizure, storage, transfer and condition of the evidence. The chain of custody is absolutely necessary for admissible evidence in court. An example of chain of custody would be the recovery of a bloody piece of cloth at a sexual violence scene:

1. Officer Mr. X collects the piece of cloth and places it into a container, then gives it to forensics technician Mr. Y.
2. Forensics technician Mr. Y takes the piece of cloth to the lab and collects fingerprints and other evidence from the piece of cloth. Mr. Y then gives the piece of cloth and all evidence gathered from the piece of cloth to evidence clerk Mr. Z.
3. Mr. Z then stores the evidence until it is needed, documenting everyone who has accessed the original evidence (the piece of cloth, and original copies of the lifted fingerprints).

The chain of custody requires that from the moment the evidence is collected, every transfer of evidence from person to person be documented and that it be provable that nobody else could have accessed that evidence. It is best to keep the number of transfers as low as possible.

Sl. No.	Sample Code No.	Sample Description	Signature
1.			
2.			
3.			
4.			
5.			
6.			

Name of person submitting evidence: _____

Designation: _____ Date: _____

Signature: _____

Official stamp:

Name of person receiving evidence: _____

Designation: _____ Date: _____

Signature: _____

Official stamp:

Annex 12. Available Emergency Contraceptives

There are three emergency contraceptive pill regimens that can be used:

1. levonorgestrel-only regimen: 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen; it is more effective and has fewer side-effects), or
2. Combined estrogen-progestogen regimen: two doses of 100 micrograms ethinylestradiol plus 0.5 mg of levonorgestrel taken 12 hours apart.
3. Use of an Intrauterine Device (IUD) as an emergency contraceptive
    - If the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle), insertion of a copper-bearing IUD is an effective method of emergency contraception. It will prevent more than 99% of expected subsequent pregnancies.
    - Women should be offered counselling on this service so as to reach an informed decision.
    - A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment, as recommended in Annex 13.
    - The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Currently, Levonorgestrel is supplied as emergency contraceptive in the name of Postinor-2 by DGFP countrywide. If it is not available then other below mentioned methods can be used as emergency contraceptive for the survivors of GBV.

Composition of dose	Tablets required per dose	Doses	Timing of administration
Levonorgestrel only LNG 1500 µgm	1	1	Within 72 hours of unprotected sex
High dose Pills EE50 µm + LNG 250 µm	2	2	First dose within 72 hours of unprotected sex, Second dose 12 hours later
Low dose Pills EE30 µm + LNG 150 µm	4	2	First dose within 72 hours of unprotected sex. Second dose 12 hours later
IUD			Up to 5 days after unprotected sex

Annex 13. STI Management[33]

Based on WHO-recommended STI treatments for Adults (may also be used for prophylaxis)

Note: Following tables are the WHO recommended treatments for sexually transmitted infections. If the diagnosis cannot be confirmed syndromic management protocols for sexually transmitted infections are followed in Bangladesh.

STI	Treatment	
Gonorrhea	Ciprofloxacin Cefexime Ceftriaxone	500 mg orally, single dose (contraindicated in pregnancy) or 400 mg orally, single dose or 125 mg intramuscularly, single dose
Chlamydial infection	Azithromycin Doxycycline	1 gm orally, in a single dose (not recommended in pregnancy) or 100 mg orally, twice daily for 7 days (contraindicated in pregnancy)
Chlamydial infection in pregnant women	Erythromycin Amoxicillin	500 mg orally, 4 times daily for 7 days or 500 mg orally, 3 times daily for 7 days
Syphilis	Benzathin benzyl penicillin	2.4 million IU, intramuscularly, once only (give as two injections in separate sites)
Syphilis, patients allergic to penicillin	Doxycycline	100 mg orally, twice daily for 14 days (contraindicated in pregnancy) (Note: This antibiotic is also active against Chlamydia)
Syphilis in pregnant women allergic to penicillin	Erythromycin	500 mg orally, 4 times daily for 14 days (Note: This antibiotic is also active against Chlamydia)
Trichomoniasis	Metronidazole	2gm orally, as a single dose or as two divided doses at a 12 hour interval (contraindicated in the first trimester of pregnancy)

***Note:** Benzathine benzyl penicillin may be omitted if the prophylactic treatment regimen includes Azithromycin 1 gm orally, in a single dose, which is effective against incubating syphilis.

[33] Tailoring clinical management practices to meet the special needs of adolescents: sexually transmitted infections. Geneva, World Health Organization, 2002 (WHO/CAH 2002, WHO/HIV/AIDS 2002.03).

Give one easy-to-take, short treatment for each of the infections, prevalent in our setting.

Presumptive treatment for gonorrhoea, syphilis and chlamydial infection for a woman who is not pregnant and not allergic to penicillin:

- Cefixime 400 mg orally + Azithromycin 1 g orally, single dose; or
- Ciprofloxacin 500 mg orally + Benzathine benzyl penicillin 2.4 million IU intramuscularly + Doxycycline 100 mg orally, twice daily for 7 days
- If trichomoniasis is prevalent, add a single dose of 2 g of Metronidazole orally.

WHO recommended STI treatment for Children and Adolescents (may also be used for presumptive treatment)

STI	Weight or Age	Treatment	
Gonorrhea	< 45 kg	Ceftriaxone Spectinomycin Cefexime	125 mg intramuscularly, single dose or, 40 mg/kg of body weight intramuscularly (up to a maximum of 2 gm), single dose or, (if >6 months) 8 mg/kg body weight orally, single dose
	≥ 45 kg		Treat according to adult protocol
Chlamydial infection	< 45 kg	Azithromycin Erythromycin	20 mg/kg orally, single dose or, 50 mg/kg of body weight daily, orally (up to a maximum of 2 gm), divided into 4 doses for 7 days
	≥ 45 kg but < 12 years	Azithromycin Erythromycin	500 mg orally, 4 times daily for 7 days or, 1 gm orally, single dose
	≥ 12 years		Treat according to adult protocol
Syphilis		Benzathine benzyl penicillin	50,000 IU/kg intramuscularly (up to a maximum of 2.4 million unit), single dose
Syphilis, patients allergic to penicillin		Erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 gm), divided into 4 doses for 14 days
Trichomoniasis	< 12 years	Metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	≥ 12 years		Treat according to adult protocol

Annex 14. Post Exposure Prophylaxis (PEP) for Sexual GBV Survivor[34]

The 2014 World Health Organization (WHO) guidelines for Post Exposure Prophylaxis (PEP) developed recommendations for PEP irrespective of exposure source in recognition of the need to simplify eligibility assessment and prescribing practice. Recommendations are based on the public health approach to deliver HIV services that seeks to ensure the widest possible access to high-quality services at a population level, aiming for a balance between best proven standard of care and feasibility.

