KINGDOM OF CAMBODIA

NATION - RELIGION - KING

Ministry of Health

National Guidelines for Managing Violence Against Women and Children in the Health System

2014

PREVENTIVE MEDICINE DEPARTMENT

Contents

PREFACE

Violence against women and children (VAW/C) is the serious public health concern and human rights violation with consequences that impact peoples' lives particularly those of women and children. VAW/C hinders the fight against HIV/AIDS and improvements in sexual reproductive and child health. The situation calls for a comprehensive health sector response. These guidelines are designed to support health care providers in their efforts to prevent and respond to VAW/C.

The development of the National Guidelines for Management of Violence Against Women and Children in the Health Sector are guided by the Ministry of Health Strategic Plan, 2008-2015, the National Strategy for Reproductive and Sexual Health 2013-2015, the Ministry of Health Fast Track Initiative for Reducing Maternal and Newborn Mortality 2010-2015, the National Action Plan to Prevent Violence Against Women 2014-2018. These guidelines are also based on international best practices including the World Health Organization *Clinical and Policy Guidelines for Responding to intimate partner violence and sexual violence against women* and the USAID's *Clinical Management of Children and Adolescents who have experienced sexual violence*.

These guidelines provide standards for the provision of high-quality and comprehensive medical services and procedures to VAW/C survivors, and encourage providers to identity and quickly mobilize resources for VAW/C survivors at health facilities. These guidelines encompass medical management, first line support and referral to key social and legal protection services. As a result comprehensive management of VAW/C in the Health System requires close cooperation with other sectors and key stakeholders as well as a system to monitor quality control.

The management guidelines are a valuable tool for health managers, and health care providers in the health centers and referral hospitals. They serve as a tool to guide health staff in a variety of settings including reproductive and child health to prevent and respond to VAW/C.

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MINISTER OF HEALTH

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CCWC	Commune Committee for Women and Children
DNA	Deoxyribonucleic Acid
DoWA	Department of Women's Affairs
DoH	Department of Health
EC	Emergency Contraception
GBV	Gender-based violence
FP	Focal Point
MDG	Millennium Development Goal
MoH	Ministry of Health
MoI	Ministry of Interior
MoWA	Ministry of Women's Affairs
MoSVY	Ministry of Social Affairs Veterans and Youth Rehabilitation
MoU	Memorandum of Understanding
OVC	Orphans and Vulnerable Children
NGO	Non-government organization
PEP	Post-exposure prophylaxis
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child transmission
RH	Reproductive health
RTI	Reproductive tract infection
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
VAC	Violence Against Children
VAW	Violence Against Women
VAW/C	Violence Against Women and Children
WHO	World Health Organization

GLOSSARY

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

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

Consent: Making an informed choice freely and voluntarily to do something. There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.

Child: Any person under the age of 18 years.

Domestic violence: Domestic violence as defined by Cambodian lawincludes violence against a husband or wife; dependent children or persons living under the roof of the house and who are dependents of the households.

Intimate partner violence refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours.

First-line support: This refers to theminimum level of (primarily psychological)support and validation of their experience thatshould be received by all women who discloseviolence to a health-care provider.

Health care provider: Refers to the nurse, midwife, doctor or other person working in the hospitals, clinics or primary care clinics or other service delivery points.

Perpetrator: A person, group or institution that directly or indirectly inflicts, supports, and condones violence or other abuse against a person or a group of persons.

Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted comments or advances or acts to traffic, or otherwise directed toward a person's sexuality, using coercion, by a person, regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Sexual assault is a subcategory of sexual violence, that usually includes the use of physical or other force to obtain or attempt to obtain sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis or other body part.

Survivor: A person who has been physically, sexually and/or psychologically violated.

Violence against women 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 private life.

Violence against children is defined as the intentional use of physical force or power, threatened or actual, against a child, by an individual or group that either results in or has a high likelihood of resulting in actual or potential harm to a child's health, survival, development or dignity. This includes all forms of physical and or emotional ill-treatment, sexual abuse, neglect or negligent treatment, and commercial or other exploitation that takes place in the context of a relationship of responsibility, trust or power.

1- INTRODUCTION

1.1 Why National Guidelines for Management of Violence Against Women and Children (VAW/C) in the Health System?

Healthcare facilities and providers may be the first or only point of contact outside the home for women and children that have experienced abuse or violence. Health providers are strategically placed to provide information and assistance, raise society's awareness of violence against women and children as a public health problem, and counsel and refer survivors' and their families. Health providers who are uninformed or unprepared may put survivors at further risk of violence or offer inappropriate care. Not addressing violence against women and children can mean missing significant sexual and reproductive health issues.

These National Guidelines for Management of VAW/C in the Health System will support health care providers in providing high-quality and comprehensive services to women and children survivors and the community. The guidelines will provide medical providers with protocols to manage VAW/C survivors and refer to appropriate services at all levels, including community resources. To support implementation of these National Guidelines there will be additional training materials that further elaborate on knowledge and skills required to implement the guidelines.

1.2 Objective of the National Guidelines for Management of VAW/C in the Health System

The guidelines primarily aim to ensure that women and children that experience violence or abuse receive a holistic, effective, and comprehensive response in the healthcare system and referral to appropriate services, including community resources. The objectives are to:

1. Guide violence against women and children response in the healthcare system including providing first-line support, obtaining informed consent for selected medical and forensic procedures, maintaining privacy and confidentiality, managing injuries, and treatment and referring patients for additional medical care and other non-medical services, when necessary.
2. Ensure standardized management of violence against women and children survivors including collection, storage and processing of forensic evidence (with the consent of the survivor), in collaboration with the key multi-sectoral partners.
3. Strengthen linkages between the health facilities and communities to increase timely and effective use of violence against women and children services.
4. Build the capacity of and train healthcare providers to deliver effective violence against women and children related prevention and response services.
5. Raise awareness among healthcare providers, of violence against women and children to better understand the need for an appropriate health sector response.
6. Guide procedures for quality assurance for comprehensive violence against women and children related services.

