Health Sector Response to Gender based Violence in Pakistan

Protocol and Standard Operating Procedures

November 2014

Contents

Abbreviations

ARV	Anti Retro Viral
BHU	Basic Health Unit
CSO	Civil Society Organization
DT	Diphtheria & Tetanus Toxoids
DTP	Diphtheria & Tetanus Toxoids & Pertussis Vaccine
ECP	Emergency Contraceptive Pills
ELISA	Enzyme-Linked Immuno Sorbent Assay Government of Pakistan
GBV	Gender Based Violence
HBV	Hepatitis B Virus
HCP	Health Care Provider
HIV	Human Immunodeficiency Virus
HSP	Health Services Provider
HW	Health Workers
INGO	International Non-Governmental Organization
IDP	Internally Displaced Person
IUD	Intrauterine Device
MoH	Ministry of Health
NGO	Non-Governmental Organization
PHD	Provincial Health Departments
Pep	Post-Exposure Prophylaxis
RHC	Rural Health Centers
RPR	Rapid Plasma Raegan
STI	Sexually Transmitted Infection
TD	Tetanus Toxoid & Reduced Diphtheria Toxoid
UN	United Nations
UNFPA	United Nations Fund for Population Assistance
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

How to use Protocol?

The protocol, a pioneering effort in Pakistan, is a multipurpose tool for the related duty bearers and stakeholders. It's intellectual and technical strength is based on consultations(a tedious, systematic and inclusive process of a broad based series of multi-level and multi-layered consultations) with all relevant stakeholders at the federal and provincial levels; published resources by WHO mainly "clinical management of rape survivors-D refugees and internally displaced persons" a revised edition World Health Organization/United Nations High Commissioner for Refugees, 2004'and World Health Organization, Guidelines for medico-legal care of victims of sexual violence,2003, UNFPA namely *Building survivor centered response services, UNFPA Pakistan, November 2010.participant manual and* A Practical Approach to Gender-Based Violence: Programme Guide for Health Care Providers and Managers.UNFPA.2001.NY, IASC's Guidelines for Gender-based Violence Interventions in Humanitarian Settings-Focusing on Prevention of and Response to Sexual Violence in Emergencies. Geneva: Inter-Agency Standing Committee, September 2005.

It is divided broadly into three chapters constituting context setting , rational and scope of protocol; public health facility based Standard Operating Procedures (SOPs) for health service providers to treat survivors of GBV; capacity building road map for duty bearers and recipient of services as well as implementation plan for the said protocols to foster multi-sectoral collaborations and response. The document can be utilized as a guideline and information resource on the subject matter; provides practical steps as SOPs to treat survivors at public health facility and technical guide for advocacy to integrate multi-sectoral GBV response as a health problem in to overall public health response of Pakistan.

It primarily attempts to describe the best practices in the clinical management of vulnerable groups i.e. women and girls, Men and boys, transgender from all ages and classes who have been abused in normal or emergency situations. While it is recognized that men and boys and transgender too experience GBV, women or girls experience it most; female pronouns are therefore used in the guide to refer to GBV survivors, except where the context dictates otherwise. The term "survivors" used in the document, is meant to indicate the individual who has faced or facing any form of GBV at the time of presentation in any clinical setting or health facility.
The specific needs of transgender, adolescents, young adults and children as victims/survivors of GBV (used as an equivalent of SGBV) should be considered extremely carefully by the health professionals, workers and service providers at any level of health facility.

The content given in this very document covers some of the most essential steps and issues but it is not seen as the final source of information. For instance Humanitarian Settings are very complex and issues of GBV become even more challenging when it comes to identification and subsequent case management. Hence it is advisable to follow standard guidelines to coordinate and manage the cases of GBV in Emergency setting.

It is not only recommended but rather should be mandatory for the users to use adaptation to each situation , taking into account national policies and practices, and availability of required forensics, medicines and other materials.

Target Audience:

The protocol is primarily aimed at health-care providers functioning at all levels of public health service delivery because they are in a unique position to address the health and psychosocial needs of survivors who have experienced violence. Health professionals can utilize this protocol for providing assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care; or gathering forensic evidence, particularly in cases of sexual violence. Moreover, the health sector can minimize the prevalence and impact of GBV through improved primary prevention i.e. promoting community awareness of prevention; secondary prevention i.e. early identification, confidentiality, monitoring and respectful treatment of survivors, addressing physical, mental and reproductive health care needs; tertiary prevention, i.e. long-term counselling, mental health care and rehabilitation and referral to social, economic and legal support.

The protocol as an evidence based technical guide for advocacy to integrate multi-sectoral response to GBV as a health problem in to overall public health response of Pakistan can also be utilized by health policy makers, practitioners, partners, CSOs, line Government's departments, law enforcement agencies and stakeholders in wider capacity.

Glossary[1]

[2]

I. **Victims:** individuals (i.e. women, men, children) who report that they have been sexually assaulted.

Sexual violence is defined as, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work". According to this definition, a very wide range of behaviors, from rape at gun-point to sexual coercion under a threat of dismissal (i.e. with false agreement), would be classed as an act of sexual violence.

II. **Sexual violence** :(synonymous with sexual abuse): a term covering a wide range of activities, including rape/forced sex, indecent assault and sexually-obsessive behavior. The terms "rape", "sexual assault", "sexual abuse" and "sexual violence" are generally considered to be synonymous and are often used interchangeably. However, these terms may have very different meanings (and implications) in varying situations and locations. More significantly, legal definitions of specific types of sexual violence may differ from the medical and social definitions, and furthermore, can vary between countries and even within countries. It is important, therefore, that health care professionals are aware of the legal definitions of sexual violence within their own jurisdiction, particularly as it applies to the age of consent and marriage.

III. **Patients:** individuals who are receiving a service from, or are being cared for by, a health worker.

IV. **Health workers:** professionals who provide health services, for example, doctors, nurses and other professionals who have specific training in the field of health care delivery.

V. **Child:** an individual under the age of 18 years. (The definition of children in particular varies considerably between countries and states.)

[3]

Advocacy:

In the context of services for intimate partner violence, the meaning of the term "advocacy" varies within and between countries, depending on institutional settings and historical developments of the role of advocates. Broadly speaking, "advocates "engage with individual clients who are being abused, with the aim of supporting and empowering them and linking them to community services. In some health-care settings, "advocates" may also have a role in bringing about systemic change, catalyzing increased recognition by clinicians of women experiencing abuse. In these guidelines, we define the core activities of advocacy as support that includes:

[1]The terms given in this section are selected from two different sources and therefore divided according to the source.

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

[3] Selected terms from Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.2013

provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; informal counseling; ongoing support; and provision of safety planning advice. In our recommendations, we have made a distinction between advocacy and psychological interventions, which reflects a relatively clear distinction in the research evidence, with the latter being based on explicit psychological methods or theories.

Empowerment:

Helping women to feel more in control of their lives and able to take decisions about their future, as articulated in Dutton's empowerment theory. Dutton notes that battered women are not "sick", rather they are in a "sick situation" and responses need to demonstrate an understanding, and take into account, their differing needs for support, advocacy and healing. Empowerment is a key feature of advocacy interventions and of some psychological (brief counseling) interventions.

First-line support:

This refers to the minimum level of (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health-care (or other) provider. It shares many elements with what is being called "psychological first aid" in the context of emergency situations involving traumatic experiences.

Health-care provider:

An individual or an organization that provides health-care services in a systematic way. An individual health-care provider may be a health-care professional, a community health worker, or any other person who is trained and knowledgeable in health. This can include lay health-care workers who have received some training to deliver care in their community. Organizations include hospitals, clinics, primary care centers and other service delivery points. In these guidelines, the term "health-care provider" usually refers to the primary care provider (nurse, midwife, doctor or other).

Health Sector: A category of stocks relating to medical and healthcare goods or services. The healthcare sector includes hospital management firms, health maintenance organizations , biotechnology and a variety of medical products.

Intimate partner:

A husband, cohabiting partner, boyfriend or lover, or ex-husband, expartner, ex-boyfriend or ex-lover.

Intimate partner violence:

Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife/spouse battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting.

Minimal Initial service package (MISP): The Minimum Initial Service Package (MISP) for Reproductive Health is a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis. It forms the starting point for reproductive health programming and should be sustained and built upon with comprehensive reproductive health services throughout protracted crises and recovery. Neglecting the MISP in humanitarian settings has serious consequences: preventable maternal and

newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV[4].

Support: For the purposes of these guidelines, "support" includes any or a combination of the following: the provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; and psychological interventions and provision of safety planning advice.

Violence against women:A broad umbrella term, defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in p**rivate li**fe". It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

Chapter 1: Introduction

Gender based violence (GBV) has emerged as a key global concern in view of its prevalence and high social and economic costs for survivors of violence and society in general. There is increasing recognition that GBV is not only a human rights issue but also a development and public health concern.It is often endorsed in the name of tradition, culture, and honor in varying combinations. GBV is one of the most widespread human rights abuses that endangers the physical integrity and emotional well-being of victims particularly women and girls across the world. Globally, one out of every three women is subjected to some form of violence[5].The violence can occur within the family, community and at the state level, cutting across class, ethnicity, religion, other social divisions and factors of inequality.

The recent research and data indicate a rising trend of different forms of GBV in Pakistan while women and girls are most frequent sufferers due to their lower social position. It ranges from direct forms of physical harm; battering; rape; trafficking of women, girls and young children; honor killing; sexual abuse to cultural and structural forms of violence. Cultural violence includes all those customs, traditions and societal practices that discriminate against women and girls such as forced marriages, exchange of women and girls in settling disputes amongst men (*wani, swara, sung chati* etc). Structural forms of violence deny women equal opportunities and access to resources such as education, skill development and employment opportunities. Low investment in human capital enhances the vulnerability of women. They are inadequately equipped to protect themselves against various forms of direct as well as cultural violence.[6]

Pakistan Demographic and Health survey(PDHS) 2012-13 revealed that; Thirty-two percent of ever-married women age 15-49 have experienced physical violence at least once since age 15. Overall, 39 percent of ever-married women (15-19 Years of age) report ever having experienced physical and/or emotional violence from their spouse in domestic setting. One in 10 women reported experiencing violence during pregnancy. Child marriage and teenage pregnancies are critical trends. 9% of young girls ages 15-19 yrs have begun child bearing and majority of teenage mothers are ages 18-19 yrs[7].