Estimates of HIV transmission risk per act vary among population groups and are difficult to interpret due to multiple confounding factors. HIV PEP is not indicated if the exposed person is already HIV infected. Nevertheless, HIV testing needs to be done but HIV testing should be voluntary, and consent for HIV testing should be obtained with standard pretest and posttest counselling according to the national protocol. Where the individual has limited or no capacity to consent (most commonly children), a parent or guardian can provide consent. Risks and benefits of testing should be sufficiently explained to the child and parent/guardian so that an informed decision can be made.

Practical Guideline for Assessing Post-exposure Prophylaxis Eligibility

● HIV PEP should be offered and initiated as early as possible in all individuals with an exposure that has the potential for HIV transmission, and ideally **within 72 hours**.
● Eligibility assessment should be based on the HIV status of the source whenever possible and may include consideration of background prevalence and local epidemiological patterns.
● **Exposure that may warrant HIV PEP include:** ○ Bodily fluids, blood, blood stained saliva, breast milk, genital secretion, pericardial or pleural fluids; ○ Mucous membrane, sexual exposure, splashes to eye, nose or oral cavity; ○ Parenteral exposures.
● **Exposures that do not require HIV PEP include:** ○ When the exposed individual is HIV already positive ○ When the source is established to be HIV negative ○ Exposures to body fluid that do not pose a significant risk, i.e. tears, non-blood stained saliva, urine and sweat.

Previously PEP guideline recommended different PEP regimens for different circumstances, with 2 drugs recommended as standard and the addition of the third drug in situation of known risk of ARV drug resistance in the source person or the community.

[34] Clinical Management of Rape Survivors: developing protocols for use with refugees and internally displaced persons; UNHCR, WHO & UNFPA; 2005.

More recent national guidelines have shifted towards **recommending a 3 drug regimen for all**, given the availability of less toxic and better tolerated medications and considering the difficulty in evaluating the risk of drug resistance and need to simplify prescribing.

The new WHO guidelines also provide recommendations for PEP prescribing and adherence support. **Prompt PEP initiation (within 72 hours post exposure, but the sooner, the better) and completion of the full 28-day course of ARV drugs for HIV PEP are thought to be required to maximize the benefit of the intervention.**

Recommended Regimens for Prophylaxis for Adults, Adolescents and Children

Number of antiretroviral drugs:
● 2 drugs PEP regimen is effective, but 3 drugs are preferred. (Conditional recommendation, low quality of evidence) ● 2 ARV drugs to be taken twice a day for 28 days. The drugs are Zidovudine & Lamivudine and are available combined in one tablet called Combivir.
Preferred antiretroviral regimen for adults and adolescents:
● TDF + 3TC (or FTC) is recommended as the preferred backbone regimen for HIV PEP in adults and adolescents. (Conditional recommendation, very low quality of evidence). ● LPV/r or ATV/r are suggested as the preferred third drug for HIV PEP in adults and adolescents. (Strong recommendation, low to moderate quality of evidence).
Preferred antiretroviral regimen for the children ≤ 10 years:
● ZDV + 3TC is recommended as the preferred backbone for HIV PEP in children aged ≤ 10 years. (Conditional recommendation, very low quality of evidence). ● LPV/r is recommended as the preferred third drug for HIV PEP in children aged ≤ 10 years. (Conditional recommendation, very low quality of evidence).
Prescribing frequency:
● A full 28 days prescription of antiretrovirals should be provided for HIV PEP following initial risk assessment. (Strong recommendation, very low quality of evidence). Provide full course (28 Days) of drugs on the first day.
Adherence Support:
● Enhanced adherence counseling is suggested for all individuals initiating HIV PEP. (Conditional recommendation, moderate quality of evidence).
Abbreviations:
TDF: Tenofovir; 3TC: Lamivudine; FTC: Emtricitabine; LPV: Lopinavir; ATV: Atazanavir; ZDV: Zidovudine.

Annex 15. Follow Up of the GBV survivors[35]

Follow up visits should take place at 2 weeks, 1 month, 3 months and 6 months after the assault.

2-week follow-up visit		
Injury	Check that any injuries are healing properly.	□
STIs	Check that the woman has completed the course of any medications Given for STIs.	□
	Check adherence to PEP, if she is taking it.	□
	Discuss any test results.	□
Pregnancy	Test for pregnancy if she was at risk. If she is pregnant, tell her about the available options. If abortion is permitted, refer her for safe abortion.	□
Mental health	Continue first line support and care.	□
	Assess the patient's emotional state and mental status. If any problems, plan for psychosocial support and stress management, such as progressive relaxation or slow breathing.	□
Planning	Remind her to return for further hepatitis B vaccinations in 1 month	□
	and 6 months and HIV testing at 3 months and 6 months, or else to	□
	follow up with her usual healthcare provider.	□
1-month follow-up visit		
STIs	Give second hepatitis B vaccination, if needed. Remind her of the 6month dose.	□
Mental health	Continue first line support and care.	□
	Assess her emotional state and mental status. Ask if she is feeling better. If new or continuing problems, plan for psycho social support and stress management.	□
	For depression, alcohol or substance use, or post-traumatic stress disorder, please see chapter 5 (psychosocial care and support) for primary care. Or, if possible refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	□
Planning	Make next routine follow up appointment for 3 months after the assault.	□
3-month follow-up visit		
STIs	Offer HIV testing and counseling. Make sure that pre and posttest counseling is available and refer for HIV prevention, treatment and care.	□
Mental health	Continue first line support and care.	□
	Assess the patient's emotional state and mental status. If new or continuing problems, plan for psycho-social support and stress management.	□
	For depression, alcohol or substance use, or post-traumatic stress disorder, please see chapter 5 (psychosocial care and support) for primary care. Or, if possible, refer for specialized care to a specifically trained healthcare provider with a good understanding of sexual violence	□
Planning	Make next follow-up appointment for 6 months after the assault. Also, remind her of the 6 month dose of hepatitis B vaccine, if needed.	□

[35] Adapted from IRC Clinical care for sexual assault survivors, psychosocial toolkit

6 month follow-up visit		
STIs	Offer HIV testing and counseling if not done before. Make sure that pre and post test counseling is available and refer for HIV prevention, treatment and care.	□
	Give third dose of hepatitis B vaccine, if needed.	□
Mental health	Continue first line support and care.	□
	Assess the patient's emotional state and mental status. If there are new or continuing problems, plan for psycho social support and stress management	□
	For depression, alcohol or substance use, or post-traumatic stress disorder, refer if possible for specific care to a specifically trained health care provider with a good understanding of sexual violence.	□

Annex 16. Register of Medical and Medico-Legal Services Provided to GBV Cases at Health Facilities[36]

How: Handwritten in a hard copy register. ***Who:*** To be maintained by health facilities. ***When:*** Case-wise entries to be updated daily for cases that have completed a round of services. ***Purpose:*** To provide an at-a-glance summary at any time of services provided.