1.3 Structure of the Guidelines

The National Guidelines for Management of Violence Against Women and Children provide:

- Introduction, Objectives and Overview of the Situation of Violence Against Women and children
- Minimum Standards and Guidance for Management of Violence against Women in the Health System.

- Minimum Standards and Guidance for Management of Violence against Children in the Health System
- Quality AssuranceProcedures

1.4Violence Against Women and Children

These guidelines are targeted to intimate partner violence, and sexual violence against women, and violence against children as defined in the Glossary above.

1.4.1 Recent statistics on Violence Against Women and Children in Cambodia

Data is limited on the prevalence and incidence of VAW in Cambodia. However some recent studies show that:

- According to the CDHS 2005,22.3% of ever-married women reported they have experienced emotional, physical and/or sexual violence by their husband.[1]
- A study conducted by Partners for Prevention, found that 1 in 3 (36%) of ever-partnered men reported perpetrating physical and/or sexual violence against an intimate partner during her lifetime, and 8 % of all men reported that they had perpetrated rape against a woman or girl who was not their partner. 5 % of all men reported that they had participated in gang rape.[2]
- In the same study, of 436 women interviewed, 1 in 10 of ever-partnered women reported having experienced sexual partner violence or rape in their lifetime.[3]
- A study conducted by CARE found that 54% female beer promotion workers reported sexual harassment and physical abuse.[4]
- A study conducted by ILO in found that 1 in 5 female garment factory workers report sexual harassment, or harassment with sexual undertones which led to a threatening work environment.[5]
- A study conducted by AusAID found that 24.4 % of women with disabilities have experienced sexual violence in their lifetime.[6]
- The Cambodia Violence Against Children Survey shows that 6 in every 10 boys and girls experience at least one form of violence in childhood; Physical violence is the most prevalent form of abuse with the majority reporting more than one incident.[7]
- The first sexual intercourse as a child was unwanted for nearly a quarter of females and almost 1 out of 10 males. [8]
- Most women and children who experience VAW/C will never tell anyone and few seek help following an incident of sexual abuse or physical violence.[9]

1.4.2 Health Consequences of Violence Against Women and Children

Intimate partner violence and sexual violence against women have serious short- and long-term physical, mental and sexual consequences for survivors, including reproductive health problems,and also for their children, and lead to high social and economic costs.

- Violence against women and children can have fatal results like homicide or suicide.

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[1](NIS, 2005)
[2](Fulu, et al. 2013)
[3](Fulu, et al. 2013)
[4](CARE 2005)
[5](ILO 2012)
[6](Astbury and Walji 2013)
[7 (]MOWA, et al. 2014)
8 (MOWA, et al. 2014)
9 (MOA, et al. 2014)

- It can lead to injuries, with 42% of women who experience intimate partner violence reporting an injury as aconsequence of this violence.
- Intimate partner violence and sexual violence against women and girls can lead to unintended pregnancies, induced abortions, gynecological problems, and sexually transmitted infections, including HIV.
- Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies.
- These forms of violence can lead to depression, post-traumatic stress disorder, sleep difficulties, eating disorders, emotional distress and suicide attempts.
- Physical and sexual violence experienced as a child can lead to social, emotional, and cognitive impairments[10], as well as health-risk behaviors such as substance abuse, early sexual activity and smoking, that cause disease, injury and social problems;[1112]

1.5Laws and Policies to address VAW/C in Cambodia

The Royal Government of Cambodia has made significant strides in setting a national policy and legal framework to address VAW/C. Following is a summary of these laws and policies.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Cambodia ratified the CEDAW in 1992 and its' Optional Protocol in 2010. As a signatory to CEDAW, and in compliance with the responsibilities set forth in the Beijing Platform for Action, Cambodia has demonstrated a firm commitment to enact legislations and policies that can address and respond to VAW.

United Nations Convention on the Rights of the Child (CRC): In 1992, Cambodia ratified the CRC and its optional protocols which sets out the basic human rights that boys and girls have, including the right to protection from all forms of physical and mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse (Article 19).

The **Constitution (1993)** enshrines the right of all Cambodians to life, personal freedom and security (Article 32), and guarantees there shall be no physical abuse of any individual (Article 38).

The **Law on Prevention of Domestic Violence and Protection of Victims (2005) (DV Law)**establishes the responsibility of local authorities to intervene in cases of domestic violence and provides for protection orders to be issued by the courts to protect the victim from any further violence.

The **Law on the Suppression of Human Trafficking and Sexual Exploitation (2008)**establishes the law against kidnapping persons for labour or sexual exploitation and **Article 31** makes managing an establishment for prostitution illegal. **Article 34-36** makes sexual intercourse with a minor under 15 illegal; Sexual intercourse or other contact with a minor over 15 by promising anything of value or soliciting a child for prostitutionis punishable by prison.

The **Penal Code** makes acts of domestic violence a crime that can be punished with imprisonment under different offenses in the code, such as intentional violence on a spouse or child.[13]The Penal Code states that

[10](Perry 2001)
[11](V J Feleti 1998)
[12](CDC 2006)
[13] Penal Code, article 222

the legal age of sexual consent is 15 years of age.[14]The Penal Code also offers imprisonment provisions for rape.[15]

T**he Civil Code (2007)**states that members of families shall respect each other's rights and freedoms and prevent domestic violence.[16]Article 1045 of the Civil Code permits discipline against children by parental power holders to the extent that they deem necessary. The Civil Code permits the court to order the divestment or suspension of the authority of a parental power holder who abuses his/her rights, upon application by a relative of the child up to the fourth degree of relationship, a commune or *sangkat* head, the head of a public child welfare institution or a public prosecutor.[17]

Under Article 172 of theCambodian Labour Law[18] (1997)and the **Criminal Code (2010)**sexual harassment and indecent behaviour in the workplace are both prohibited.

The **Safe Village/Commune/Sangkat Policy(2010)** issued by the Ministry of Interior (MoI) designates rape, domestic violence and anti-trafficking as priority areas for commune, municipal, district, and provincial councils to address. This policy urges collaboration between the local authorities and all sectors including political parties, NGOs, private sectors, and citizens to build collective forces, actions and measures to implement the policy.