In the structurally and culturally patriarchal society of Pakistan, the public is not sensitized to gender-based violence and the health sector also shares the common societal beliefs and norms, limiting its response to acting only as a public health service provider. GBV issues are considered “controversial private and domestic issues”, not to be taken up as public health problems. Women and girls face tremendous challenges in disclosing cases of domestic abuse. Even after disclosure, they are met with an unsupportive institutional response and the attitudes of the health providers, medico-legal professionals and law enforcement agencies are often insensitive. Often, the blame is put upon the woman herself. The lack of capacity among health care providers is a key barrier to addressing gender-based violence as a health problem. They fail to diagnose and register GBV case. Often this is due to sociocultural and traditional barriers, lack of time and resources, and inadequate facilities. However,

[5] Velzeboes, M (2003), “ Violence against Women: The Health Sector Responds” The Pan American Health Organization

[6] Gender based Violence in Pakistan: Response in the Perspective of Health sector Devolution (2011) by WHO Pakistan

[7] Status of Women and Men in Pakistan 2012 by UNWOMEN

even more so, it is due to lack of awareness and knowledge, poor clinical practice, restricted direct communication and inability to do a full physical examination. In addition, record-keeping is poor with little data on the effectiveness and quality of care. Fear of violence at the household and community level and stigma from society further reduce many victims' willingness to use health services. [8]

Human Rights and Equity Underpinning of Health Response to GBV

WHO constitution enshrines the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. Health, a basic right of all human beings is fundamentally affected and influenced by factors lying outside the health sector and health systems. Thus political will, governance, religious beliefs, traditions, culture, gender and social inequities significantly influence the individual health. Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as living conditions, state of environment, income and education level, state of social relations have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact.[9]

The right to health means that governments must generate conditions in which everyone regardless of gender and other social, cultural and ethnic disparities can be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working conditions, adequate housing and nutritious food. The right to health has been enshrined in international and regional human rights treaties as well as national constitutions all over the world. UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, adopted a General Comment on the Right to Health in 2000. In Pakistan health is not considered as a right in constitution of Pakistan, 1973 rather placed as a policy principle that allows state to provide highest attainable standards of health services for all.

GBV is a violation of health related human rights. Every human being has the right to his/her physical, sexual, emotional integrity and health. The United Nations Charter of Human Rights, 1945 grants equal rights to both men and women. The United Nations Declaration on the Elimination of Violence against Women (VAW) defines VAW as, "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 threat of such acts, coercion , or arbitrary deprivation of liberty whether occurring in public or private life". Whereas gender based violence is defined as "violence involving men and women in which the female is usually the victim; and which is derived from unequal power relationship between men and women".

There are number of international covenants, conventions and agreements such as Convention on Elimination of all forms of Discrimination against Women (CEDAW) 1979, World Conference on Human Rights, Vienna, 1993, International Conference on Population and Development (ICPD), Cairo, 1994, UN Fourth Conference of Women, Beijing, 1995, Declaration of the General Assembly of the United Nations on the Elimination of Violence against Women, Beijing Platform of Action, Millennium Development Goals (MDGs), that all call for the protection of women and other socially excluded groups against violence and for the achievement of optimal health.Pakistan is signatory to the aforementioned

[8] Rapid Assessment on Health Sector Capacity and Response in Pakistan by WHO (2011)
[9] http://www.who.int/hia/evidence/doh/en/

international agreements and commitments. The Constitution of Pakistan also guarantees equality to all its citizens. Article 25 of the Constitution of Pakistan states, “there will be no discrimination on the basis of sex alone” while article 28 stipulates, “steps shall be taken to ensure full participation of women in all spheres of national life”.

Research indicates the causal relationship between violence and the health status of people. The physical and psychological impacts of GBV result in high social and economic costs not only for the survivors of violence but also for the family and the society. The health consequences of GBV range from physical injury, chronic headaches, permanent disabilities and chronic pelvic pain and psychological disorders such as depression, trauma, anxiety, fear, loss of self-confidence and self-esteem. Suicide, homicide, maternal mortality and HIV/AIDS constitute the more severe health outcome of GBV.

The impact assessments of GBV on women’s sexual and reproductive health indicate unwanted pregnancies, miscarriages, female feticide, unsafe abortions, gastrointestinal disorders, and gynecological and pregnancy related complications. Women’s vulnerability to sexually Transmitted Infections (STIs) such as HIV, gonorrhea, syphilis and Hepatitis C increase when there are unequal power distributions like difficulties for women in negotiating safe sex with spouses because of fear or threat of violence.[10]Pervasiveness of family violence in women’s lives debilitates them in relation to control over their bodies and reproductive choices. Violence by spouses or other male relatives is one of the most common forms of violence that affect women’s reproductive health and weakens their ability to negotiate reproductive choices with their spouses.

The health sector response to GBV in a sensitive manner demands for awareness and understanding on part of health service providers, practitioners and policy makers towards all these socio-cultural issues, inequalities and different social positioning particularly when they treat survivors of GBV. Health sector readiness and sensitive attitudes can prevent the difficulties of GBV survivor’sin an equitable manner particularly of vulnerable groups like women, girls and young children who suffer abuse.

Integration of GBV into Public Health Response of Pakistan

The recognition, integration and response to GBV as a public health issue in to health policy, provincial health strategies, health curricula, service delivery mechanisms even overall health system has not yet become a practical reality. Moreoverhealth service providers and decision-makers in the health sector are largely driven by the same attitudes, beliefs and laws that are prevalent in all Pakistani society, and discriminate against women and other excluded groups. For instance, although many health service providers shared that they “helped” or “counselled” victims, on probing it was found that “helping” is mostly equated to medical treatment and “counselling” has an emphasis on compromise with the violence or ignoring the crime due to social norms. To a large extent, health service providers are unconvinced of their role in addressing gender-based violence or the relevance of the subject to the health sector.According to the key findings of a rapid assessment by WHO Pakistan in 2010, for the capacity of the health sector in Pakistan to integrate the issues of gender-based violence; the health sector, despite certain strengths such as infrastructure, human resources and renewed political will, is characterized by limited Intersectoral and multisectoral coordination at all levels; poor funding; inefficient utilization of available and allocated health resources and virtually non-existent monitoring and evaluation systems to track progress within the sector in order to make corrective measures.

[10]National Study of STIs Prevalence in Pakistan (2001) by National Aids Control Programme

The study reconfirmed that the connection between gender and health is not only poorly understood but also that GBV is not internalized as a public health issue by the majority of health service providers at different levels. The health sector does not have a policy for addressing GBV. There is no mention of it in the job description of any health service provider and there is no requirement to include it in reporting mechanisms. The links between disaster management and gender and health are also less understood and visibility cannot be determined. Currently the health sector has no data management systems on gender-based violence and has virtually no support mechanisms or Intersectoral and multisectoral links to address the issues of GBV. In order to address GBV as a public health issue the health service providers need to;

- understand the relevance of health, gender and gender-based violence health needs of different sexes and age groups;
- improve communication in relation to GBV;
- clearly understand the social and health outcomes of GBV
- have a clear protocol and guidelines to treat survivor of GBV at service delivery level and integrate GBV response in health at policy level

In Pakistan there are many opportunities and challenges within and outside of the health sector to integrate GBV in overall public health response at policy, programme and service delivery level;

Strengths and Opportunities:

1. Pakistan is a signatory and has ratified many international conventions that provide a framework to respond to GBV and ensure commitment.

2. Comprehensive services are available at health service delivery points and a good infrastructure exists in terms of health care delivery (excepting many of the areas affected by the flooding), including some outreach delivery services through lady health care workers.

3. Health care providers have the opportunity and they are in unique position to identify access and screen GBV survivors because communities are more receptive to community level health care providers. LHWs and other female health care providers can access and treat female survivors of victims

4. Reproductive health services are an effective means to reach GBV survivors.

5. The curriculum of community midwives now includes gender sensitization, though without technical GBV component

6. In Punjab a number of initiatives have been taken in the Health Department to address gender issues i.e. Gender and Equity Advisory Group, Health Promotion Advisory Group, Health Promotion Department, Health Promoters Network have been mandated and capacitated to address gender issues, though still no GBV-specific initiatives. Successes/precedents in provinces like Punjab can be replicated in other provinces.

7. Legal framework and laws now exist to indirectly respond to/prevent GBV e.g. women protection bill, sexual harassment bill etc. Laws in the Ministry of Women Development facilitate protection against violence against women. Provision to identify and refer GBV survivors is there e.g. center for women development providing legal protection.

8. Collaborative programs between related Ministries are addressing GBV.

9. Devolution of Ministry of Health through 18th constitutional amendments in Pakistan giving more autonomy to provinces for health planning and implementation

10. Partnerships between international partners and public and private sectors as well as GBV coordination mechanisms for emergency response are strengths for addressing GBV in Pakistan.

11. The current humanitarian crisis has brought national/international interest in Pakistan and provides the opportunity to raise the issue of GBV and mobilize resources with greater accountability. There already exists a multi-sectoral GBV coordination group in Islamabad and the provinces to address GBV response coordination in the emergencies like flood response. Additional resources that should be utilized include the IASC Guidelines on addressing GBV in Emergencies, WHO's CMR guidelines, and UNFPA's MISP capacity development structure.

12. Civil society and existing GBV technical expertise can build capacity and strengthen GBV services at health service delivery points.

13. The media has also played a positive role in raising awareness of GBV, though with a need for capacity building on responsible reporting that respects the privacy and confidentiality of survivors.

    Pakistan being one of the pilot countries for the One UN has also been strength in addressing GBV.

Gaps and Challenges:

1. There is a lack of recognition of the linkage between GBV and health systems by both the health and other sectors.

2. There are no guidelines on GBV in National Health Policy and this prevents the health sector from addressing GBV as well as indicating lack of commitment to address GBV in the health sector.

3. Medical staff isn't equipped with the technical capacity to address GBV and there aren't guidelines/protocols for them to properly deal with survivors of gender-based violence.

4. There is insufficient protection against GBV particularly domestic violence in the law and this contributes to institutional weaknesses to address GBV, including weakness in the health sector.

5. Socio-cultural norms contribute to a non-responsive attitude of health care providers and mistrust in sharing information regarding GBV cases, especially those involving sexual abuse or rape

6. Health care providers are not sensitized and they have low levels of understanding on GBV issues, especially sexual violence, and survivors face challenges in reaching out to health care providers on GBV issues because of socio-cultural constraints.

7. A lack of resources exacerbates the problems in addressing GBV in Pakistan and there is insufficient data to guide actions on GBV.

8. There is an absence of institutional referral mechanisms for female survivors of violence and health care providers are not aware of where to refer GBV cases particularly survivors of domestic violence.

9. The procedures for instituting medico-legal procedures are complicated and not well known or understood by health providers.

10. GBV particularly domestic violence is not considered as a crime at the family level and many abuses are categorized as a private crime, which means that certain laws of state protect the perpetrators, e.g., accepting forgiveness by taking money.

11. Protection of survivors and Health care providers during treatment of survivors

Proper systems for psycho social support and medico-legal examination are not in placed. Demand should be created when systems are in place

Scope of the Protocol

The lack of policies, guidelines and requisite capacities among health care providers is a key barrier to address GBV as a health problem. In order to address these challenges, WHO Pakistan provided technical support to Government and provincial health departments to develop National Protocols on Health Sector Response to GBV as a multi sectoral responsibility including public health facility-based Standard Operating Procedures (SOPs) to prevent, support and treat survivors and their families of GBV through a long consultative process all over Pakistan and across all stakeholders. It was initially developed as short version of protocol through three days National Stakeholder's Consultation Workshop on Health Sector Response to Gender Based Violence (GBV) in Islamabad, in 2010. The key objective of the consultation exercise wasto promote the Multi-sectoral collaborations and support to enhance capacities and increase effective responses of the health sector in Pakistan including AJK in addressing GBV.