Survivor Register

Name of Health Facility : _____ **District & Upazila :** _____ **Month** _____**Year**_____

Survivor information												Medical care provided												Referral		Remarks
						Sex			Type of GBV															From	To	
Sl. No.	Date	Date of incidence	Survivor registration No.	Age (years and months)	Address	Male	Female	Transgender	Sexual	Physical	Psychological	Physical examination	Medico-legal examination	Treatment of Injury	Emergency contraceptive	Treatment of Sexually transmitted infection (STIs)	Post Exposure Prophylaxis (PEP) for HIV	Basic Psycho-social support	Specialiged Psychological treatment	Other Treatment (please specify)	HIV testing and counseling (HTC)	Pregnancy test	Follow-up	Self=1, Relatives=2 OCC=3, Police=4 NGO=5, Health facility=6 Others=09 (please specify)	OCC=1, Police=2, Lawyer=3, Medical college/specialized hospital=5 Others=09 (please specify)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
Total																										

[36] Table is adapted from 'monitoring and Reporting Manual for One Stop Crisis Management Center': Developed by Government of Nepal, July 2014 130

Annex 17. Monitoring Tool for GBV Service Delivery

Name of Health Facility with address:		**Name of Service Providers and designations**	
		1.	
		2.	
Date of visit:		**Name of Observers and designations**	
		1. 2.	

Sl. No.	Performance	Verification Criteria	Yes	No	Comment
1.	The facility has an adequate physical infrastructure for examination and counseling	**Observe that the facility has:**			
		• One room where confidentiality and privacy could be maintained			
		• Examination bed			
		• Chairs for survivor, provider and companion			
		• Hand washing facilities inside or nearby, area for hand washing, running water facility/bucket with tap			
		• Buckets and safety boxes for waste segregation and disposal			
		• Required instruments, materials and medications for medico-legal examination			
		• Necessary forms and guidelines for recording and reporting			
		• Training guidelines			
		• Treatment protocols			
		• IEC materials (printed and electronic), different audio-visual aids			
		• Phone service			
2.	The facility has survivor friendly examination and counseling area	**Observe that:**			
		• The room is clean and equipment kept in place			
		• Curtains or screen to prevent seeing the examination area from the door			
		• The room is well ventilated			
		• The room provides privacy for the survivor so that other waiting survivors cannot hear what is being said			
3.	The facility has adequate equipment for examination	**Observe that the health facility has a complete examination set:**			
		• Good light source/torch light			
		• Sheet to cover the survivor			
		• 0.5% chlorine solution			
		• Stethoscope and phygmomanometer			
		• Tongue depressor			

Sl. No.	Performance	Verification Criteria	Yes	No	Comment
		• Weighing machine			
		• Cheatle forceps with jar			
		• Lignocaine jelly			
		• Povidone Iodine			
		• Gloves sizes 6 (5 and 7)			
		• Cusco's bivalve speculum			
		• Sim's speculum			
		• Slides and Container for the slides			
		• Ayer's spatula			
		• Sterile test tube to collect specimen			
		• Proctoscope			
		• Pregnancy test strip			
		• Essential drugs and Emergency contraception			
		• Disposable syringe			
		• Dressing and Suture sets			
		• Vaccinations for tetanus toxoid and hepatitis B			
		Observe that the health facility has a complete examination set:			
		• Tray for sharp instruments			
		• STI and PEP drugs			
4.	The facility has adequate trained human resources for 24 hours services for GBV survivors	**Observe that there are at least:**			
		• Medical officer: 3			
		• Nurses/Midwife: 3 (trained in psycho-social counseling)			
		• Paramedics/Lab Assistant: 2			
5.	The health worker treats the survivor and counseling services	**Observe that the provider:**			
		• Treats physical injuries			
		• Advises, explains and provides emergency contraception (pills and IUD)			
		• Performs urine pregnancy test if needed, counsels and/or refers survivor for safe MR services			
		• Tests and gives presumptive treatment for STI			
		• Tests and immunizes for hepatitis B and TT if indicated			
		• Tests and counsels for HIV test (not mandatory)			
		• Counsels and provides PEP for HIV if survivor accepts			
6.	The health worker collects specimen for forensic/medico legal examination	**Observe that the provider takes:**			
		• Vaginal swab / endocervical swab for presence of spermatozoa			
		• Blood for HIV, HbsAg, VDRL (not mandatory in first visit)			
		• Urine for pregnancy test where appropriate			
		• Where appropriate clothes and under garments for forensic examination			

Sl. No.	Performance	Verification Criteria	Yes	No	Comment
		• Takes photographs/used pictograms for recording of injuries			
		• Documents and preserves evidences safely for future legal use			
7.	The health worker takes a detailed history	**Observe that the provider:**			
		• Obtains consent before medical examination			
		• General medical history			
		• Gynaecological history			
		• History of the assault			
		• Date, time and location of the assault			
		• Name, identity and number of assailants			
		• Use of medication / drugs / alcohol / inhaled substance			
8.	The health workers advice referral when necessary	**Observe that the provider:**			
		• Refers for most suitable support services depending on survivor's needs and circumstances and facility/resource availability (medical, legal, shelter)			
		• Give contact number/address for further assistance			
9.	The health workers advise for follow up	**Observe that the provider:**			
		• Advises for follow up after 2weeks, 1 months, 3months, 6 months			
		• Check for completion of medication course			
10.	The health worker maintain documentation and records	**Observe that the provider:**			
		• Enters the information in the medical record and the course of treatment in the register			
		• Assess whether recorded in the standard format			
		• Ensures that these medical records are stored confidentially and give one copy to the survivor in an envelope, keep one copy for the health facility and one copy for police to take legal action.			