The ***Prakas* on Procedures on Alternative Care** obligates the Commune Committee for Women and Children (CCWC), to visit the home of a child who is a victim of, or who is at risk of, violence, physical or sexual abuse, or exploitation from his or her family members. The CCWC is required to interview the child, to assess the risk situation, and in case of an immediate danger to the child's safety, to remove the dangerous adult or the child from the home, in cooperation with other local authorities.[19]

[14] Penal Code, article 239

[15] Penal Code, article 239

[16] Civil code, article 943

[17] Civil Code, article 1048.

[18]Article 172: All employers and managers of establishments in which child laborers or apprentices less than eighteen years of age or women work, must watch over their good behavior and maintain their decency before the public. All form of sexual violation (harassment) is strictly forbidden.

[19]*Prakas* on Procedures on Alternative Care, article 14-15.

2-RESPONDING TO VIOLENCE AGAINST WOMEN (VAW) IN THE HEALTH SYSTEM

Comprehensive management of VAW survivors at different levels of the healthcare system demands minimum standards for staffing, health care facility settings, materials, equipment, drugs, medical supplies and administrative supplies.

2.1 Guiding Principles

The National Guidelines for Management of VAW in the Health System are based on the following guiding principles:

Ensuring safety: All actions taken on behalf of a VAW survivor shall beaimed at restoring or maintaining health and safety and not placing survivors at greater risk of violence.

Respect and dignity for the survivor: Survivor's opinions, thoughts, and ideas shall be listened to and treated with respect. Survivors should be treated with respect and not experience "blame the victim" attitudes. Survivors of VAW that disclose any type of violence or abuse by an intimate partner, or a sexual assault should be offered immediate first-line support.

Privacy and confidentiality: At all times the privacy and confidentiality of the survivor and their families shall be respected. Services should be provided in quite, private easily accessible rooms. Information about survivors should be collected, used, and stored in a confidential manner. In a small facility or where there is limited space, healthcare providers shall create a private space to ensure privacy and confidentiality.

VAW survivors' identify should not be shared or discussed in any meeting inside or outside of the health facility without the survivor's permission. This means sharing only the necessary information as agreed by the survivor with those involved in providing medical assistance. Any discussion of the case for medical consultation should leave out the person's identity. Disclosure of medical information may be allowed with the survivor's consent to:

- Other treatment providers involved in the care of the survivor;
- The person in charge at the court or police with the survivor consent; and
- Other people requested by the survivor.

Non-discrimination: All survivors are equal and shall be treated the same and have equal access to services. There shall be no discrimination or different treatment for anysurvivor based on gender, ethnicity; religion; social class, disability or other factors.

Consent: Consent shall be obtained for specific procedures and services. Options for consent shall be explained to the survivor and the survivor's decision to consent to either a, b, or c shall be respected.

a) Physical examination and treatment only
b) Physical examination, treatment and forensic examination
c) Physical examination, treatment, forensic examination, police investigation and legal justice

2.2 Integrating VAW Services into Existing Health Services

2.2.1 National Health Infrastructure

Ministry of Health (MoH) is responsible for health policy and planning, while facilitating multi-sectoral coordination and external aid.**Provincial Department of Health (PDOH)**is tasked with connecting the central MoH to the operational districts through the implementation of policies in the health sector plan via the annual operations plan. ***Operational Districts (OD)*** are based on population and cover a population of 100,000 to 200,000 population and comprise referral hospital and a network of health centers. ODs

therefore act as the primary entry point of the population into the health system through their service delivery. ***Health Centers*** are geographically located to serve a catchment area of between 8,000 and 12,000 people. Services include initial consultations and primary diagnosis, emergency first aid, chronic disease care, maternal and child care (including normal delivery), birth spacing advice, immunization, health education and referral. ***Referral Hospitals*** are located at the National Level, the Provincial Level and the Operational District Level. The Referral hospitals are expected to support primary care and have resources and expertise available for health centers. There are 3 Complementary Package of Activities (CPA)s at referral hospitals, CPA1, CPA2 and CPA3. CPA 1 Referral Hospitals have no large scale surgery, but have basic obstetric service; CPA2 has emergency care and large scale surgery; and CPA3 have all services at CPA 1 and 2, and have specialize services such as blood transfusions, , ear nose and throat, and others.

2.2.2 Key Entry Points for VAW Survivors

Key entry points for survivors of VAW survivors in the health system are:

- Emergency Departments
- Family Planning Services
- Reproductive Track Infection Care Services
- Antenatal Care Services
- Neonatal Care Services
- Postnatal Care Services
- Emergency Obstetric and Newborn Care Services
- Child Immunisation Services
- Safe Abortion Services
- Voluntary Confidential and Counseling and Testing (VCCT)
- Prevention of Mother-to-Child Transmission (PMTCT)

Universal screening of VAW is not recommended, but health care providers are encouraged to raise the topic with women or children who have injuries or conditions that they suspect may be related to violence.

2.3 Minimum Standards for Management of VAW Survivors

2.3.1Minimum Package of Services

The minimum package of services that all health care facilities should provide is:

- Reception and First-Line Support;
- Ensuring confidentiality and obtaining informed consentfor selected medical and forensic procedures;
- Immediate clinical management (history taking, physical exam), treatment for all injuries that the health facility has the capacity to treat;
- Provision of or immediate referral for HIV Post Exposure Prophylaxis (PEP within 72 hours) (in case of sexual violence)
- Provision of or immediate referral for Sexually Transmitted Infection Screening and Treatment (in case of sexual violence);
- Provision of or immediate referral for Emergency Contraception (EC) (in case of sexual violence);
- Provision of or an immediate referral for a Forensic Exam (based on consent of Survivor Consent)
- Referral of survivors to higher level facilities for additional medical care; and
- Referral to other services available for VAW/C such as psycho-social support, safe shelter, legal, aftercare or rehabilitation,reintegration or other services.