The protocol covers both public health responses to GBV in routine as well as in humanitarian crisis. It can be utilized as a guideline and information resource on the subject matter; provides practical steps as SOPs to treat survivors at public health facility and technical guide for advocacy to integrate multi-sectoral GBV response as a health problem in to overall public health response of Pakistan. The protocolis primarily aimed at health-care providers functioning at all levels of public health service delivery because they are in a unique position to address the health and psychosocial needs of survivors who have experienced violence. Health professionals can utilize this protocol for providing assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care; or gathering forensic evidence, particularly in cases of sexual violence. Moreover, the health sector can minimize the prevalence and impact of GBV through improved primary prevention i.e. promoting community awareness of prevention; secondary prevention i.e. early identification, confidentiality, monitoring and respectful treatment of survivors, addressing physical, mental and reproductive health care needs; tertiary prevention, i.e. long-term counselling, mental health care and rehabilitation and referral to social, economic and legal support.

What is Gender based Violence?

"Gender based violence (GBV) is an umbrella term for any harmful act that is perpetrated towards men, women, boys, girls and vulnerable groups like transgenders/ transsexuals against their will and based on socially constructed gender differences. Gender based violence has a greater impact on women and girls than on men and boys. Therefore the term "Gender based violence" is often used interchangeably with the term "violence against women." The term "Gender based violence" highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. However, men and boys may also be victims of Gender based violence, especially sexual violence"

Note: *Social, cultural, economic exploitations and discriminations also come under GBV along with physical, sexual and psychological harm.*

Source: *Adapted from IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings, September 2005).*

Target Objectives:

Strengthening of all Primary Health Care Facilities and Selective Secondary Facilities on GBV Response

The recommended target constitutes two critical components as under to be addressed through multi-sectoral response;

1) Development and Implementation of National Protocol/SOPs to technically support Provincial health departments and health sector partners for addressing GBV in health system delivery

2) Capacity building of health delivery staff in appropriately recognizing, responding, and managing GBV cases including health care provision for survivors, survivor-centered case management skills for health providers, and increased Minimum Initial Service Package (MISP) capacity

Overarching Principles[11]:

1. Federal level health structure should takes ownership and leadership in facilitation role at policy level over enhancing health sector response to GBV

2. Provincial health departments are actively involved from the beginning stages in the development/adaptation of GBV materials, protocols, and guidelines

3. Strengthened role and collaboration with Civil Society Organizations for Advocacy

[11] The participants of the consultative workshop unanimously urged adherence to the said overarching principles.

Guidelines for GBV Protocol:

1. Integration of GBV response in the overall Health Policy and health programmes i.e. MNCH/RH, PHC/LHWP and NACP while taking into account the ratified international commitments on GBV, WDD National Policy and provincial strategies for Women Development/Empowerment and National Plan of Action, PWD population policy

2. Establish a multi-sectoral coordination group to work towards national operational mechanisms for GBV-Health response guidelines and protocol like GBV coordination group for flood emergency response in Pakistan

3. Active involvement and consultations with provincial health departments in developing national protocol on GBV to ensure ownership and facilitate implementation at provincial levels.

4. Development of Strategy/Action Plan based on policy issues including activities, outcomes, indicators, vulnerable groups, assigning responsibilities, monitoring mechanism etc).

5. Periodic review for gaps identification and revision

6. Gender sensitive health service delivery that will address increased gender balance at all levels of health staff, and at all levels of health clinic operation; hours of operation that are sensitive for women; increased provision of GBV-related health services (CMR, PEP, EC, surgery, etc.) at the community and primary health care level to increase survivors access to these services.

7. Resource Material Development

8. Inclusion of GBV issues/subject in pre as well as in service training programmes for health delivery staff i.e. GBV definition, components, broader outline of health sector related response.

9. Increased access to GBV-related commodities (rape and RH kits); and relevant trainings on how to utilize and administer them. Includes clear protocols on how to maintain surplus of stocks.

10. Incorporation of mental health and psycho-social support, with a survivor-centered approach, at all levels of operational health care provision.

11. Development of Standard Operating Procedures (SOPs) for health delivery staff under following areas:

    - Screening of GBV cases that builds the capacity of relevant health care providers on case recognition, identification, case management and referrals for women, transgender and child survivors. Moreover, the screening protocol would cover GBV case management mechanisms.

    - Treatment of GBV Cases (including provision of care for survivors of domestic violence, survivors of sexual violence, child survivors, and completion of medical certificates/reports if desired by survivor as well as PEP Kits for HIV response and emergency contraception)

    - Recording, reporting, collection, storage, and maintenance of GBV case data, development of formats for confidential recording and reporting as well as inclusion in existing recording tools, capacity building of health managers and service delivery staff on tools, documentation of cases/ data collection, and specific research on GBV.

- Medico-legal procedures and support clarified for the survivors choosing to report to police and for those survivors who wish to access health care, but choose NOT to report to police.

- Confidentiality and referral that include mechanisms for further treatment, counseling, social support, legal aid; linkages development for referral and social protection; identification and contacts for relevant follow-up (psychosocial care, medical follow-up, Police/Legal Aid, Women's advocacy groups, NGOs, CSOs, etc).

- Prevention of GBV

12. Support and linkages with 'GBV Humanitarian Coordination Clusters' for GBV Health response in emergency setting. These mechanisms aim to address both immediate humanitarian service delivery needs and action to prevent and respond to GBV, as well as longer-term development of services, systems, and structures to protect the affected population from GBV, with an emphasis on addressing the needs of women and girls. In terms of linkages with National Protocol on Health Sector Response to GBV the cluster will provide the following support;

    - The overall approach of the GBV sub-cluster will be consistent with the priorities of the GBV national protocols for Health sector.
    - It will ensure linkages between GBV National Health protocol partners, and the humanitarian community, emphasizing the establishment of sustainable response approaches, capacity development and resource provision to national health bodies to effectively respond to GBV, and increasing linkages between humanitarian and emergency funding mechanisms, and GBV emergency response actors, MoH partners, and civil society actors.

Implementation of GBV Protocol and Devolution of Ministry of Health:

The outcomes of the stakeholder's consultation interventions on the issue of implementation suggested following steps and procedures;

1. Train and mobilize health staff for GBV case data collection and ensure privacy and confidentiality of data
2. The health care providers and professionals in all capacities should report data to higher authorities according to set protocols
3. Responsive and positive media involvement to address GBV
4. Provide back support at primary health care level to community health workers i.e. LHWs, CMWs and General Practitioners (GPs) for practicing GBV care and support
5. Mobilize community leaders including religious, social and political in favour of GBV policy/protocol implementation
6. Integrate and link health care work with the interventions of CSOs/NGOs for advocacy and putting pressure on policy makers and implementing authorities.
7. Gain ,disseminate and practice knowledge about GBV including sensitization on the issue and introduction in to health curriculum at all levels

Role of Provincial Health Departments:

1. Strengthen medical and health information and record keeping systems/documentation on GBV related issues.
2. Standard setting for maintenance of confidentiality and privacy of GBV survivors at health facility. Guidelines for early identification of GBV cases and provision of long term counselling, mental health care and rehabilitation
3. Policy management and advocacy for policy reforms in the area of GBV
4. Partnership with CSOs and private sector to enhance awareness, prevent, monitor and manage GBV
5. Monitor the effectiveness and efficiency of interventions. Accountability system to ensure feedback exchange, supervision, handling of negligence and evaluation.
6. In-service trainings of HCPs. Capacity building of medical and Para-medical staff for the implementation of protocol at grass root level. Training of MLOs
7. Incorporation of GBV awareness in Health Education material and interventions
8. GBV research needs to be promoted in health. Periodic information and dissemination on evolution of response mechanisms
9. GBV prevention through community awareness. Sensitization of the community on GBV through CMWs and LHWs for the implementation as grass-root level: Incorporation in LHWs role/TORs. Involvement of communities and formation of health committees. Strengthen and extended role of community health providers particularly LHWs and CMWs.
10. Field testing of GBV and Health protocols. Incorporation of GBV protocols in to medical curriculum
11. Ensure equal distribution of services at one facility through guidelines/ standards/business rules. Setting guidelines for health staff with medical ethic consideration to treat GBV survivors
12. Ensure effective legislation for medico-legal procedures and forensic examination of GBV survivors. Placement of a specialised medico legal at district level.
13. Ensure availability of health and other facilities (for referral to forensic labs, MLCs and social support) to health staff as near as possible (maximum at district level) to GBV survivors. Incorporation of GBV treatment protocols in to the job descriptions of health providers and professionals.
14. Coordination between health, education, legal and social welfare sectors, systems and work places to address GBV. Designation of a focal person within health department
15. Comprehensive and selective services for the survivors and victims' at primary, secondary and tertiary care level e.g. clinical psychologist for mental health treatment and psychosocial care
16. Capacity building of the Local Government System i.e. municipal officers up to Taluka level, UC *Nazims*, religious and influential leaders in collaboration with CSOs
17. Building local (particularly district) capacity on GBV related knowledge and data collection
18. Build political will and ensure allocation of adequate resources to address GBV
19. Advocacy with statuary and regulatory bodies like PMDC and PNC for their effective involvement and role
20. Advocacy with Provincial assembly and parliamentarians to pass legislation/act for addressing GBV in health. GBV protocol should be passed as a bill from provincial assemblies
21. Actions and measures for the protection, safety and security of HCPs dealing GBV related cases through legislation, political commitment, allocation of resources, institutional support, increased role of private sector.

Functions of Federal Health Structure:

- Complete cell needs to be established for the utilization and implementation of GBV and Health related data collected by the province
- Role of exploring and referring capacity building opportunities for medical and Para-medical staff and in-service trainings on GBV and health management
- Support and facilitate PHDs for building political will and allocation of adequate resources to address GBV

Support PHDs for effective legislation for medico-legal procedures and forensic examination of GBV survivors

Role of Civil Society:

Education and awareness of civil society including teachers, police, lawyers, social workers, media and other sections through CSOs .

- **NGOs:** organize awareness raising programmes like seminars and workshops for the awareness of GBV survivors/victims and civil society
- **Media:** Positive and responsive role to support and ensure GBV case proceeding
- **Bar Councils:** Free legal aid to support GBV survivors/ victims by advocates
- **Religious leaders:** vital role for the prevention of GBV cases in the guideline of holy Quran and Sunnah during Jumma Prayers and Khutbas
- **Teachers:** Community awareness through information and education for prevention of GBV problems

Health Sector Response to GBV in Humanitarian Crisis:

Pakistan is a disaster prone country. The health sector and system are yet to be aligned with the need of the vulnerable populations in the wake of disasters. The following section is an adaptation from IASC guidelines provides some essential and relevant information to the HSP.

GBV is especially problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse, and are the most vulnerable to exploitation, violence, and abuse simply because of their gender, age, and status in society. During a crisis, such as armed conflict or natural disaster, institutions and systems for physical and socialprotection may be weakened or destroyed. Police, legal, health, education, and social services are oftendisrupted; many people flee, and those who remain may not have the capacity or the equipment to work. Families and communities are often separated, which results in a further breakdown of community support systems and protection mechanisms.