Total Standard for GBV Services	
Total standard	**100**
Total standards met	
Percent achievement (%)	

Annex 18. Relevant Selections from Bangladesh Law

2.5.1 Act and Rules

A. Penal Code, 1860

Under section 375 of the Penal Code "rape" occurs when a man has "sexual intercourse" with a woman under one of the following circumstances: Firstly. Against her will. Secondly. Without her consent. Thirdly. With her consent, when her consent has been obtained by putting her in fear of death, or of hurt. Fourthly. With her consent, when the man knows that he is not her husband, and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married. Fifthly. With or without her consent, when she is under fourteen years of age.

An explanation of what qualifies as "rape" is provided at the end of the definition, which states: "penetration is sufficient to constitute the sexual intercourse necessary to the offence of rape." An exception is listed where the sexual intercourse occurs between a husband and his wife. When this occurs, and the wife is not under the age of 13, then the act does not constitute rape.

The maximum punishment for committing the offense of rape, under section 376 of the Penal Code, is life imprisonment. An exception to this punishment exists where the rape is perpetrated by a husband against his wife (who is then under the age of 12). Under such a set of circumstances, the maximum punishment is two years and a fine.

Regarding the offense of sexual assault, the Penal Code offers a section addressing "assault or criminal force to woman with intent to outrage her modesty" with a maximum punishment of imprisonment and a fine.

B. The Dowry Prohibition Act, 1980

If any person, after the commencement of this Act, gives or takes or abets the giving or taking of dowry, he shall be punishable with imprisonment which may extend to five years and shall not be less than one year or five or with both (3)[37]

C. Nari-O-Shishu Nirjatan Daman Ain, 2000 (as amended in 2003)

This act provides provisions to punish the perpetrators of Violence against Women and Children under Special Tribunals. This Act takes the punishment for rape one step further than the Penal Code. The punishment for rape, under this Act, is a maximum of life imprisonment with a fine. But, if the victim later dies, or the rape is committed by more than one man (i.e. gang rape), then the maximum penalty imposed is capital punishment, i.e. death penalty.

Offenses of sexual assault and sexual harassment are termed the offense of "sexual oppression" under this Act. Whoever, to satisfy his sexual urge illegally, touches the sexual organ or other organ of a woman or a child with any organ of his body or with any substance, his act shall be said to be sexual oppression and he shall be punished with imprisonment for

[37] The Dowry Prohibition Act, 1980

either description which may extend to ten years but not less than two years of rigorous imprisonment and also with fine.

Whoever, to satisfy his sexual urge illegally, assaults a woman sexually or makes any indecent gesture, his act shall be deemed to be sexual oppression and he shall be punished with imprisonment for either description which may extend to seven years but not less than two years of rigorous imprisonment and also with fine.

D. The Acid Crime Control Act, 2002

This act is expedient to frame laws for the suppression of offences rigidly relating to Acid. If any person causes the death of another person by acid he shall be convicted to death sentence or for rigorous life imprisonment and in addition shall be fined up to taka one lakh (section 4)[38]

E. The Acid Control Act, 2002

This act is expedient to frame laws for the controlling import, production, transportation, stocking, selling and, misuses of acid as a combustible objects and to provide medical, rehabilitation and legal support to the victims of acid.

F. Information and Communication Technology (ICT) Act 2006

ICT Act prohibits to publish any false and obscene materials in the website or other electrical media. Section 57 (1) says: "If any person deliberately publishes or transmits or causes to be published or transmitted in the website or in any other electronic form any material which is false and obscene and if anyone sees, hears or reads it having regard to all relevant circumstances, its effect is such as to influence the reader to become dishonest or corrupt, or causes to deteriorate or creates possibility to deteriorate law and order, prejudice the image of the state or person or causes to hurt or may hurt religious belief or instigate against any person or organization, then this activity will be regarded as an offence." For this offence the maximum punishment is rigorous imprisonment for 14 years with fine of Taka 1 (one) crore.

G. The Mobile Court Act, 2009

The executive magistrate was given power to take steps by linking Section 509 of the Bangladesh Penal Code in the schedule of Mobile Court Act to prevent sexual harassment of the girls and women.

H. The Domestic Violence (Prevention and Protection) Act 2010 and Rules 2013

As a signatory state to the U.N. Charter on Prevention of All Forms of Discrimination to Women, 1979 and the Child Rights Convention 1989 and to uphold the Constitution of Bangladesh, the Domestic Violence (Prevention and Protection) Act, 2010 was passed for establishing equal rights of women and children and for protection of women and children from family violence. Under this Act, the psychological and economical violence are also prohibited. One can file an application for protection order from the court if she is in the apprehension of any violence from the family members. The Domestic Violence (Prevention and Protection) Rules, 2013 was also passed under this Act.

[38] Acid Crime Control Act, 2002

I. The Human Trafficking (Deterrence and Suppression) Act, 2012

This act is expedient to frame laws for the prevention and control human trafficking and to ensure protection and rights of the victims of human trafficking and to secure immigration. If any person having been convicted for human trafficking or sexual abuse or harassment under section 2(15) said that any other abuses of abduct, hide or confined of any other person he shall be convicted up to ten years and not less than five years rigorous imprisonment and in addition shall be fined up to taka twenty thousand (section 10.1)[39]

J. The Pornography Control Act, 2012

If any person relating with producing pornography or contracting other persons for production, or to force any women, man and child to participate or attracting any women, man and child with consent or without consent taking still picture, video or film, he shall be convicted for rigorous imprisonment maximum seven years and in addition shall be fined up to taka two lakh. (Section 8.1)[40]

If any person using any child for producing pornography, printing and publishing or selling child pornography, supply or exhibition or broadcasting the advertisement of child pornography, he shall be convicted for rigorous imprisonment maximum ten years and in addition shall be fined up to taka five lakh. (Section 8.6)

K. The Child Act, 2013

This Act has been replaced by the child Act 1974 by modifying and expanding in accordance with United Nations on Child Rights convention 1989 and the National Children Policy 2011. Child Court is established to deal all children accused under this Act.

L. Deoxyribo Nucleic Acid (DNA) Act, 2014

As per the Act, DNA sample can collect from the body, cloths, place of occurrence. Police by himself or under the order of the court can request the victim, suspected person, alleged accused or any other relevant person involved with the crime to provide the sample. Without written consent no sample can be collected for DNA profile. Under the law government will establish a national DNA database.