2.3.3.1 Response Available at Different Health Care Provider Levels

Responses	Health Center	Referral Hospital CPA1	Referral Hospital CPA2	Provincial and National Referral Hospital CPA3
Receive and triage for appropriate care	√	√	√	√
Provide first-line supportensuring confidentiality	√	√	√	√
Take history, obtaining consent and undertake examination		√	√	√
Manage minor injuries	√	√	√	√
Manage major injuries			√	√
Provide Post Exposure Prophylaxis (PEP)				√
Provide Emergency Contraception	√	√	√	√
Provide Tetanus Toxoid Vaccinations (TT Vaccination)	√	√	√	√
Treat STI	√	√	√	√
Psycho-social services				
Establish good interpersonal relationship with survivor	√	√	√	√
Link survivor with other VAW Services	√	√	√	√
Follow Up	√	√	√	√
Forensic Services				
Collect and document findings from forensic-related investigations		√	√	√
Document findings related to forensic history and physical examinations		√	√	√
Complete Forensic Medical Examination Form		√	√	√
Referrals and Linkages				
Refer complications to higher level facilities	√	√	√	√
Educate, orient, and provide information about other VAW services	√	√	√	√

2.3.2 Minimum Medical and Administrative Supplies by Level of Provider

Health Center	Referral Hospitals
Medical Supplies and Medications	
-Supplies and equipment for preventing and controlling infections -Sterile stitches and dressing trays -Sanitary supplies -Pregnancy test kits -Syphilis test kits -Tetanus Toxoid -Analgesics -Local Anesthesia for suturing -Antibiotics -Emergency contraception -Treatment of STIs	Supplies at Health Center plus: -Post Exposure Prophylaxis (PEP) at Referral Hospitals (CPA3) Forensic Exam Kit that includes *:* -Syringe -Speculum -Empty sterile bottles -High vaginal swab -Paper bags for storing clothing -Digital Camera (if possible) -Lubricant -Additional clothing, sanitary pads or other comfort supplies
Administrative Supplies	
Consent Form VAW/C Medical Form Resource and Referral Information	Consent Form VAW/C Medical Form Resource and Referral Information Forensic Medical Examination Form

2.3.3 Minimum Training of Health Care Personnel

All health care facilities should provide a minimum specialized training on:

- Relevant laws related to VAW;

- Dynamics of intimate partner violence, sexual violence and assault;
- Signs and symptoms of VAW;
- Engaging Survivors and providing First-Line Support;
- Using Medical Protocols including providing post-exposure prophylaxis, emergency contraception and other health care services as required;
- Understanding and Conducting the Forensic Examination (at the Referral Hospital Level);
- Knowledge and Referral to Community Resources;
- Using a woman centered approach; and
- Other topics as appropriate.

Men and sexual violence

Men may also be victims of partner violence and sexual assault. However, generally women experience more sexual violence, more severe physical violence, and more controlling behavior from male partners than women do.

While these guidelines are designed to focus on violence against women and children, much of the advice is also relevant to sexual violence against men.

2.4 Guidelines for Management of Survivors of VAW in Health System

2.4.1 Identification of VAW

Women subjected to violence often seek health care for related emotional and physical conditions, including injuries. However often they do not tell the health care professional about the violence for fear of being judged or fear of their partner. It is ***not*** recommended to ask every women receiving health care about violence, but health care providers are encouraged if they suspect injuries or conditions may be related to violence to raise the topic with women. The woman may have experienced intimate partner violence or sexual violence.

You may suspect a woman has experienced violence if she has any of the following:

- Injuries that are repeated or not well explained;
- Delay between injuries and seeking treatment;
- Vague complaints that have no obvious physical cause;
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
- Repeated sexually transmitted infections;
- Unwanted pregnancies;
- Ongoing emotional health issues, such as stress, anxiety or depression;
- Harmful behavior such as misuse of alcohol or drugs;
- A male partner who is overly attentive, controlling or unwilling to leave the woman's side during medical appointments;

If you suspect that a woman has experienced violence from a partner or rape some questions are:

"Your symptoms may be related to stress. Do you and your husband (partner) fight alot? Have you ever gotten hurt?"

"Sometimes when I see an injury like yours, it is because somebody hit them. Did that happen to you?"

"You know it is not uncommon these days for a person to have been emotionally, physically or sexually victimized sometime in their life and this can affect their health years later. Has this ever happened to you?"

"Have you been forced to have sex that you did not want?"

- Never raise the issue of intimate partner violence unless the woman is alone.
- Always try to establish rapport with the woman before asking sensitive questions.
- Do not pressure the woman to disclose intimate partner violence or sexual violence.
- If a woman does not disclose but you suspect violence tell her about services and offer information on the effects of violence on health and children

2.4.2 Receiving the Survivor

When a woman has disclosed violence, the healthcare provider shall provide services with compassion and support and show concern about the well-being and safety of the victim.**Immediately refer patients with life-threatening or severe conditions for immediate emergency care treatment.**

Key Steps to Receiving the Survivor

- Introduce yourself to the survivor (if you are a new person)
- Reassure the survivor she is in a safe place now
- Take the survivor to a private place away from other patients
- Ask the survivor if she wants to have a specific support person present
- Explain the steps of any actions you are about to undertake

2.4.3 First Line Supportfor intimate partner and sexual violence against women

2.4.3.1 General Considerations

- All health care providers should be able to provide basic First Line Support to VAW survivors;
- First-line support provides practical care and responds to the survivors' needs.
- VAW survivors undergo psychological distress, some immediately, while others may suffer in the short or long term;
- Respect privacy and confidentiality of the survivor.

2.4.3.2 Providing First LineSupport[20]

First Line Support involves 5 simple tasks: *Listen, Inquire about needs and concerns, Validate feelings, Enhance Safety and Support her.* This is the most important care you can provide. Even if this is all you can do you have greatly helped the patient. First Line Support helps people who have been through various upsetting or stressful events, including women subjected to violence. Remember you are not responsible for solving the survivor's problems, and the survivor's right to make her own decision and her privacy and confidentiality should be respected at all times.