The key considerations and actions to respond GBV in humanitarian situation are as under:

- To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a coordinated manner to prevent and respond to gender-based violence from the earliest stages of an emergency
- Survivors/victims of GBV need assistance to cope with the harmful consequences. They may need health care, psychological and social support, security, and legal redress. At the same time, prevention activities must be put in place to address causes and contributing factors to GBV in the setting.

- Providers of all these services must be knowledgeable, skilled, and compassionate in order tohelp the survivor/victim, and to establish effective preventive measures. Prevention and response to GBV therefore require coordinated action from actors from many sectors and agencies.

There are five cross-cutting functions that require action from multiple organizations and sectors. These cross-cutting functions are

1. Coordination
2. Assessment and Monitoring
3. Protection
4. Human Resources
5. Information Education Communication

In addition to the cross-cutting functions, there are specific interventions organized by sector. (Note that protection is both a cross-cutting function and a sector)

1. Protection
2. Water and Sanitation
3. Food Security and Nutrition
4. Shelter and Site Planning and Non-Food Items
5. Health and Community Services
6. Education

Although there are guidelines and codes of conduct for GBV programming in emergency settings, there are a number of challenges to implementing them in practice. GBV programmes need to be sensitive to local socio-cultural norms and the inequalities which hinder women's access to services; up-to-date and relevant data on GBV prevalence is necessary in order to provide appropriate responses, but is often difficult to obtain; lack of capacity and resources are constraints to implementing programmes; and limited coordination between relevant agencies and services makes an integrated response difficult.

Provincial autonomy and empowerment earned through the devolution in Pakistan provide a window of opportunity for strengthening public health recognition of GBV. In the post devolution context provincial governments indeed are powerful enough to pass laws that are needed to protect women from family and societal violence.In nutshell health sector in Pakistan can only respond to GBV cases when the complex linkages between health and human rights including women and child rights are understood in letter and spirit at policy level. In the absence of this health care facilities even if they meet minimum heal care delivery standards would fail to offer the required medical care to GBV victims.

Chapter 2: Standard operating Procedures for GBV Case Treatment and Management

When caring for GBV survivors, the overriding priority must always be the health and welfare of the patient. The provision of medico-legal services thus assumes secondary importance to that of general health care services (i.e. the treatment of injuries, assessment and management of pregnancy and sexually transmitted infections (STIs). Performing a forensic examination without addressing the primary health care needs of patients is negligent.

Concern for the welfare of the patient extends to ensuring that patients are able to maintain their dignity after an assault that will have caused them to feel humiliated and degraded. In addition, medical and forensic services should be offered in such a way so as to minimize the number of invasive physical examinations and interviews the patient is required to undergo[12].

Thestandard operating procedures (SOPs) in this chapter, are the outcome of long series of stakeholder's consultations, advocacy and capacity building with MoH, Provincial health departments, health sector partners, other concerned line departments i.e. women development, population welfare, social welfare, human rights, UN partner agencies and CSOs.

The SOPs are derived from the recommendations, opinion and outcomes of Provincial level health sector consultations with Provincial departments of Health, women development, population welfare, social welfare, human rights, CSOs and UN partner agencies all over Pakistan. The given SOPs target the role of Health care providers at all level including primary health care with focus, secondary and tertiary.

The Ideal Health Facility for GBV Case Treatment & Management

1. Examination room, equipped with, and laid out, as follows:
- an examination couch positioned so that the health worker can approach the patient from the right-hand side; the couch must allow examination with the legs flopped apart (i.e. in the lithotomy position);
- thermally neutral (i.e. not too cold or too hot);
- auditory and visual privacy (particularly for undressing);
- clean bed-linen and a gown for each patient;
- lighting sufficient to perform a genito-anal examination;
- hand-washing facilities (with soap and running water);
- forensic supplies;
- a table or desk for documenting and labelling specimens;
- a lockable door to prevent entry during the examination;
- a telephone.

2. A separate room containing a table and chairs where a support person could talk with the patient, and facilities for offering patients refreshments and a change of clothing and also for children who may be attending as patients or accompanying an adult.
3. Shower and toilet for the patient.
4. A room for the police
5. A reception area that could also be used as a room for waiting family and friends

6. **Accessibility** 24-hour access to service providers is preferable.
7. **Security** At both an individual and community level there may be some antagonism to sexual assault services. There should therefore be adequate measures to protect patients, staff, health records and the facility itself. Strategies could include the use of a guard to control access, adequate lighting, video-surveillance, lockable doors and cabinets, and fire prevention equipment.
8. **Cleanliness** A high standard of hygiene is required in the provision of any medical service. The facility should also comply with local safety and health regulations as they apply to fire, electricity, water, sewerage, ventilation, sterilization and waste disposal.
9. **Privacy** Unauthorized people should not be able to view or hear any aspects of the consultation. Hence, the examination room(s) should have walls and a door, not merely curtains. Assailants must be kept separate from their victims.

Source: *Adapted from Guidelines for medico-legal care for victims of sexual violence © World Health Organization 2003*

A. SOPs for Identification and Screening of GBV Case

<u>Public Health Facility:</u> BHU, RHC, DHQ, THQ and Humanitarian Crisis Setting

1. **Identify** whether the patient seeking health care is a GBV case and nature of the violence. Filtering patients coming frequently with unexplained injuries patterns , bruises and psychological signs and symptom of abuse
2. **Provide** First Aid (if needed) to stable the condition of survivor
3. **Prepare** the survivor for screening through provision of empathetic and conducive environment (privacy, confidentiality and sensitive communication) for disclosure of abuse / incident. This preparation is of utmost importance in humanitarian settings and demands even more carefulness fro HCP and all relevant actors.
4. **Take consent** for medical examination to record of injuries, bruises, fractures and overall condition of the survivor, severity of problem as well as her/his needs. The primary objective of the physical examination is to determine what medical care should be provided to the survivor. Work systematically according to the medical examination form
5. **Facilitate** survivor for disclosure of GBV. Ask about violence through compassionate attitude, positive behaviour, patience and trust building effort
6. **Note** physical and psychological signs and symptoms of abuse e.g. depression, anxiety, constant headaches pain, and vomiting, repeated visits with unexplained injuries, scars and bruises, location of external and internal injuries /scars. Assess needs for psychological treatment and required investigations
7. **Offer Treatment Options** ranging from medical, lab testing, psycho social and legal support, medico-legal care and decide about referral option for further medical attention
8. **Record and document** screening results/assessment including nature of abuse and type of GBV.
9. **Referral** if required and Follow up

A1. Screening Checklist

1. Privacy, safety and security of the survivor
2. First Aid/medical Kit, necessary equipments like stethoscope, BP apparatus etc.
3. List of screening questions
4. List of signs and symptoms of GBV
5. Information of available services for referral

Entry Points for Screening	**Sample Screening Questions**
1. taking a routine health history with new patients; 2. at an initial visit for a new complaint; 3. at a periodic health review e.g. , family planning, post-natal checkup; 4. when reviewing repeat prescriptions; 5. when there are signs or symptoms of abuse	**Opening& Indirect Questions** "Is everything alright? I am concerned that your medical problem may be the result of someone hurting you. Is that happening? Many patients have health problems because of fights inside the home. Do you know anyone who has had that problem? Has that problem ever happened to you? Is it happening to you now?" **Direct Questions** **"I** noticed that you have a number of bruises/cuts/burns; i. Could you tell me how you got those injuries? ii. Do you ever feel frightened of your spouse, or other family members at home? iii. Have you ever been slapped, kicked or punched by your family/relatives? iv. Does anyone of your family members often shout or lose their temper with you? v. Has your family or relatives ever: - destroyed or broken things you care about? - threatened or hurt your children? - forced sex on you, or made you have sex in a way you did not want? vi. Does your family members get jealous of you seeing friends, talking to other people or going out? If so, what happens? vii Is your spouse responsible for your injuries in a state of guilt ? viii. Does your spouse/relatives use drugs or alcohol excessively? If so, how does he behave at this time?"

B. SOPs for GBV Case Management

<u>Public Health Facility:</u> BHU, RHC, DHQ, THQ and Humanitarian Crisis Setting

1. **Clinical Management**[13]

- **Review screening results** and ensure that detailed history has been taken at screening stage including assessment of severity of problem, nature, injuries, and damages, physical and psychological needs for medical attention.
- Initiate **detailed history taking** (if needed) including current and past history of the problem
- Detailed **clinical examination** for diagnosis and medical treatment after informed consent of the survivor. The availability of Female care providers is mandatory by law for the examination of female survivors
- **Medication** and surgical Intervention (if needed)
- **Physiotherapy**
- **Refer** for further medical treatment, lab tests (HIV/AIDs, Hepatitis and pregnancy in case of sexual violence) and Psychological consultation (if needed)
- Documentation and recording (in detail) of diagnosis , treatment and referral

2. **Psycho social support**

- Prepare survivor carefully for psychosocial support through initial counseling and communication during humanitarian crisis
- Consultation with clinical psychologist (preferably) or any locally trained counsellor
- Psychological examination and diagnosis
- Counselling and information provision
- Refer social ,community and survivor support groups
- Documentation and recording of diagnosis and treatment

3. **Referral**

- For further medical treatment and laboratory testing
- For Medico-legal examination
- For legal aid
- For protection/ shelter/ crisis centres
- To social support groups, rehabilitation centres and institutions for social and economic rehabilitation
- Referral should be recorded and documented

It is recommended that all relevant HCP/HSP/HW should have a directory and adequate knowledge for referrals. Referral steps and pathways in the context of Pakistan including the concerned health care providers

4. **Follow-up care during consultations throughout the healing process**

- provide maximum input during the first visit, as this may be the only visit.
- survivors seen at a health facility immediately after the rape are likely to be extremely distressed and may not remember advice given at this time.
- repeat information during follow-up visits.
- prepare standard advice and information in writing, and give the survivor a copy before

[13] Users are requested to read and apply information given in Annexure 1 to 8).

he/she leaves the health facility (even if the survivor is illiterate, he/she can ask someone trusted to read it later).

- Give the survivor the opportunity to ask questions and to voice her concerns.

Considerations for Child Survivors of GBV

Health care providers responsible for screening and treating children in cases of sexual abuse may find it useful to bear in mind the following:

● All children should be approached with compassion, extreme sensitivity and their vulnerability recognized and understood during the face of consultation, examination and medical care

● Try to establish a neutral environment and rapport with the child before beginning the consultation.

● Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time, and that they may use terminology differently to adults making interpretation of questions and answers a sensitive matter.

● Always identify you as a helping person.

● Ask the child if he/she knows why they have come to see you.

● Establish ground rules for the screening, including permission for the child to say he/she doesn't know, permission to correct the interviewer, and the difference between truth and lies.

● Ask the child to describe what happened, or is happening, to them in their own words.

● Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity.

● When planning investigative strategies, consider other children (boys as well as girls) that may have had contact with the alleged perpetrator. For example, there may be an indication to examine the child's siblings. Also consider interviewing the caretaker of the child, without the child present.