M. The Child Marriage Restraint Act, 2017

This act is expedient to restrain the solemnization of child marriages; child means a person who, if a male, is under twenty-one years of age, and if a female, is under eighteen years of age.

2.5.2 High court rule on Two Finger Test (TFT)

On 12th of April 2018, the Hon'ble High Court Division delivered a judgment in writ petition no. 10663 of 2013, clearly banning the "two-finger test" on rape survivors.

The Court also pronounced following 8 (eight) directions:

1. The TFT is not scientific, reliable, valid and hereby prohibited in any examination of rape victim.

[39] Human Trafficking (Deterrence and Suppression) Act (2012)
[40] Pornography Control Act 2012

2. The respondents shall make available the health care protocol (Health Response To Gender Based Violence-Protocol For The Health Care Providers) to forensic experts, physicians who conduct medical examination on rape victims; police officers who conduct investigation of rape case; public prosecutors appointed in Nari O Shishu Nirjataon Tribunal and other interested private lawyers
3. Physicians/forensic experts shall issue medical certificates about examination of rape, they shall not use the degrading word "habituated to sexual intercourse" and shall not ask any questions of her previous sexual experience.
4. In case of a deep-seated intra-vaginal examination the matter shall be referred to a Gynecologist for an expert opinion to identify an injury or for medical reasons.
5. Per speculum examination is not a must in the case of children/young girls when there is no history of penetration and no visible injuries.
6. The bimanual test is not related to TFT and being related to obstetric and gynecological examinations only, same shall not be practiced in rape victim.
7. The Government shall appoint trained doctors and nurses for medical examination of rape victim. Such examination shall be conducted in presence of preferably female police, female relative and preferably by female physicians. The concern physicians and forensic experts shall strictly maintain the privacy of the victim.
8. The Nari-o-Shishu Nirjaton Tribunal shall ensure that no lawyer shall ask any degrading question to rape victim which is not necessary to ascertain any information of rape.

2.5.2 High Court directives to prevent violence against women and children

A. Sexual Harassment[41]:

High court provided guideline for preventing sexual harassment against women and children in workplace/educational institution. This guideline will be applicable for all the government and non-government educational institution. The goal and objective are creating awareness on sexual harassment; creating awareness on the effect of sexual harassment; creating awareness that the sexual harassment is punishable offence.

B. Sexual harassment against women and children:[42]

The word eve teasing or teasing shall not be used from now on. In lieu of that all law enforcement agencies, government agencies/offices, media uses the term sexual harassment for describing so called eve teasing or teasing/harassment incidences.

C. The Extra judicial Punishment in the name of the Fatwa is illegal[43]

The Extra judicial Punishment in the name of the Fatwa has been declared illegal by the judgment. 1. If any person punished other then he and his associates shall be punished as per

[41] High Court Writ Petition No5916/2008

[42] High Court Writ Petition No 8769/2010

[43] High Court Writ Petition No 5863/2009 with Writ Petition 754/2010 and 4275/2010

the section of penal code and other existing laws. 2. Law enforcement agencies, Union Parishad and Pourasava around the country will take necessary action for stopping incidence like fatwa under his areas. If the incidence occurs then they will take necessary legal action against the related offender. 3. Government i.e. local government division hereby informed that the extra judicial punishment in the name of the fatwa is illegal and it will consider as punishable offence. Government will create awareness among the mass people that extra judicial punishment in the name of the fatwa is illegal.4. Government i.e. Ministry of Education incorporated articles in the syllabus and other educational materials in school, college, university and specially madrasas which will ensure the maximum respect of the constitution and legal dominion; and will take necessary steps for discourage to use the extra judicial punishment in the name of the Islamic Sharia/Fatwa as it is illegal.

D. Nobody is compelled to obey the Fatwa[44]

1. Appropriate educated person have the right to give Fatwa, which depends on spontaneous acceptance.
2. Fatwa cannot be given in that way which will destroy the fame of any person to accept existing laws of the country.
3. No one can be punished physically or psychologically under Fatwa.

E. Executive order of the Ministry of Women and Children Affairs to prevent child marriage.[45]

In spite of prohibition of child marriage in Act, due to the increase of the child marriage according to the write petition no 4781/2012 on 20/06/2012 from the High court division of Supreme court, according to the letter on 13/08/2012 Ministry of Women and Children Affairs requested to act carefully on: a) Register nikah on the basis of National identity card and birth certificate for the Muslim men and women. b) Avoiding registering on nikah for children.

F. Presence of Female Physicians/Nurse/MLSS is must for examining Rape Survivor & Girls for ascertaining Age:

The Hon'ble High court Division of the Supreme Court of Bangladesh issued a rule and direction to take necessary steps to appoint necessary number of female physicians, nurse and female MLSS for the purpose of examination of rape victim and girls referred for ascertaining age in all hospitals of the Government, in the alternative to take necessary measures for the same. Upon this direction, the Director General of Health have appointed 44 female physicians in different hospitals and also have directed all the directors, civil surgeon and necessary authorities.[46]

[44] High Court Writ Petition No 4275/2010
[45] Executive order of the ministry of Women and Child Affairs to prevent Child Marriage
[46] Suo Moto Rule 05 of 2013

G. Directive from MOHFW, 2019

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রনালয়
স্বাস্থ্য সেবা বিভাগ
জেন্ডার এনজিও অ্যান্ড স্টেকহোল্ডার পার্টিসিপেশন ইউনিট

নম্বর - ৪৫.০৫.০০০০.০১০.৩৬.০০২.১৯.২৮৮

তারিখ: ৬ শ্রাবণ, ১৪২৬ বঙ্গাব্দ / ২১ জুলাই, ২০১৯ খ্রি:

পরিপত্র

বিষয় : স্বাস্থ্য খাতে জেন্ডার জনিত সহিংসতায় সেবা প্রদান সম্পর্কিত।

নারী উন্নয়ন ও ক্ষমতায়ন নিশ্চিত করতে সরকার নারী ও শিশু নির্যাতনের প্রতিকার ও প্রতিরোধে সংকল্পবদ্ধ। এ লক্ষ্যে "নারী ও শিশু নির্যাতন দমন আইন ২০০০" এর ৩২ নং ধারা , এসিড নিয়ন্ত্রণ আইন ২০০২ এর ৪৩ (২) নং উপধারা, ও এসিড অপরাধ দমন আইন, ২০০২ এর ২৯ নং ধারায় নির্যাতনের শিকার ব্যক্তিদের চিকিৎসা ও মেডিকেল পরীক্ষা সংক্রান্ত বিধান রয়েছে। সুপ্রিম কোর্টের হাইকোর্ট ডিভিশনের রীট পিটিশন নং-৫৫৪১/২০১৫ এর ১৮ ই ফেব্রুয়ারী ২০১৬ খ্রি: এর রায় এবং রীট পিটিশন নং-১০৬৬৩/২০১৩ এর ১২ ই এপ্রিল, ২০১৮ খ্রি: এর রায়ে মহামান্য আদালত সুনির্দিষ্ট দিক নির্দেশনা প্রদান করেছেন। বর্ণিত নির্দেশনার আলোকে সংশ্লিষ্ট সকলকে অনুসরণের জন্য নিম্নোক্ত নির্দেশনা জারী করা হলো:

ক) পুলিশ রেফারেন্স ছাড়াও ধর্ষণ ও যৌন নিপীড়নের শিকার কোন নারী ও শিশু যে কোন সরকারী অথবা সরকার কর্তৃক এতদুদ্দেশ্যে স্বীকৃত বেসরকারী হাসপাতালে কর্তব্যরত চিকিৎসকের শরণাপন্ন হলে তাৎক্ষণিকভাবে চিকিৎসক তাকে যথানিয়মে পরীক্ষা করবেন এবং অপরাধ সংঘটনের বিষয়টি নিকটস্থ থানাকে অবহিত করবেন। পরবর্তীতে মেডিকেল সার্টিফিকেটের এক কপি নির্যাতিতকে, এক কপি আইনী প্রয়োজনে কোর্ট/পুলিশকে প্রদান করবেন এবং এক কপি স্বাস্থ্যকেন্দ্রে সংরক্ষণ করবেন।

খ) স্থানীয় পর্যায়ে নারী ও শিশু নির্যাতন প্রতিরোধ কমিটির সভায় হাসপাতাল ব্যবস্থাপক ও সিভিল সার্জন নিয়মিত যোগদান করবেন, চিকিৎসা/মেডিকেল সনদপত্র বিষয়ে ত্বরিত ব্যবস্থা নেবেন, নির্যাতিতের অনুকূলে সেবা প্রদানের মাসিক তথ্য প্রতিবেদন জেন্ডার এনজিও অ্যান্ড স্টেকহোল্ডার পার্টিসিপেশন (জিএনএসপি) ইউনিট, স্বাস্থ্য সেবা বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় বরাবরে প্রেরণ করবেন।

গ) ধর্ষণ অথবা যৌন নিপীড়নের ক্ষেত্রে অপরাধ সংঘটনের ৪৮ ঘন্টার মধ্যে রাসায়নিক/ডিএনএ পরীক্ষার নমুনা সংগ্রহ করে পরীক্ষার প্রয়োজনে পুলিশের মাধ্যমে প্রেরণ করতে হবে।
ঘ) ধর্ষণের ক্ষেত্রে Two finger test – করা যাবে না।
ঙ) শিশু ও কিশোরীদের ক্ষেত্রে স্পেকুলাম পরীক্ষা অত্যাবশ্যকীয় নয় বিবেচনা করতে হবে।
চ) সকল ক্ষেত্রে নির্যাতিতের গোপনীয়তা অবশ্যই রক্ষা করতে হবে।
ছ) মেডিকেল সার্টিফিকেটে অবমাননাকর "যৌন কাজে অভ্যস্ত (habituated to sexual intercourse)" এরূপ শব্দ ব্যবহার করা যাবে না।

২। নারী ও শিশু নির্যাতন প্রতিকার ও প্রতিরোধে স্বাস্থ্যখাতের বিশেষ ভূমিকা রয়েছে। এ ক্ষেত্রে হাসপাতালসমূহে চিকিৎসা ও মেডিকোলিগ্যাল সেবা দেয়া হচ্ছে। সেবাপ্রদানে উপর্যুক্ত বিষয়াবলীর প্রতিপালন নিশ্চিত করার জন্য বিভাগীয়, জেলা, উপজেলা পর্যায়ে সংশ্লিষ্ট সকলে যথাযথ পদক্ষেপ গ্রহণ করবেন।

৩। বর্ণিত সেবাপ্রদান কার্যকরী করার জন্য স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয় কর্তৃক প্রণীত এবং সুপ্রীম কোর্টের হাইকোর্ট ডিভিশন নির্দেশিত "Health Sector Response to GBV Survivors: Protocal for Health Care Providers" শীর্ষক গাইড লাইন যথাযথভাবে অনুসরণ এবং মেডিকেল সার্টিফিকেট ও মেডিকোলিগ্যাল পরীক্ষার নির্দিষ্ট ফরমেট ব্যবহার করার জন্য সংশ্লিষ্ট সকলকে অনুরোধ করা হ'ল।

৪। নির্যাতিতদের অনুকূলে সেবা প্রদানের ডাটা দৃশ্যমান করার লক্ষ্যে অনতিবিলম্বে MIS, স্বাস্থ্য অধিদপ্তরের DHIS2 -তে সন্নিবেশিত করতে হবে।

৫। বর্ণিত পদ্ধতি ও ব্যবস্থাপনা অনতিবিলম্বে কার্যকর হবে।

(মো: আসাদুল ইসলাম)
সচিব
স্বাস্থ্য সেবা বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়

কার্যার্থে বিতরণ : (জ্যেষ্ঠতার ক্রমানুসারে নয়)

১। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা।
২। মহা-পরিচালক, পরিবার পরিকল্পনা অধিদপ্তর, কাওরান বাজার, ঢাকা।
৩। মহা-পরিচালক, মহিলা বিষয়ক অধিদপ্তর, ৩৭/৩, ইস্কাটন গার্ডেন, ঢাকা।
৪। বিভাগীয় পরিচালক, স্বাস্থ্য/পরিবার পরিকল্পনা (সকল বিভাগ)-----।
৫। পরিচালক, মেডিকেল কলেজ হাসপাতাল (সকল) ----------।
৬। জেলা প্রশাসক (সকল)----------।
৭। পুলিশ সুপারিনটেনডেন্ট (সকল) ----------।
৮। সিভিল সার্জন (সকল) ----------।
৯। জেলা মহিলা বিষয়ক কর্মকর্তা (সকল)---------- ।
১০। জেলা সমাজ সেবা কর্মকর্তা (সকল)---------- ।
১১।উপ-নিয়ন্ত্রক, বাংলাদেশ ফরমস ও প্রকাশনা অফিস, তেজগাঁও, ঢাকা।
১২। উপজেলা নির্বাহী অফিসার (সকল)---------- ।
১৩। উপজেলা স্বাস্থ্য ও পরিবার কল্যাণ কর্মকর্তা (সকল) -------।
১৪। ভারপ্রাপ্ত কর্মকর্তা (সকল থানা) ----------।
১৫। উপজেলা সমাজ সেবা কর্মকর্তা (সকল)----------।
১৬। উপজেলা মহিলা বিষয়ক কর্মকর্তা (সকল)----------।