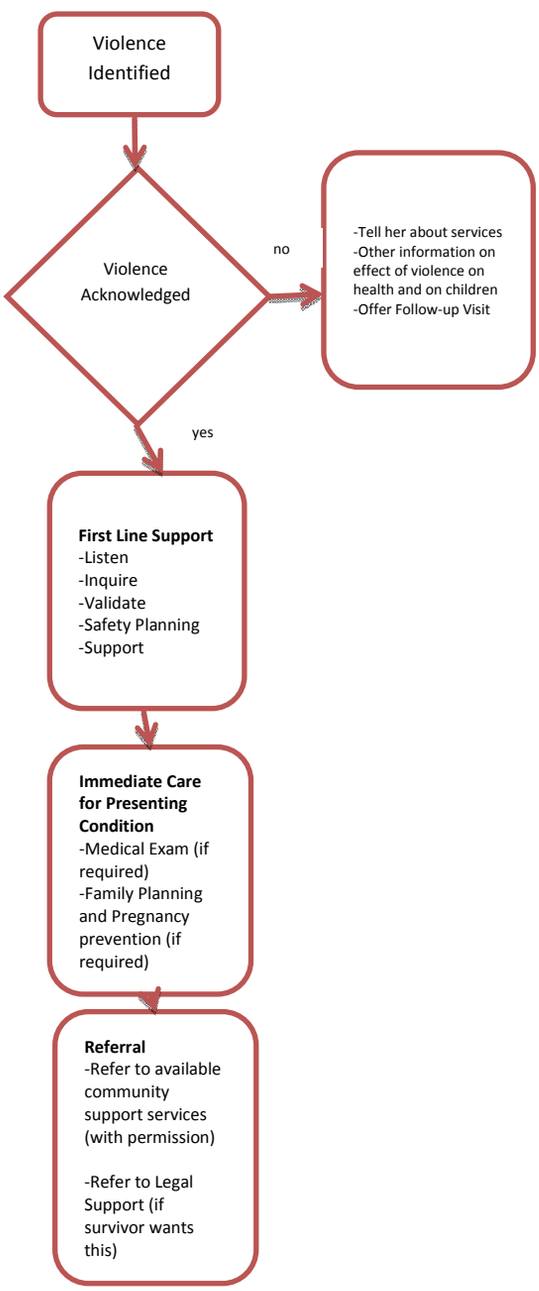
You do not need to:

- Solve her problems;
- Convince her to leave a violent relationship;
- Convince her to go to any other services such as police or courts;
- Ask detailed questions that force her to relive, the painful events;
- Pressure her to tell you her feelings or reactions to an event

[20] WHO Draft Clinical Handbook for Care of Intimate Partner Violence and Sexual Violence Against Women

Listen	Listen to the woman closely, with empathy, and without judging
Inquire about needs and concerns	Assess and respond to her various needs and concerns, emotional, physical, social and practical*
Validate (Believe)	Show her that you believe her. Assure her that she is not to blame
Enhance Safety	Discuss her plan to protect herself from further harm if violence occurs again.
Support	Support her by helping to connect her to information, services and social support

*Remember you are not responsible for solving her problems



2.4.4 Additional care for survivors of intimate partner violence

In addition to First Line Support survivors who report intimate partner violence should be provided the following:

2.4.4.1 Physical Examination, Treatment of Injuries and Documentation

Immediate medical care should be provided to the survivor based on the injuries experienced. The health care provider should follow standard protocol for treatment for physical injuries. Injuries should be documented in a patient file and maintained. If the injuries are more serious the woman should immediately be referred to a higher level facility.

2.4.4.2 Information on Intimate Partner Violence including its impact on women

Resource materials should be available such as posters or pamphlets that describe the impact of intimate partner violence. A key caution is that the victims' safety should be considered when taking any information outside the facility, as this may put her at higher risk of intimate partner violence (i.e. if partners suspects women has disclosed the violence).

Safety Assessment and Planning

- Has the physical violence happened more often or gotten worse in the last 6 months?
- Has he used a weapon or threatened you with a weapon?
- Has he tried to strangle you?
- Do you believe he could kill you?
- Has he ever beaten you while you were pregnant?
- Is he violently and constantly jealous of you?

If a woman answers yes to at least 3 of these questions she may not be safe to return home. She should be referred to a safe place such as a friends' home or as safe shelter

Figure 1:*Pathway for care for violence by intimate partner*

Adapted from Draft Clinical Handbook for Care of Intimate Partner and Sexual Violence Against Women

2.2.4.3 Family Planning and Pregnancy Prevention

Many survivors of intimatepartner violence have unmet need for contraception. They often have a partner and are at risk for unintended, unplanned or mistimed pregnancy. For this reason, health centers should do the following:

- Explore current family planning status including current method used and whether the survivor needs it.
- Provide family planning counseling and a contraceptive method as needed. Make a referral if the facility is not able to provide the FP method selected

2.2.4.4 Referral to Community Resources

The Health Care provider can be a key contact point for referring survivors of intimate partner violence to other services such as legal authorities, police, or community resources. A key element is to ensure her safety, and the safety of her children. Referrals should be provided but the survivors' right to refuse should be respected.See 2.8 below for key referral sources.

2.4.5 Additional care for adult survivors of rape or sexual violence

In addition to First Line Support, survivors of rape or sexual violence should be provided the following:

- Information about medical examination, forensic examination and reporting to the police
- Get *informed consent* and take *history*
- Complete *Physical Examination*
- *Treat any physical injuries*
- *Counsel on risk of STI and HIV and offer Testing and Preventive Treatments* including Emergency contraception, treatment against sexually transmitted (infections), and post-exposure prophylaxis (PEP) against HIV infection
- Referral to services
- Provide resource materials and information