B1. GBV case Management Checklist

- Formats for history taking (sample given)
- Medical equipments, essential medicines, bandages, Kits like PEP, Rape, reproductive health and hygiene, pregnancy testing, emergency contraceptives etc.
- Referral directory including contacts and details of available services like medico-legal, testing labs, shelter homes, crisis centres, local CSOs and help lines, counselling facilities, legal aid services, vocational training and business incubation centres, police station and law enforcement agencies
- Supporting health staff including WMOs, LHVs, CMWs , LHWs

[14]For sexual violence, health care includes, at least:

- Examination and history taking
- Treatment of injuries
- Prevention of disease, including STIs/HIV
- Prevention of unwanted pregnancy
- Collection of minimum forensic evidence
- Psychological/emotional support
- Medical documentation
- Follow up care

Signs and Symptoms of Gender based Violence		
Physical	**Psychological and Emotional**	**Health Consequences**
• Unexplained burns or Bruises • Bruising patterns indicative of abuse • Area of bruising consistent with slaps • Multiple injuries and fractures • Repeated or chronic injuries • Injuries in areas of the body inconsistent with falls or other explanation offered • Damage to sutures following operation or delivery • Injuries to the breast, chest and abdomen-women are 13 times more likely to be injured here in case of domestic violence • Injuries to face, head, hands or neck • Perforated eardrums, detached retinas • Evidence of sexual abuse or frequent gynecological problems • High incidence of	• Panic attacks and • Headaches • Symptoms of anxiety and Hypertension • Depression • Feelings of isolation • Drug use • Suicide attempt • Self-harm **Procedural** • Delay in presentation • Referral by a General Practitioner • Delay in Medico Legal examination and reporting • History of loss of consciousness • Frequent visits with vague complaints or symptoms	**Physical Health** • Headache • Fatigue • Chronic lower abdominal pain • Functional limitation and disability • Chronic pain syndromes • Fibromyalgia • Gastrointestinal disorders • Premature Mortality **Mental Health and Behavioral Problems** • Depression • Anxiety • Post-Traumatic Stress Disorder • Phobias and panic disorders • Sleeping disorders • Low self-esteem • Psychosomatic disorders • Obesity or Anorexia • Aggression and Violence • Inter-generational violence • Sexual risk taking • Self-harm including Suicide

[14] Source: Gender-based Violence Resource Tools supporting implementation of the Guidelines for GBVInterventionsinHumanitarianSettings:FocusingonPreventionofandResponseto SexualViolenceinEmergencies.IASC2005

miscarriage, terminations, preterm labor • Frequent use of pain medication or tranquillizers		**Sexual and Reproductive Health** • Sexual and Gynecological disorders • Pelvic Inflammatory disease • STIs including HIV/AIDS • Cervical Cancer • Sexual dysfunction • Obstetric complications • Unwanted pregnancy • Abortions (safe and unsafe) • Miscarriages • Premature labor • Low birth weight • Fetal injuries • Increased maternal, neonatal and infant mortality

C. SOPs for Medico Legal Care and Support

<u>Public Health Facility:</u>RHC, THQ, DHQ, Teaching Hospitals, District Standing Medical Board (DSMB), Provincial Standing Medical Board

- **Take** written consent and prepare the survivor for Medico Legal Examination (MLE)
- **Provide** medical aid if survivor directly approaches for MLE. Police docket is not mandatory to start medical care. Survivor's life and welfare is a first priority
- **MLE of women/girls** GBV survivors would be conducted by a lady MLO on public health facility authorised for MLE as per approved procedures in Pakistan
- **MLE of rape survivors** must be conducted within 72 hours to avoid incomplete samples
- **Ensure** Sensitive Communication and non-judgmental attitude during examination and forensic evidence collection
- **Collect,store and record** forensic evidences completely as well as un-biased.
- **Protect** forensic samples from tempering and right of survivors for legal aid
- **Records** must be in detail and complete
- **Refer** the survivor for MLE in Humanitarian crisis if he/she is willing

Forensic Considerations[15]

A consent form may be required. Information gained under informed consent may need to be provided to other parties, in particular, law enforcement authorities (i.e. the police) and the criminal justice system if the patient pursues legal action on the case.It takes time to conduct a thorough forensic examination; the examination usually involves a "top-to-toe" inspection of the skin and a genito-anal examination.Detailed documentation is required; information so recorded may be used in criminal proceedings. Certain areas of the body (e.g. the axilla, behind the ears, in the mouth, the soles of feet) not usually examined as part of a routine medical examination are of forensic interest and must be inspected. Unusual specimens, such as clothing, drop sheets and hair, are collected as part of a forensic examination. The chain of custody of specimens must be documented. Opportunities for follow-up examinations may not arise; it is thus vital to make full use of this single patient contact.

Principles for Specimen Collection:

- collect carefully, avoiding contamination
- collect specimens as early as possible. 72 hours after the assault the value of evidentiary material decreases dramatically
- label all specimens accurately
- dry all wet specimens
- ensure specimens are secure and tamper proof
- maintain continuity
- document details of all collection and handling procedures.

D. SOPs for Confidentiality, Privacy and Sensitive Communication

<u>Public Health Facility:</u> BHU, RHC, DHQ, THQ and Humanitarian Crisis Setting

The maintenance of privacy, confidentiality and safety from screening to treatment are rights of survivors. The health care providers should seek to empower patients to make informed decisions and choices about their lives, and not try to make decisions on their behalf.The safety of the woman (and of any dependent children) should be the paramount consideration. Children who have witnessed or experienced a violent episode may also need an immediate response to address their own needs and fears. The security and safety of health care providers themselves is equally important in the course of handling such situations.

Confidentiality:

- **Enable** GBV survivors to disclose their experiences about violence and its impacts. Their physical safety of survivors can be dependent on confidentiality being maintained.
- **Do not disclose** confidential information and records of GBV survivors during contact with perpetrators even relatives of survivors.
- **Understand,** and be honest about, the limits of confidentiality particularly if the life threatening situations of women and children as well as legal evidences are involved.

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

- **Restrict and limit** access to records to specified and concerned medical staff.The principles of confidentiality are also applied on medical records and information shared by the survivors.
- **Keep** all documents and records including medical record and MLE reports/ evidencessafely, out of reach and view of patients' family, media and health staff at facility.

Privacy:

- **Respect** and ensure privacy, and recognize the real dangers to survivors which may be created if this is breached.
- **Conduct** consultation for screening of abuse in separate room with effective sound and visual barriers like closed doors, windows and curtains in the absence of survivor's relatives, children, medical staff and other patients at the facility.
- In **Humanitarian situation** maintain privacy and confidentiality for consultation at camps with GBV survivors.

Sensitive Communication with GBV Survivors

The sensitive and positive way of communication helps both health care providers and GBV survivors to delicately manage the case based on the **survivor-centered approach**. It covers verbal communication, facial expression, body language and gestures. . In humanitarian crisis sensitive communication is the key to overcome trauma and sufferings of survivors followed by a proper psychosocial support. The key principles for health service providers to interact and communicate sensitively are;

- **choose** positive and polite words, preferably local language (of the survivors) for consultation and during examination. The selection of words is important to start communication sensitively
- **avoid** negative, judgmental and critical comments, stereotypical statements, social myths or an interrogation style
- **practice** active listening and give full attention to the suffering of survivors;
- **be aware** of inadvertent negative body language. The health care providers should avoid to give facial expressions and gestures that they are irritated, in hurry and not believing the statement of survivor;
- **make** women and girl survivors realize that 'abuse is not their fault'. This kind of treatment is unacceptable and they have right to safety against violence.
- **ensure** clarity and accuracy while providing information about available local services.

E. SOPs for Recording and Reporting of GBV Case

<u>Public Health Facility:</u> BHU, RHC, DHQ, THQ and Humanitarian Crisis Setting

- **ensure** privacy and confidentiality of the communication with survivor to protect his/her dignity
- **record** medical history and examinationin detail about GBV case including its impacts on health,survivor's needs for treatment, relief services (in humanitarian crisis), rehabilitation and referral
- **complete** and store records safely without access of media and other staff at health facility.
- **document** complete and actual statement of and communication with survivor without subjectivity, treatment and referral given for follow up purposes. Give your observation separately
- **maintain** data register for disaggregated information (by age and sex) of GBV cases to report to Health Information Management System (HIMS), development and relief workers about problem prevalence and needs of survivors . **Electronic records** should be stored with restrictions and permission e.g. issuance of pass word only to concerned and authorized health staff at facility.
- **share**records of GBV case if legal action is required for legal relief and risk to life is involved but with consent of survivor

Chapter 3: Capacity Building Road Map & Implementation Framework

Ideally there should be an ensured provision of a supportive, violence-aware practice environment where HSPs are using sympathetic and empowering language that is appropriate to each patient, where they know how to conduct a physical examination to confirm physical/sexual assault, and are aware of local services to which women, who are abused, can be referred as an important step towards the prevention of VAW/GBV.

It is also very important that the HSPs know how to provide thorough treatments of not only the physical consequences of abuse but also the mental health ramifications, including post-traumatic stress disorder.

The consulting physicians or another HSP should consider treatment of the abuse of women as a complicated and multidimensional clinical problem, and the provision of specific practical suggestions and resources relevant to the continuum of care, from identification to diagnosis, immediate intervention, and long-term management. To meet such standards, the capacity of not only the doctors but the entire administrative machinery and paramedics needs to be built up. This exercise must be preceded by a careful research that clearly identifies capacity gaps, training needs and essential set of information, knowledge and skills that should be imparted. Needless to emphasize the need of attitudinal and behavioral change exercises, that must be embedded within such trainings[16]." This was one of the key recommendations from "Rapid Assessment: Health Sector Capacity and Response to Gender based Violence in Pakistan," was the study commissioned by WHO in selected districts of Pakistan in 2010.

One important output of that very study was identification of the areas of capacity gaps where special attention must be paid. It is proposed that training and capacity building of all relevant duty bearers, on topics mentioned in the following matrix must be carried out bearers.

Suggested Areas of Training

S #	Training & Capacity building (themes/topics/areas)
1.	Empathy
2.	Perceptions and understanding of Gender/Essential Concepts
3.	Health staff attitudes/ acknowledging biases within the health providers/becoming non judgmental
4.	Forms of GBV and VAW
5.	Ability to identify hidden symptoms of GBV abuse and clinical management
6.	Medical jurisprudence (for doctors and EDOs/DHOs)
7.	Communication skills (with community/clients/victims/perpetrators)
8.	Knowledge about existing support mechanisms, laws to protect women

[16]"Rapid Assessment: Health Sector Capacity and Response to Gender based Violence in Pakistan," was the study commissioned by WHO in selected districts of Pakistan in 2010

	and linkages
9.	Definitions and meanings of youth and adolescent and their specific health needs
10.	History taking skills
11.	Psycho-social counselling skills
12.	Assertive negotiation skills (to be conveyed to the victims)
13.	Survivor-centered approach
14.	Engaging men in ending VAW
15.	Record keeping/data management

It was recommended by the participating stakeholders, in developing this very protocol that investments in capacity building of different tiers of HSP and decision makers in health systems is a must for the effective implementation of the protocols.