অনুলিপি (সদয় জ্ঞাতার্থে): (জ্যেষ্ঠতার ক্রমানুসারে নয়)

১। মন্ত্রি পরিষদ সচিব, মন্ত্রি পরিষদ বিভাগ, বাংলাদেশ সচিবালয়, ঢাকা।
২। প্রধানমন্ত্রীর মুখ্য সচিব, প্রধানমন্ত্রীর কার্যালয়, তেজগাঁও, ঢাকা।
৩। সচিব, জনপ্রশাসন মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
৪। সচিব, আইন, বিচার ও সংসদ বিষয়ক মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
৫। সচিব, সুরক্ষা সেবা বিভাগ/জননিরাপত্তা বিভাগ, স্বরাষ্ট্র মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
৬। সচিব, মহিলা ও শিশু বিষয়ক মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
৭। সচিব, সমাজ কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
৮। মহা-পুলিশ পরিদর্শক, পুলিশ সদর দপ্তর, ঢাকা।
৯। বিভাগীয় কমিশনার (সকল)---------- ।
১০। মাননীয় মন্ত্রীর একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
১১। মাননীয় মন্ত্রীর একান্ত সচিব, স্বরাষ্ট্র মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
১২। মাননীয় মন্ত্রীর একান্ত সচিব, মহিলা ও শিশু বিষয়ক মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।
১৩। সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য সেবা বিভাগ / স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, বাংলাদেশ সচিবালয়, ঢাকা।

Annex 19. One Stop Crisis Centre and One Stop Crisis Cell: MSP-VAW initiative

Following the commitment of the Government of Bangladesh to the Beijing Platform for Action (BPFA) 1995 for addressing violence against women and children, "Multi-Sectoral Programme on Violence Against Women (MSPVAW)" of the Ministry of Women and Children Affairs is being implemented jointly by the Government of Bangladesh and Government of Denmark in collaboration with the a) Ministry of Law, Justice and Parliamentary Affairs, b) Ministry of Information, Ministry of Social Welfare, c) Ministry of Home Affairs, d) Ministry of Health and Family Welfare, e) Ministry of Education, f) Ministry of Religious Affairs, g) Ministry of Youth and Sports, h) Ministry of Local Government, i) Rural Development and Cooperatives, j) Ministry of Posts, Telecommunication and Information Technology and k) Ministry of Labour and Employment. The major components of MSPVAW are:

1. Eleven One-Stop Crisis Centre's (OCC) in medical college hospital;
2. 47 One-Stop Crisis Cells at district Sadar Hospitals and 20 at Upazila Health Complexes;
3. National Forensic DNA Profiling Laboratory in Dhaka and seven divisional DNA screening laboratories at medical college hospitals;
4. National Trauma Counseling Centre in Dhaka;
5. National Helpline Centre for Violence Against Women and Children (Toll Free Helpline 109);
6. Regional Trauma Counseling Centre
7. National Database on Violence Against Women and Children;
8. National Centre on Gender based Violence
9. Mobile Apps Joy to combat violence against women and children.

One-Stop Crisis Centers (OCC):

Eleven One-Stop Crisis Centre have been established in Dhaka, Rajshahi, Chittagong, Sylhet, Barishal, Khulna, Rangpur, Faridpur, Mymensingh, Bogura and Cox's Bazar Medical College Hospital.

The idea behind the OCC is to provide all required services for the women and children survivors of violence in one place.

Services of One Stop Crisis Centers:

There are three category of services which include i) the supports for the victims who can stay in the OCC for a short period, ii) the outdoor services where the victims receive the services like treatment and advice who do not want to stay in the OCC, and iii) there are victims who can consult the OCC personnel over telephone for various supports. The OCC provides medical treatment, police assistance, forensic DNA test, legal assistance, psychosocial counseling, social welfare services, short term shelter support, rehabilitation and social reintegration.

Management:

Each OCC team is composed of:

- 3 Doctors (Senior Doctor is the functional Coordinator of the OCC)
- 2 Sub-Inspectors of Police
- 2 Constables of Police
- Six Nurses
- Social Welfare Officer
- Lawyer
- Counselor
- Computer Operator and
- Four Messengers cum Cleaners.

The One-Stop Crisis Centre is run by overall supervision and guidance of the Director of the respective Medical College Hospital. The functional head of the OCC is the Coordinator. The overall management of the OCC runs under the chairmanship of the Director of the Medical College Hospital and the members of the committee include representatives of the concerned departments/wards of that Medical College Hospitals.

One-Stop Crisis cells (OCc)

To extend the support for women and children survivors of violence around the country a total of 67 One-Stop Crisis Cell (OCC) that include 47 in District Sadar Hospitals and 20 in Upazila Health Complexes were established.

The Objective of the OCc is to develop coordination between the activities of Government and Non-government organizations to ensure the service to the survivors as well as establish vertical and horizontal linkages among the available services for the women and children survivors.

Each One-Stop Crisis Cell is composed of one Programme Officer, one Computer Operator and one Messenger cum Cleaner. Superintendent/Upazila Health and Family Planning Officer (UH&FPO) of respective hospital supervises the activities of the cell and ensures the medical services at District Sadar Hospital and Upazila Health Complex (UHCs).

Services of One Stop Crisis Cells:

Cells make linkages among the government and non-government organizations, civil societies and others stakeholder at district and upazila level for rehabilitation and re-integration of the women and children survivors of violence to the society. Moreover, Programme Officer of the cell is the member of the legal aid committee and violence against women and children committees at district and upazila level. Cell shared the information of violence to the district and upazila level VAW committee and also with the National Legal Aid Organization, follow up the cases of the family court, follow up the cases of violence against Women and Children repression prevention tribunal.