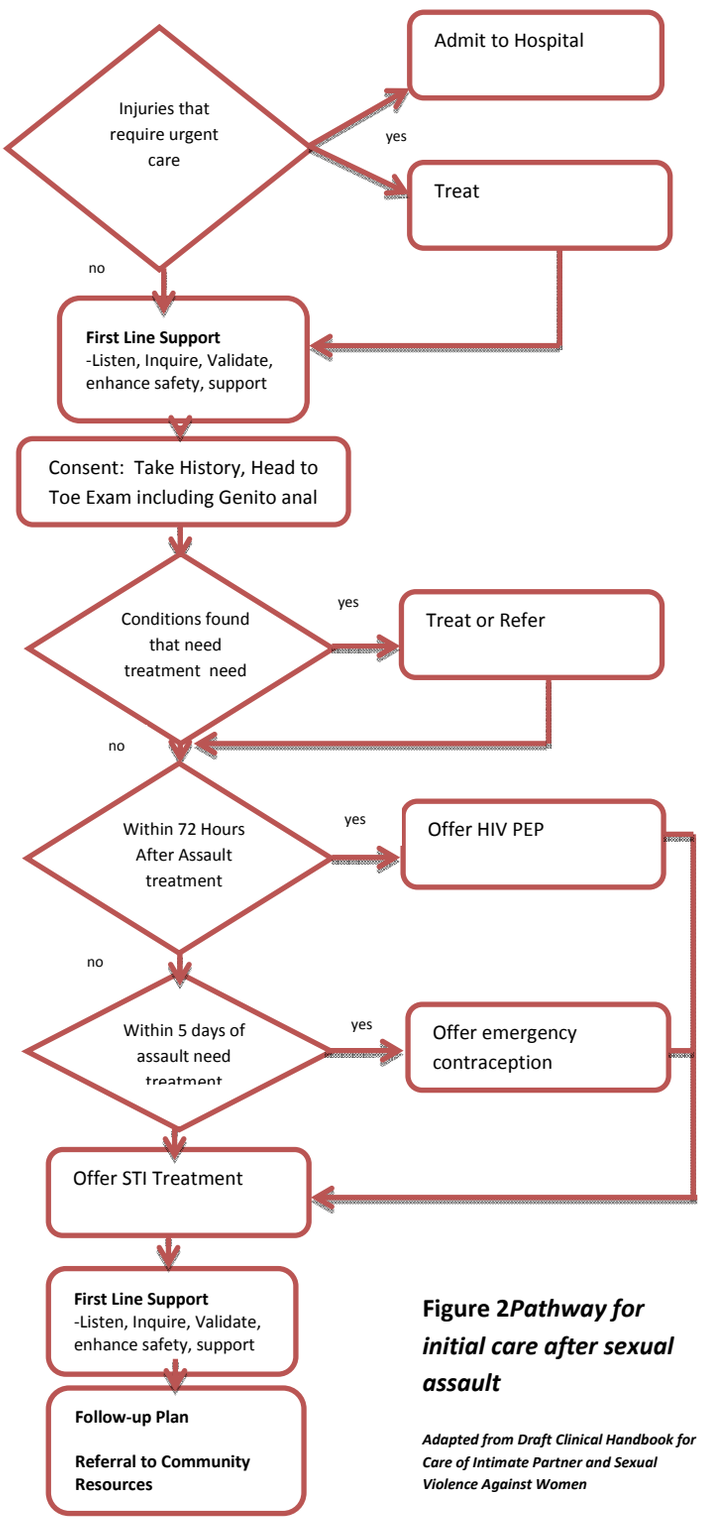


Figure 2*Pathway for initial care after sexual assault*

Adapted from Draft Clinical Handbook for Care of Intimate Partner and Sexual Violence Against Women

2.4.5.1Informed Consent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent is obtained. In practice, obtaining informed consent means explaining all aspects of care to the survivor. It is crucial that the patient understands the options open to her and she is given sufficient information to enable her to make an informed decision about her care. The health

care provider shall inform the rape or sexual violencesurvivor that she can refuse any part of the examination or treatment.

In the consent process, the health care provider shall:

- Provide information on the medical consequences related to rape or sexual violence, including the risk of an STI, HIV and pregnancy;
- Provide information on availability of Emergency Contraception and HIV testing;
- Explain to the survivor the health provider's role in treating her and the importance of documenting the medical examination for the survivor's records;
- Explain the procedures for gathering forensic evidence and that any evidence gathered may be used to provide evidence in court;
- Explain adequately the medical aspects of VAW;
- Other consequences of VAW will be explained by the police, CCWC Focal Point, MoWA Judical Police and the legal system

If rape or sexual violence has been perpetrated on the victim, it is best practice to refer to the a Referral Hospital immediately for more comprehensive treatment and preventive care *even* if the patient chooses not to have the Forensic Medical Examination. *However the adult patient has the right to decline.*

The survivor's decision to consent to either A, B, or C shall be respected:

Level of Consent (Care)	**Location of Service**
A) Physical examination Only (includes medical exam and pelvic exam)	-Referral Hospital Preferred with CPA 1, CPA 2 or CPA 3 -Health Center can provide treatment for basic injuries, some preventive treatments and referral to community based services only
B) Physical examination, including collection of evidence (Forensic Medical Exam)	Provincial Referral Hospital ***Immediate transfer to a Referral Hospital that provides the Forensic Examination*** (if needed stabilize injuries)
C) Physical examination, including collection of evidence (Forensic Medical Exam) and turnover of evidence to Police	Provincial Referral Hospital ***Immediate transfer to aReferral Hospital that provides the Forensic Examination*** and ***Refer to the Police*** (if needed stabilize injuries)

The Forensic Medical Examination must be completed at a Referral Hospital because it has the authority to issue a Medical Forensic Certificate.

2.4.5.2History Taking

Do not force a woman to talk about the assault if she does not want to. In all cases limit questions to what is required for medical care. However if a woman wants to talk about what happened, listen empathetically and allow her to talk

2.4.2.1Generalinformation

- Name address, residence, telephone number, sex date of birth (or age in years)
- General health
    - Tell me about your general health?
    - Have you seen a doctor or nurse recently?
    - Have you been diagnosed with any illnesses
    - Have you had any operations?

- Do you have any infectious diseases?
- Do you have any allergies?
- Are you currently taking any medications?

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

2.4.2.2 Descriptionoftheincident

It is important that the health care provider understands the details of what happened in order to check for possible injuries:

- Describe what happened and note the date, time and place.
- Obtain information about the perpetrator (male, female, age, location)
- When did the assault take place?
- Was there penetration (oral, vaginal or anal?)
- Did the assailant use physical or psychological force?
- Did the assailant use physical object? How many assailants were there?
- Was it a single assault or was it repeated over hours or days?
- Did the survivor lose consciousness, and was the assailant known to the survivor?
- What did the survivor do after the incident? Ask if the survivor bathed, urinated, vomited, etc. since the incident. This may affect the collection of forensic evidence.