A realistic number of a series of Training of Trainers should be conducted at district level, at RHC and BHU levels in order to raise the required capacities. Main themes of such ToTs should be:

- Gender/GBV perceptions, interpretations.
- Understanding of Pro women and health related laws & their interpretations & essentials of Medical Jurisprudence.
- health care systems and
- Role of health care providers and managers in addressing GBV.

It was also strongly recommended to pay special attentiveness towards sensitization of bureaucrats and other decision makers in the public machinery so that the links and relevance of GBV as a public health issue and human rights issue could be internalized.

Matrix: Capacity building Road Map for Health Sector Response to GBV

Contents of training needed to promote the capacity of health HCP/HSP/outreach workers	Facility level					HSP/HCP/Nursing staff/outreach workers-HW.LHV,LHW			
	BHU	**RHC**	**DHQ**	**THQ**	**TERTIARY CARE HOSPITAL**	**CMO**	**MOs**	**MLOs**	**Outreach Workers& Nursing & allied staff**
Meet survivors medical and emotional needs at	✓	✓	✓	✓	✓	•	•	•	•

identification of GBV cases stage									
Document cases, if and when necessary and appropriate	✓	✓	✓	✓	✓	●	●	●	●
Provide case management	✓	✓	✓	✓	✓	●	●	●	
Ensure efficient and appropriate referral and follow up of cases	✓	✓	✓	✓	✓	●	●	●	
Proper Understanding of GBV Issue within area specific socio-cultural context	✓	✓	✓	✓	✓	●	●	●	●
Intensity of the issue (evidence-based, qualitative data on GBV, trends and patterns analysis, etc.)	✓	✓	✓	✓	✓	●	●	●	
Adequate knowledge of laws and policies on GBV	✓	✓	✓	✓	✓	●	●	●	
Meet survivors medical and emotional needs at identification of GBV cases stage particularly treatment of physical (at least minor) injuries of survivors	✓	✓	✓	✓	✓	●	●	●	●
Document cases, if and when necessary and appropriate	✓	✓	✓	✓	✓	●	●	●	●
Provide case management	✓	✓	✓	✓	✓	●	●	●	●
Contents of training needed to promote the capacity of health sector related decision makers						**Decision Makers**			
						Parliamentarians	EDO/DHO	Bureaucrats(provincial secretaria	Msc. Eg.Financ e
Proper Understanding of GBV Issue						○	○	○	○
Intensity of the issue (evidence-based, qualitative data on GBV, trends and patterns analysis, etc.)						○	○	○	
Adequate knowledge of laws and policies on GBV						○	○	○	○
Health ManagersProper Understanding of GBV Issue within area specific socio-cultural context						○	○	○	○
Intensity of the issue						○	○	○	

(evidence-based, qualitative data on GBV, trends and patterns analysis, etc.)					

Implementation Framework

In respect and adherence to the principles of multisectoral collaboration and partnership, the stakeholders developed an implementation roadmap, indicating their organizational commitments to provide support to health sector, GOP and Provincial Department of Health Pakistan in achieving the recommendations.

National Protocol/SOPs on addressing GBV in Health System Delivery: Road Map for Multi-sectoral Response			
Recommended actions	[17]**Duty Bearers**	**Right Holders**	**Timeline**
Task force on GBV and Health response representing different stakeholders is established - Identification and listing of forums for advocacy	UN System, GoP and CSOs	Survivors Family Members of survivors Dependents of survivors	
Advocacy with parliamentarians, Elected Representatives, Health Policy makers and Department of Health for endorsement and action of Department of Health (DOH) to include GBV in the National Health Framework and Provincial Health Strategies	GoP UN system – (WHO, UNWOMEN, UNAIDS, UNICEF, UNFPA, UNHCR) CSOs	Survivors Family Members of survivors Dependents of survivors	
Policy dialogues on GBV with DOH/health sector policy makers and stakeholders including parliamentarians, Government's line departments with active involvement of CSOs	GoP UN system (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors Survivors Family	

[17]Organizational commitments to provide support to GoP and Provincial Department of Health

		Members of survivors Dependents of survivors	
Development of National and Provincial Plans, Strategies, Guidelines and Protocols for GBV integration in Health Systems focusing both mainstream development, emergencies and Humanitarian crises - Identification and listing of relevant staff and focal points within health sector for GBV management	GoP UN system (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	
Facility based Protocols/SOPs for different cadres of health staff to response to survivors of gender-based violence focusing both mainstream development and emergencies are developed and endorsed by DOHs and health sector stakeholders - Medico legal care strategy and referral mechanisms developed and strengthened	GoP UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	
Assessment of number of PHC facilities and selective secondary facilities that have separate concealed areas available for consultations/ examination and/or PEP kits/equipment for medico-legal response to GBV as well as existing mechanisms and processes on GBV response - Qualitative assessment and formative research on common needs of survivors, role of	GoP UN system – (WHO, UNWOMEN, UNAIDS, UNFPA), CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	

community including community elders, village councils and women for prevention measures should be included along with PHC facility based assessment			
Capacity building of health delivery staff in appropriately recognizing, responding, and managing GBV cases			
Recommended actions	**Organizational commitments to provide support to GoP and Provincial Health Departments**	**Right holders**	
Training materials on health protocols are developed/ adapted from existing GBV materials (both emergencies and normal settings) and approved for use in training of health staff and care providers endorsed by Federal health structures and DOHs	UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	
Capacity building of health delivery staff including WMOs using approved training materials (MISP, CMR, legal/medical protocols, survivor's benefits package on GBV etc.)	CSOs UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) White Ribbon Campaign GBV	Survivors Family Members of survivors Dependents of survivors	

	Coordination Sub-cluster for emergency response		
Development of national and provincial specific SBCC material for development of a health sector communication strategy (both for emergencies and normal settings) for GBV - Health sector Communication strategy would include robust communication action plan focusing grass root level stakeholders, health education officers, HCPs, DOH/DGHO, other line departments with complete inter departmental coordination structure	GoP UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	
Capacity development of DOHs Health Education Unit in addressing GBV (both in emergency and normal setting)	UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	
Development of clear cut messages for media regarding GBV (existing service provision; referral system; provision of legal protection etc.)	UN system – (WHO, UNWOMEN, UNAIDS, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	

Awareness sessions of media personnel on health sector strategies/approaches to GBV	UN system – (WHO, UNWOMEN, UNAIDS, UNICEF, UNFPA) CSOs GBV Coordination Sub-cluster for emergency response	Survivors Family Members of survivors Dependents of survivors	

Annexure

Annexure 1 : Sample Medical History Format

After the incident, did the survivor	**Yes**	**No**			Yes	No
Vomit?			Rinse mouth?			
Urinate?			Change clothing?			
Defecate?			Wash or bathe			
Brush teeth?			Use tampon or pad			
Contraception use						
Pill			IUD	Sterilization		
Infectable			Condom	Other		
Menstrual/obstetric history						
Last menstrual period			Menstruation at time of event		Yes_A	No A
Evidence of pregnancy	Yes_A	No A	Number of weeks pregnant	____weeks		
Obstetric history						
History of consenting intercourse (only if samples have been taken for DNA analysis)						
Last consenting intercourse within a week	Date:		Name of individual:			
prior to the assault						
Existing health problems						

History of female genital mutilation, type
Allergies
Current medication

Vaccination status	**Vaccinated**	**Not vaccinated**	**Unknown**	**Comments**
Tetanus				
Hepatitis B				
HIV/AIDS status	Know		Unknown	

Medical Examination

Appearance (clothing, hair, obvious physical or mental disability)

Mental state (calm, crying, anxious, cooperative, depressed, other)

Weight:	Height:	Pubertal stage (pre-pubertal, pubertal, mature):	

Pulse rate:	Blood pressure:	Respiratory rate:	Temperature:
Physical findings			
Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae,			
marks, etc. Document type, size, color, form and other particulars. Be descriptive, do not interpret the findings.			
Head and face			*Mouth and nose*

Eyes and ears	*Neck*
Chest	*Back*
Abdomen	*Buttocks*
Arms and hands	*Legs and feet*

GENITAL AND ANAL EXAMINATION

Vulva/scrotum	*Introitus and hymen*	*Anus*
Vagina/penis	*Cervix*	*Bimanual/rectovaginal examination*
Position of patient (supine, prone, knee-chest, lateral, mother's lap)		
For genital examination:	For anal examination:	

INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result

EVIDENCE TAKEN

Type and location	Sent to…/stored	Collected by/date

TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and Comments	
STI prevention/treatment				**45**
Emergency contraception				
Wound treatment				
Tetanus prophylaxis				
Hepatitis B vaccination				
Post-exposure prophylaxis for HIV				
Other				

COUNSELLING, REFERRALS, FOLLOW-UP

General psychological status

Survivor plans to report to police OR has already made report		Yes A No A
Survivor has a safe place to go	Yes ANoA	Has someone to accompany her/him Yes ANoA

Counselling provided:

_____

Referrals

_____

Follow-up required

Date of next visit

Name of health worker conducting examination/interview: _____

Title: _____ ***Signature:*** _____ ***Date:*** _____

Source: clinical management of rape survivors-D refugees and internally displaced persons-revised edition World Health Organization/United Nations High Commissioner for Refugees, 2004.

Annexure 2 Physical and Behavioral Indicators of Child Sexual Abuse

Physical Indicators	Behavioural Indicators
Unexplained genital injury	Regression in behavior, school performance or attaining developmental milestones
Recurrent vulvovaginitis	Acute traumatic response such as clingy behavior and irritability in young children
Vaginal or penile discharge	Sleep disturbances
Bedwetting and fecal soiling beyond the usual age	Eating disorders
Anal complaints (e.g. fissures, pain, bleeding)	Problems at school
Pain on urination	Social problems
Urinary tract infection	Depression
STI**a**	Poor self-esteem
Pregnancy**b**	Inappropriate sexualized behaviorsc
Presence of sperm**b**	
a Considered diagnostic if perinatal and iatrogenic transmission can be ruled out. Diagnostic b in a child below the age of consent. No one behavior can be considered as evidence of c sexual abuse; however, a pattern of behaviors is of concern. Children can display a broad range of sexual behaviors even in the absence of any reason to believe they have been sexually abused.	

Health consequences

Both the physical and psychological health problems that are associated with sexual abuse in children have been well documented in the scientific literature. The physical health consequences include:gastrointestinal disorders (e.g. irritable bowel syndrome, non-ulcer dyspepsia, and chronic abdominal pain); gynecological disorders (e.g. chronic pelvic pain, dysmenorrhea, menstrual irregularities); somatization (attributed to a preoccupation with bodily processes).

The following psychological and behavioral symptoms have been reported in child victims of sexual abuse:

— depressive symptoms;
— anxiety;
— low self-esteem;
— symptoms associated with PTSD such as re-experiencing, avoidance/ numbing, hyper arousal;
— increased or inappropriate sexual behavior;
— loss of social competence;
— cognitive impairment;
— body image concerns;
— substance abuse.

Annexure 3: Documenting the case of GBV – Example Rape

1. Record the interview and your findings at the examination in a clear, complete, objective, non-judgmental way.
2. It is not the health care provider's responsibility to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
3. Completely assess and document the physical and emotional state of the survivor.
4. Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds.