Annex 20. GBV in Humanitarian Settings

Sexual violence is common in humanitarian settings. It may become more acute in the wake of a natural disaster, and it occurs at every stage of a conflict. The victims are usually women and adolescents, whose vulnerability is exacerbated in the chaos of a crisis. Being separated from one's family and community, or undertaking certain roles, such as foraging for food or firewood, can put them at even greater risk of exploitation and abuse.

Breakdown in law and order mean that perpetrators often abuse with impunity. And in many conflicts, women's bodies become battle grounds, with rape used as a tactic to humiliate, dominate or disrupt social ties. Wide spread sexual violence is also endemic in many post-conflict situations, where it can perpetuate a cycle of anxiety and fear that impedes recovery.

Guidelines for Gender-based Violence Interventions in Humanitarian Settings

The guidelines recommend specific key interventions for preventing and responding to gender-based violence in humanitarian emergencies. The matrix is an overview of recommended key intervention for preventing and responding to sexual violence, organized by the three general phases of emergencies:

- Emergency Preparedness
- Early Phase (Minimum Prevention and Response)
- Stabilized phase (Comprehensive Prevention and Response)

During the Emergency Preparedness Phase, a number of actions should be taken that can enable rapid implementation of minimum prevention and response to sexual violence in the early stages of an emergency. Minimum Prevention and Responses are described in the interventions in the early phase. In more stabilized phases of an emergency, after the initial crisis and into recovery and rehabilitation, Comprehensive Prevention and Response will be needed. This will include widening the scope of interventions to address other forms of GBV that are occurring in the setting.

Functions and Sector	Emergency Preparedness
1. Coordination	• Determine coordination mechanisms and responsibilities • Identify and list partners and GBV focal points • Promote human rights and best practices as central components to preparedness planning and project development • Advocate for GBV prevention and response at all stages of humanitarian action • Integrate GBV programming into preparedness and contingency plans • Coordinate GBV training • Include GBV activities in inter-agency strategies and appeals • Identify and mobilize resources
2. Assessment and Monitoring	• Review existing data on nature, scope, magnitude of GBV • Conduct capacity and situation analysis and identify good practices • Develop strategies, indicators, and tools for monitoring and evaluation
3. Protection (Legal, social and physical)	• Review national laws, policies, and enforcement realities on protection from GBV • Identify priorities and develop strategies for security and prevention of violence • Encourage ratification, full compliance, and effective implementation of international instruments • Promote human rights, international humanitarian law, and good practices • Develop mechanisms to monitor, report, and seek redress for GBV and other human rights violations • Train all staff on international standards

Minimum Prevention and Response (to be conducted even in the midst of emergency)	Comprehensive Prevention & Response (Stabilized phase)
1.1 Establish coordination mechanisms and orient partners 1.2 Advocate and organize resource	• Transfer coordination to local counterpart • Integrate comprehensive GBV activities into national programmes • Strengthen networks • Enhance information sharing • Build (human) capacity • Include governments and non-governments in coordination mechanisms • Engage community in GBV prevention and response
2.1 Conduct coordinated rapid situation analysis 2.2 Monitor and evaluate activities	• Maintain a comprehensive confidential database • Conduct a comprehensive situation analysis • Monitor and evaluate GBV programs, gender-balanced hiring, application of Code of Conduct • Review data on prevention measures, incidence, policies and instruments, judicial response, social support structures • Assess and use data to improve activities
3.1 Assess and provide security in accordance with needs 3.3 Advocate for implementation of and compliance with international instruments	• Expand prevention of and response to GBV • Strengthen national capacity to monitor, and seek redress for, violations of human rights/international humanitarian law • Ensure that GBV is addressed by accountability mechanisms • Ensure that programmes for reintegration and rehabilitation include survivors/victims of GBV and children born of rape • Provide training to relevant sectors including health service providers

Functions and Sector	Emergency Preparedness
4. Human Resource	• Train staff on gender equality issues, GBV and guiding principles, and international legal standards • Develop a complaints mechanism and investigations strategy
5. Water and Sanitation	• Train staff and community on design of water supply and sanitation facilities
6. Food Security and Nutrition	• Train staff and community on design of food distribution procedures • Conduct planning • Ensure supplies
7. Shelter and site planning and nonfood items	• Train staff and community groups on shelter/site planning and non food distribution procedures • Ensure safety of planned sites and of sensitive locations within sites • Plan provision of shelter facilities for survivors/victims of GBV
8. Health and community services	• Map current services and practices • Adapt/develop/disseminate policies and protocols • Plan and stock medical and RH supplies • Train staff in GBV health care, counselling, referral mechanisms, and rights issues • Include GBV programmes in health and community service planning
9. Information, education and communication	• Involve women, adolescent, and men in developing culturally appropriate messages in local languages • Ensure use of appropriate means of communications for awareness campaigns

Minimum Prevention and Response (to be conducted even in the midst of emergency)	Comprehensive Prevention & Response (Stabilized phase)
4.1 Disseminate and inform all partners on codes of conduct 4.2 Implement confidential complaints mechanism	• Monitor effectiveness of complaint mechanisms and institutional changes where necessary • Institutionalize training on GBV for all staff, including peacekeepers • Ensure representation of women in committees
5.1 Implement safe water and sanitation program	• Conduct ongoing assessments to determine gender-based issues related to the provision of water and sanitation
6.1 Implement safe food security and nutrition program	• Monitor nutrition levels to determine any gender-based issues related to food security and nutrition
7.1 Implement safe site planning and shelter program 7.2 Ensure that survivors of sexual violence have safe shelter 7.3 Provide sanitary materials to women and girls	• Conduct ongoing monitoring to determine any gender based issues related to shelter and site location and design
8.1 Ensure women's access to basic health services 8.2 Provide sexual violence related health services 8.3 Provide community based psychological and social support for survivors	• Expand medical and psychological care for survivors/victims • Establish or improve protocols for medico-legal evidence collection
9. Inform community about sexual violence and the availability of services	• Provide IEC through different channels • Support women's groups and men's participation to strengthen outreach programmes

Minimum Prevention and Response (to be conducted even in the midst of emergency)	Comprehensive Prevention & Response (Stabilized phase)
	• Implement behaviour change communication programmes • Integrate GBV medical management into existing health system structures, national policies, programmes, and curricula • Conduct ongoing training and supportive supervision of health staff • Conduct regular assessments on quality of care • Support community-based initiatives to support survivors / victims and their children • Actively involve men in efforts to prevent GBV • Target income generation programmes to girls and women

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