Explain that learning what happened will help you give the best care. Assure her that you will keep what she says private unless she wants the police to take her case

Avoid blaming questions like "What were you doing there alone or Why did you…?"

2.4.2.3GynecologicHistory

- Obtain the date of the first day of the last menstrual period.
- Obtain history on prior sexual encounters, as well as whether they were consensual. Find out if the survivor has a sexual partner (s).
- Determine the last time the survivor had sexual intercourse prior to the incident.
- Determine if the survivor has had an STI before and if she was treated.
- Determine if the survivor has ever tested for HIV and her HIV status.
- Determine if the survivor has been pregnant before. If so what was the outcome.
- Determine if the survivor uses contraception. If so, the type, since when they have used it and whether they have used it consistently.

2.4.5.3 PhysicalExamination

2.4.5.3.1 GeneralConsiderationsforPhysicalExamination

- If the consent is for the physical examination only and not for collection of Forensic Evidence some elements are not required.
- At each step of the exam explain what is going to happen and regularly ask if she has any questions. The clinician should examine the survivor systematically.
- The survivor should be informed that at any point during the physical examination, she can ask the provider to stop.
- The examination should be done, from head to toe, paying special attention to the face, upper limbs, neck, breasts, thighs, and perineum.
- The survivor should be provided treatment for physical injuries.

Before every step of the examination explain what you are doing and exactly what will be happening

- The survivor should be provided Emergency Contraception if of reproductive age.
- The survivor should be provided PEP if at risk for HIV. Survivors at risk of HIV are defined below in Section 2.7.3.

Additional considerations if evidence is collected for Forensic examination

- Specimens collected for forensic examination shouldbe put in a paper bag. If the survivor is going to be undressed, she can do this over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs hat would support her information about the assault or violence.
- The examination is best done under natural light. However, there are special lamps that can be used to see injuries better, such as woods lamp or UV light.
- At the same time obtain smears from the skin, oral mucosal, external and internal vagina and rectum and collect urine and blood samples systematically.
- Legally if specimens are collected (urine, semen, and other evidence in general), they should be sealed appropriately and signed and delivered to the lab by certified personnel to preserve the chain of evidence.
- All findings should be recorded on the Forensic Medical Examination Form.

2.4.5.3.2 Head to Toe Examination

- Note the general appearance of the survivor
- Take vital signs
- Examine the upper limbs for any signs of injuries
- Inspect the face, eyes and ears
- Examine the scalp for any injuries and signs of inflammation
- Examine the neck for bruises and life-threatening assaults
- Examine the breasts and trunk for bites or other injuries
- Do abdominal and chest examinations for any internal injuries/pregnancy
- Examine the lower limbs thoroughly
- *If doing the forensic medical exam collect any specimens as you examine the survivor as described above*

2.4.5.3.3Genital and Anal Examination

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

- Examine the external genitalia
- Examine the labia and other related structures

Additional procedures if evidence is collected for Forensic examination

- Take all the swabs, in the following order, external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swabs. The other swabs are oral swabs for secretor factors in cases where oral sex is implicated and skin swabs when a suspicious seminal stain is present on the skin.
- Do speculum and digital examinations (under no circumstances should this be done prior to taking the swabs).
- Obtain pubic hair and any other pieces of physical evidence that maybe be seen in the genitalia
- Document any wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration)

2.4.5.4Laboratory Investigations

The common laboratory test for VAW survivors of sexual assault may include Voluntary Confidential Counseling and Testing for HIV (VCCT), pregnancy tests, urinalysis and screening for STIs, but additional tests can be done according to the clinicians' opinion and procedures for the health facility.

2.4.6TreatmentofVAWSurvivors'

2.4.6.1 GeneralConsideration

- All VAWsurvivors should be treated as an emergency and should not be allowed to wait;

2.4.6.2 Physical Injuries

- Refer severe conditions for emergency treatment;
- Treatless severe physical injuries according to standard protocols;

With any physical injuries resulting in breach of the skin and mucous membranes, immunize with 0.5 mls of tetanus toxoid according to the schedule in the table below.

Dosing Schedule	Administration Schedule	Duration of Immunity conferred
1st TT Dose	At first contact	Nil
2nd TT Dose	1st month after 1st TT	1-3 years
3rd TT Dose	6 months after 2nd TT	5 years
4th TT Dose	1 Year after 3rd TT	10 years
5th TT Dose	1 Year after 4th TT	20 years

Tetanus toxoid should be given to all survivors of sexual violence (all sexes and all ages) if there are any physical signs of injuries to the skin and/or mucous membranes.

2.4.6.3 PreventiveTreatments

2.4.6.3.1 Guidelines for Prevention of HIV

Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. PEP is recommended for women and children at risk of HIV infection. Talk to the woman or child (parent/guardian) about whether HIV PEP is appropriate in their situation. You should consider PEP if:

- The perpetrator is HIV-infected or unknown status;
- The woman is not known to be HIV positive;
- The woman has been exposed to blood or semen;
- The woman has experienced oral, vaginal and/or anal penetration;

Guidelines for PEP should be based on the current national guidelines for HIV and AIDs management. Remember the longer it takes to start administering this preventive measure for HIV, the lower the efficiency of the procedures.

- PEP should be initiated within 72 hours.
- HIV pre- and post-test counseling should be done before and after the HIV test is done, respectively.
- If test is negative give PEP for 28 days; provide adherence counseling for PEP before administering the drug; inform the survivor that PEP only reduces the changes of acquiring HIV; inform the survivor about potential side effects, how to deal with them, including that they will diminish with time.
- If the result is positive, discontinue the PEP, as this shows survivor had HIV prior to VAWincident and refer appropriately.
- Blood should be monitored for Hemoglobin, Alanine Amino Transferase and Spirate Amino Transferase.