Minimum care for rape survivors in low-resource settings: Checklist of supplies

1.	**Protocol**	**Available**
	# Written medical protocol in language of provider	
2.	**Personnel**	**Available**
	# Trained (local) health care professionals (on call 24 hours a day)	
	# A "same language" female health worker or companion in the room during examination	
3.	**Furniture/Setting**	**Available**
	# Room (private, quiet, accessible, with access to a toilet or latrine)	
	# Examination table	
	# Light, preferably fixed (a torch may be threatening for children)	
	# Access to an autoclave to sterilize equipment	
4.	**Supplies**	**Available**
	# "Rape Kit" for collection of forensic evidence, including:	
	3 Speculum	
	3 Set of replacement clothes	
	3 Tape measure for measuring the size of bruises, lacerations, etc.	
	# Supplies for universal precautions	
	# Resuscitation equipment for anaphylactic reactions	
	# Sterile medical instruments (kit) for repair of tears, and suture material	
	# Needles, syringes	
	# Gown, cloth, or sheet to cover the survivor during the examination	
	# Sanitary supplies (pads or local cloths)	
5.	**Drugs**	**Available**
	# For treatment of STIs as per country protocol	
	# Emergency contraceptive pills and/or IUD	
	# For pain relief (e.g. paracetamol)	
	# Local anesthetic for suturing	
	# Antibiotics for wound care	
6.	**Administrative supplies**	**Available**

	# Medical chart with pictograms	
	# Consent forms	
	# Information pamphlets for post-rape care (for survivor)	
	# Safe, locked filing space to keep confidential records	

Annexure 4: Pregnancy Prevention and Management

Most female victims of sexual violence are concerned about the possibility of becoming pregnant as a result of the assault. If a woman seeks health care within a few hours and up to 5 days after the sexual assault, emergency contraception should be offered. If she presents more than 5 days after the assault she should be advised to return for pregnancy testing if she misses her next menstrual period .

Emergency contraception

The most widely used means of pregnancy prevention is the oral administration of the emergency contraceptive pill (ECP), otherwise known as the "morning after pill". ECPs act by preventing or delaying ovulation, by blocking fertilization, or by interfering with implantation. They are not abortion pills and do not affect an existing pregnancy . Criteria for administering ECPs include:

— a risk of pregnancy;
— patient presents for treatment within 5 days of the assault and wants to prevent pregnancy;
— patient has a negative pregnancy test or it has been determined that she is not currently pregnant (if pregnancy cannot be ruled out with certainty, ECPs can still be prescribed so long as the patient is informed that if she is already pregnant, the pills will not be effective but neither will they affect the pregnancy nor harm the fetus).

There are no known medical conditions for which ECP use is contraindicated. Medical conditions that limit the continuous use of oral contraceptive pills are not relevant for the use of ECPs. Some jurisdictions require the patient to sign an informed consent form for emergency contraception.

ECP dosing regimens

Pre-packaged ECPs are available in some, but not all, countries. If pre-packaged pills are not available, other oral contraceptives can be substituted (the placebo tablets must not be used).There are two main categories of ECPs, the combined estrogen-progesterone pill, and the progestin-only pill (i.e. levonorgestrel only). The preferred regimen for emergency contraception is the latter; relative to the progestin-only pill, the combined estrogen-progesterone pill appears to be less effective and more likely to cause side-effects such as nausea and vomiting. With all ECPs, the sooner they are taken after the assault, the more effective they are.

The recommended dosing regimens for ECPs are given in Table; important points are as follows:

Progestin-only ECPs can be given in a single dose, up to 5 days after unprotected intercourse (*58*).

In the absence of progestin-only pills, combined estrogen-progesterone pills can be given in two doses, 12 hours apart and within 72 hours of the assault.

Annexures

9.1. Performa for medico- legal examination of female survivors of sexual assault

Government of the Punjab, Health Department
MEDICO LEGAL EXAMINATION CERTIFICATE
FOR FEMALE SURVIVORS OF SEXUAL VIOLENCE

Casualty/Emergency No _____ MLC No _____

Name of the Institution/Department _____

Name of the Doctor _____

1. PATIENT DEMOGRAPHIC INFORMATION

Name:_____ Daughter/wife of: _____ Age:_____

Caste:_____ NIC No:_____ Telephone No: _____

Address:_____

_____

Date and time of : a) Arrival:_____ b) Examination:_____

Brought / accompanied by: _____

No./date of court order: _____

Name of official accompanying: _____

Two identification marks:-

i) _____

ii) _____

Date & Time of : a) Admission:_____ b) Discharge: _____

*Signature of doctor:*_____

2. HISTORY

i. Details from the victim

a- Date/time of incidence: _____ Location: _____

b- Assailant(s): (Number and relationship to victim, if any) _____

c- Relevant details of assault

d- Previous such incidence _____ If yes when (date, year) _____

ii- Details from other parties (e.g., police, family, witnesses).

iii- Relevant Medical/ Surgical/Psychiatric History.

iv- Relevant Gynecological History

v- Current Symptoms.

Signature of doctor: _____

3. EXAMINATION

i. EXAMINATION OF CLOTHES

Sr. No.	Observation	Remarks
1	Number, colour, texture, size, type of clothes etc.	
2	Cuts, tears, holes, broken buttons, zipper etc.	
3	Staining with blood, urine, faeces, vomit, semen etc.	
4	Staining with non biological material	

ii- PHYSICAL EXAMINATION

a- General :-

Sr. No.	Observation	Remarks
1	Physique (average, strong, weak etc.) including comments on sexual development	
2	Confident, Well oriented in time and space	
3	Confused, shy, depressed, agitated, cooperative, intellect, emotional state etc.	
4	Height and weight	
5	Size, shape, site and characteristics of the injury. Note: Use body charts for diagrams.	

Signature of doctor _____

b- Local/ Specific examination:-

Sr. No.	Observation by naked eye/ digital and instrumental examination	Remarks
1	Tears, lacerations, bruises, abrasions, swellings, hyperemia at the private parts with specific site in reference to lithotomy position on and around the private parts.	
2	Rupture of hymen, if present fresh or old.	
3	Evidence of bleeding/staining with blood.	
4	Evidence of seminal stain	

c. Systemic examination:

Examination with reference of any particular history, e.g., of pregnancy, abortion or any particular disease etc.

Signature of doctor _____

4. EVIDENCE COLLECTED

Sr. No.	Type	Description	Handed over to	Signature of receiving person
1	Clothes			
2	Blood, Urine, Vomitus etc			
3	Vaginal and anal swabs			
4	Oral swabs			

5. INVESTIGATIONS ADVISED

Sr. No.	Type	Reason for investigation	Report number	Signature of receiving person
1	X-rays (CT Scan / MRI if required)			
2	Ultrasound (Abdomino-pelvic cavity).			
3	Blood or any other investigations			

ii- COUNSELLING, REFFERALS

a) Psychological
b) Referral to a shelter home
c) Police
d) Lawyer

Signature of doctor _____

iii- OPINION/REMARKS

a. NATURE OF INJURIES (UNDER CRIMINAL AMENDMENT ACT).

b. PROBABLE DURATION OF INJURIES

c. KIND OF WEAPON / POISON etc.

iv RESULTS OF INVESTIGATIONS/EXPERT OPINION/TREATMENT/OPERATION NOTES *(attach notes and give the report number in the space)*

v- FINAL OPINION OF K.U.O. INJURIES

ii- FINAL OPINION REGARDING SEXUAL VIOLENCE

Medico-legal report handed over to (Name, designation & signature)	**Medico Legal Examiner** (Signature with by name & designation stamp)
	Date

9.2. FORENSIC EVIDENCE FORM: inside kit

i- Miscellaneous/ Debris collection paper on which patient undressed to be placed in envelope.

ii- Is the clothing worn now the same as worn during the assault? **Yes** **No**
(If not, request clothes worn during the assault to be submitted)

1- Clothing evidence to be placed in BAG 1

Clothing Evidence	**1A**	**1B**	**1C**	**1D**					
Items (To be labeled by doctor as 1A, 1B, 1C etc)									

1- Body evidence samples duly labeled to be placed in BAG 2

Body Evidence Label		**Quantity to be taken**	**Tick ✓ if sample collected**	**Sample not collected : Give Reason**
2A	**Oral Swabs**	2 swabs		
	Give 10ml of saline to rinse the mouth and then collected in a sterile container			
2B	**Blood stains on body** Site Site Site Site	2 swabs each		
2C	**Foreign material on body** Site Site Site	2 swabs each		
2D	**Seminal stains on body** Site Site Site Site	2 swabs each		
2E	Other stains (specify site and suspected nature material)	2 swabs each		

2F	**Head hair combing**			
2G	**Scalp hairs**	5-10 strands cut not plucked		
2H	**Take nail scrapings** first of both hands separately			
2I	**Nail clippings of both hands all separately** (Write if deeply cut already)			
2J	**Blood for grouping in citrate vial**	2ml		
2K	**Blood for alcohol levels / drugs, double oxalate**	5ml		

1- **Genital and Anal evidence samples duly labeled to be placed in Bag 3**

Genital and Anal Evidence		**Quantity to be taken**	**Tick ✓ if sample collected**	**Sample not collected : Give Reason**
3A	**Matter public hair**			
3B	**Combing of public hair** (mention if shaved)			
3C	**Cutting of public hair of survivor** (mention if shaved)	5 - 10		
3D	**Vulval swabs**	2		
3E	**Vaginal swabs** (mention site) 1. Anterior 2. Posterior 3 & 4. Lateral	4		
3F	**Normal saline / distilled water and pipette out**			
3G	**Anal swab**	2		
3H	**Vaginal smear**			

Name of patient _____

Kit No _____

Hospital name and location _____

_____

Date _____

Doctor's full name and signature _____

9.3. List of equipments/instruments/medicines/general items etc.

a- FIXTURES

i- Examination couch

ii- Desk, chairs and filing cabinet - For victim, accompanying persons and health worker.

iii- Light source - Ideally mobile.

iv- Washing facilities and toilet - Facilities should be available for the victim to wash at the conclusion of the examination. There should also be a facility for the health worker to wash the hands before and after an examination. Facilities should include a shower, a hand basin and soap.

v- Refrigerator and cupboard - For the storage of specimens, preferably lockable.

vi- Telephone

vii- Fax machine

b- GENERAL MEDICAL ITEMS

i- Tourniquet

ii- Syringes, needles and sterile

iii- swabs

iv- Blood tubes (various)

v- Speculums (various sizes)

vi- Sterilizing equipment - For sterilizing instruments (e.g. specula)

vii- Proctoscope / anoscope

viii- Examination gloves

ix- Pregnancy testing kits

x- STI collection kits

xi- Lubricant, sterile water normal saline

xii- Sharps container

xiii- Scales and height measure - For examining children.

xiv- Plastic specimen bags - For collection or transport of other (dry) forensic items

xv- Tweezers, scissors, comb - For collecting foreign debris on skin. Use scissors or comb to remove and collect material in hair.

c- TREATMENT

i- Analgesics - A range of simple analgesics may be useful.

ii- Emergency contraception

iii- Suture materials

iv- Tetanus and hepatitis

v- prophylaxis/vaccination

vi- STI prophylaxis

d- LINEN

i- Sheets and blankets - For examination couch.

ii- Towels

iii- Clothing - To replace any damaged or retained items of the victim's clothing.

iv- Patient gowns - To allow patient to fully undress for examination.

v- Sanitary items (e.g. pads, tampons)

e- STATIONERY

i- Examination record or Performa - For recording findings (see Annex 9.1).

ii- Labels - For attaching to various specimens.

iii- Consent form - This should be completed as required by local rules or protocols (see Annex 9.1).

iv- Pathology/radiology referral - For referring patient for further investigation or tests.

v- Information brochure - Ideally the patient should be provided with information about the service they have accessed, methods of contacting the treating practitioner if required and details of follow-up services. These brochures should supplement any verbal information that the victim has been provided with.

vi- In addition to reinforcing important information that the victim may forget, brochures may provide information to other potential service users.

f- SUNDRY ITEMS

i- Camera and film - Photography is useful but not necessarily an essential tool for injury documentation. Police or hospitals may also be able to assist.

ii- Coloscope or magnifying lens - Useful for obtaining a magnified view of a wound.

iii- Microscope May be used by the practitioner to check for the presence of spermatozoa, particularly if no laboratory facility is accessible.

iv- Patients may present with a range of physical conditions. There should be ready access to the facilities, equipment and items required to treat these conditions. If not held at the centre they should be available nearby (e.g. at a hospital or clinic). Other medications (e.g. for the treatment of insomnia and anxiety) may also be required.

g- Contents of the Sexual Assault Forensic Evidence (SAFE) Kit

i- Manual
ii- Checklist
iii- Paper Envelopes
iv- Sterile Swabs
v- Comb (Medium /Small)
vi- Nail Cutter
vii- EDTA bulb (2mL)
viii- Double Oxalate Tube (5mL)
ix- Syringe (10cc)
x- Distilled water (5mL)
xi- Disposable Gloves (Size 6)
xii- Scissors (Small)
xiii- Disposable Speculum
xiv- Glass slide

9.4. Design of Medico-legal clinic

There should be an adequate waiting area for relatives accompanying the survivor. There should be no windows or curtains in the examination room. Sufficient lighting, a comfortable chair and examination table (preferably a lithotomy table) are necessary for a thorough examination. An attached bathroom should be available.

9.5. Relevant Sections of PPC, CPC, Q&D and Hadood Ordinance

Relevant sections of the laws dealing with hurt and their descriptions

Injury	Provision of the Pakistan Penal Code (PPC)	Description
Hurt	Section 332	1) Whoever causes pain harm, disease, infirmity or injury to any person or impairs, disables or dismembers any organ of the body or part thereof of any person without causing death, is said to cause hurt. 2) The following are the kinds of hurt: 1 Itlaf-i-udw; 2 Itlaf-i-salahiyyat-i-udw; 3 Shajjah; 4 Jurh; 5 All kinds of other hurts.
Itlaf-i-udw	Section 333	When any limb or organ is dismembered, amputated or severed. * Fingers of hand or toes of foot are not organs. Similarly, teeth are not an organ; the whole jaw is an organ.
Itlaf-i-Salahiyyat-i-udw	Section 335	When the functioning, power or capacity of an organ is destroyed, permanently impaired or permanently disfigured. The injury covers: 1 Permanent impairment of the power of any member or joint. 2 Privation of sight of either eye, hearing of either ear, or any member or joint. 3 Cutting of any lip. 4 Uprooting of the hair of the head, eye, brows, eye lashes or any other part of the body. 5 Privation of complete sight. 6 Privation of complete hearing. 7 Loss of sexual power. 8 Cutting of nose- part or whole. 9 Loss of tooth other than milk tooth. 10 Loss of milk tooth if amounts to permanent loss of tooth. 11 Loss of one finger or thumb whether of hand or foot.

Shajjah	Section 337	When hurt is caused on the **head** or **face** of any person but does not amount itlaf-i-udw or Itlaf-i-Salahiyyat-i-udw. The following are the kinds of Shajjah, namely: **Shajjah-i-Khafifah:** Any hurt in which bone of the victim is not exposed. **Shajjah-i-Mudihah:** Any hurt in which bone of the victim is exposed without being dislocated. **Shajjah-i-Hashimah:** Any hurt in which bone of the victim is fractured without being dislocated. **Shajjah-i-Munaqillah:** Any hurt in which bone of the victim is fractured and dislocated. **Shajjah-i-Ammah:** Any hurt which fractures the skull of the victim so that the wound touches the membrane of the brain. **Shajjah-i-Damighah:** Any hurt which fractures the skull of the victim and the wound ruptures membrane of the brain.
Jurh	Section 337 - B	Any hurt on any part of the body, other than the head or the face, which leaves a mark of the wound, whether temporary or permanent. Jurh is of two kinds, namely: 1 Jaifah 2 Ghayr-jaifah
Jaifah	Section 337 - C	Injury which extends to the body cavity of the trunk. 3 Any injury which extends to the thoracic or peritoneal cavity. 4 Penetrating injuries involving pleural or peritoneal cavity. 5 Blunt trauma abdomen leading to rupture or damage of abdominal viscera is covered by this category of hurt. 6 Blunt trauma chest resulting in fracture of rib leading to haemothorax, pneumothorax or haemopneumothorax is covered by this category of hurt. *As these injuries are life threatening, therefore Section 337-L(1) is also applicable.

Ghayr-Jaifah	Section 337 - E	Jurh which does not amount to Jaifah amounts to Ghayr-jaifah. The following are the kinds of Ghayr-jaifah, namely: **Damiyah:** Where the skin is ruptured and bleeding occurs. **Badi'ah:** Where the flesh is cut or incised without exposing the bone. **Mutalahimah:** Where the flesh is lacerated. **Mudihah:** Where the bone is exposed. **Hashimah:** Where the bone is fractured without being dislocated. **Munaqqillah:** Where the bone is fractured and dislocated.
Any other kind of hurt	Section 337 - L	1) Any injury not mentioned above but endangers life and leaves the injured in severe bodily pain for twenty days or more or renders him unable to follow his ordinary pursuits for twenty days or more. 2) Any injury not covered by sub-section (1) such as contusions and bruises on body and neck excluding head and face or dislocating of joints not covered by the above stated sections.
Isqat-i-Hami	Section 338	Injuries to a woman, with a child whose organs have not been formed, to cause miscarriage except in good faith for the purpose of saving the life of the woman or providing necessary treatment to her.
Isqat-i-Janin	Section 338 - B	Injuries to a woman, with a child some of whose limbs or organs have been formed, to cause miscarriage except in good faith for the purpose of saving the life of the woman.

Rape	Section 375	A man is said to commit rape who has sexual intercourse with a woman under circumstances falling under any of the five following descriptions; (i) against her will (ii) without her consent (iii) with her consent, when the consent has been obtained by putting her in fear of death or of hurt (iv) with her consent, when the man knows that he is not married to her and that the consent is given because she believes that the man is another person to whom she is or believes herself to be married, or (v) with or without her consent when she is under sixteen years of age. *penetration is sufficient to constitute the sexual intercourse necessary to the offence of rape.

Note: Section 174-A of the Code of Criminal Procedure, 1898

174-A. Grievous injury by burns

1. Where a person, grievously injured by burns through fire, kerosene oil, acid, chemical or by any other way, is brought to a Medical Officer on duty designated by the Provincial Government for this purpose or, such incident is reported to the Officer-in-Charge of a Police Station, such Medical Officer on duty, or, as the case may be, Officer-in-Charge of a Police Station, shall immediately give intimation to the nearest Magistrate. Simultaneously, **the Medical Officer on duty shall record the statement of the injured person immediately on arrival so as to ascertain the circumstances and cause of the burn injuries.** The statement shall also be recorded by the Magistrate in case the injured person is still in a position to make the statement.

2. The Medical Officer on duty, or, as the case may be, the Magistrate, before recording the statement under sub-section (1), shall satisfy himself that the injured person is not under any threat or duress. The statement so recorded shall be forwarded to the Sessions Judge and also to the District Superintendent of Police and Officer-in-Charge of the Police Station. For such action as may be necessary under this Code.

3. If the injured person is unable, for any reason, to make the statement, before the Magistrate, his statement recorded by the Medical Officer on duty under sub-section (1) shall be sent in sealed cover to the Magistrate or the trial Court if it is other than the Magistrate and may be accepted in evidence as a dying declaration if the injured person expires.

Annexure 6: Major Laws Relating to Women in Pakistan

S#.	Particulars
1	Guardian and Ward Act, 1890
2	Foreign Marriage Act, 1903
3	The Child Marriage Restraint Act, 1929
4	Dissolution of Muslim Marriage Act, 1939
5	Muslim Family Laws Ordinance, 1961
6	The West Pakistan Rules Under Muslim Family Laws Ordinance, 1961
7	West Pakistan Family Courts Act, 1964
8	West Pakistan Family Court Rules, 1965
9	The Dowry and Bridal Gifts (Restriction) Act, 1976
10	The Dowry and Bridal Gifts (Restriction) Rules, 1976
11	Hadood Ordinance, 1979
12	Family Courts (Amendment) Ordinance, 2002
13	Criminal Law Amend Act, 2004
14	Protection of Women Criminal Law Amendment Act, 2004
15	Amendment to the Pakistan Penal Code
16	Protection Against Harassment of Women at the Workplace, 2010
17	Acid Control and Acid Crime Prevention Act, 2010
18	Prevention of Anti Women Practices Criminal Law Amendment Act, 2011
19	Women in Distress and Detention Fund (Amendment) Act, 2011

Annexure 7: Referral pathways

TELLING SOMEONE AND SEEKING HELP (REPORTING)	
Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial "entry point:	Survivor self-reports to any service provider

IMMEDIATE RESPONSE **The service provider must p**rovide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals; accompany the survivor to assist her in accessing services	
Medical/health care entry point [Enter name of the health centre(s) in this role]	**Psychosocial support entry point** [Enter name of the psychosocial provider(s) in this role]

IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - *OR* - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS *TO OTHERS* Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police	
Police/Security [Enter specific information about the security actor(s) to contact - including where to go and/or how to contact them]	**Legal Assistance Counsellors** **or Protection Officers** [Enter names of organisations]

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's choices **can** include any of the following (details in Section 6):			
Health care	Psychosocial services	Protection, security, and justice actors	Basic needs, such as shelter, ration card, children's services, safe shelter, or other

Source: Gender-based Violence Resource Tools supporting implementation of the Guidelines for GBVInterventionsinHumanitarianSettings: Focusing on Prevention of and Response to SexualViolenceinEmergencies.IASC2005

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Web sites

1. www.who.int/mediacentre/factsheets/fs323/en/

2. www.iawg.net/resources2013/misp-implementation/

3. www.af.org.pk/PDF/VAW%20Reports%20AND%20PR/Annual%20Report%202012%20VAW%20pdf.pdf

4. www.dcp2.org/main/Home.html and

5. web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/

6. http://www.nesri.org/programs/what-is-the-human-right-to-health-and-health-care