2.4.6.3.2GuidelinesforPregnancyPrevention

A woman or girl under 18 that has started menses who has been raped is likely to worry if she will get pregnant. The health care provider should ask if she has been using an effective contraceptive method

such pills, injectable, implants, IUD or female sterilization. If so it is not likely she will get pregnant. If she has not been using effective birth control, Emergency contraceptive (EC) should be offered to non-pregnant, females of child bearing age.

- A baseline pregnancy test should be done first, though this should not delay the dose of EC
- EC is most effective when given within 120 hours (5 days) of assault
- Another pregnancy test should be given 6 weeks after the incident at the follow-up visit, whether or not they took EC after the rape.

Alternative EC Regimes and Doses

Progestin only pills	Prostinor 2	1 Tab 12 hours apart (total 2 tabs) or 2 tabs at one time
Progestin only pills (1.5 mg Levonorgestrel)	NorLevo	1 Tab (single dose)
Combined oral contraceptive pills with high dose of oestrogen (50 µg)	Euginon	2 Tabs 12 hours apart (total 4 tabs)
Combined oral contraceptive pills with low dose of oestrogen (30 µg)	Nordette Microgynon	4 Tabs 12 hours apart (total 8 tabs)

Note: The Survivor can be given any of the above three regiments.

2.4.6.3.3 Prevent Sexually Transmitted Infections

Women who have been sexually assaulted should be given antibiotics and treat the following sexually transmitted infections (STIs) – chlamydia, gonorrhea, trichomonas, and if common in the area syphilis.

- Offer treatment immediately
- These is no need to test for STI before treating
- Give preventive antibiotic treatment for STIs

Drugs used for STI Prophylaxis

Non-pregnant adults	Norfloxacin	800 mg Stat
	Doxycycline	100 MG BD one week
Pregnant women	Spectimonycin	2 g Stat
	Amoxycillin + Probenicid	3 g Stat 1 g Stat
	Erxthroycin	500mg QDS one week
Children	Amoxycillin	15 mg/kg TDS one week
	Erythomycin	10 mg/kg QDS one week

2.4.7 Follow-up Care and Referral

2.4.7.1 Follow-up care

Healthcare providers shall use guidelines for each treatment to plan follow-up after examination and treatment. Time-sensitive treatments should be followed-up based on the schedule of the treatment

The survivor should be referred to additional medical and legal resources based on the individual treatment plan of the survivor.The survivor should be made aware of services based on the individual needs of the survivor.

2.4.7.2 Referral of Survivors for Legal Intervention and Multi-Sectoral Services

It is usually not possible for the health care provider to respond to all the survivors needs. She might need time to make decisions. All referrals to legal or Community Services and Supports should be voluntary and with the consent of the adult survivor.

Tips for Giving Referrals

Be sure that the referral meets her most important needs and concerns

If she expresses problems with going to a referral help her think about ways to solve the problems

If she accepts referral make it easier for her

Tell her where to go, the address, how to get there and who she will see

Offer to make an appointment for her

2.4.7.3 Legal Response

The right of the survivor to request legal intervention should be respected. If the survivor chooses to report the crime and seek legal intervention, the options for reporting are to the:

- Commune Police
- District Anti-Trafficking Police
- District Military Police
- Village Chief, Commune Chief
- Judicial Police Officer of MoWA
- Prosecutor at the Provincial Court

2.4.7.4Other Community Services and Supports for VAW Survivors

Experts have identified that women and children survivors of violence require a myriad of resources and supports based on their individual situation and the type of violence experienced. These services can include crisis services, psycho-social support and counseling, aftercare and rehabilitation, and re/integration.

Some services are provided by the Government and some services by NGOs. The Health Care Facility should collect resources available in their province, district or commune on the available referral resources. It is best to have formal referral agreement with service providers and a system for how the survivor obtains the service.

Some examples of services are:

Commune Committee on Women and Children (CCWC) Focal Point for Women and Children: The Focal Point for Women and Children is responsible for responding to and referring women and children that have experienced violence to government or community resources.

District Department of Social Affairs Veterans and Youth Rehabilitation (DoSVY): The District DoSVY social Worker can assist with re-integration of a woman back into the community if she has been in residing in safe shelter.

District Department of Women's Affairs (DoWA): The District DoWA staff can help to refer survivors to services for VAW including to the Judicial Police for legal advocacy at the Provincial DoWA.

Safe Shelter: Some NGOs provide safe shelter for women and children who are victims of VAW. Shelter is usually provided in a central location and survivors can stay for extended periods of time. Shelters typically provide other supportive services such as counseling, legal information, support and advocacy, vocational training, and re/integration services.

Legal Information, Support and Advocacy: Legal information, support and advocacy are provided by the MoWA Judicial Police Agents (Provincial Level), and some NGO service providers. This can be in the form of information, representation or advocacy and support as the survivor goes through a legal process.

Psycho-social counseling and emotional support: A range of psycho-social counseling and emotional support is provided. Some NGOs specialize in different types of psycho-social counseling such as individual or group counseling, and others as a part of other services.

Economic Empowerment: Both NGOs and government ministries such as the Ministry of Labor and Vocational Training and Ministry of Women's Affairs (MoWA) offer vocational training for women survivors, targeted to promoting economic empowerment. Some is offered on site at NGO shelters, others are stand-alone services.

Re-integration: For women and children that have been in safe shelter or residential care some NGOs, and Ministry of Social Affairs Veterans and Youth Rehabilitation (MoSVY) offer services to help the survivor re-integrate back into their home community or another community.

2.4.8 Documentation

The healthcare provider shall:

- Complete necessary paperwork, including the VAWdocumentation forms;
- The healthcare provider is responsible for safe custody of the documentation forms, medical records and forensic specimens; and
- Health care providers should ensure proper documentation and safe keeping of medical records for purposes of security and for future use.

3- RESPONDING TO VIOLENCE AGAINST CHILDREN (VAC) IN THE HEALTH SYSTEM

3.1Guiding Principles

Ensuring safety: All actions taken on behalf of a VAC survivor shall be aimed at restoring or maintaining health and safety and not placing the child at greater risk of violence.

Respect and dignity for the survivor: VAC survivor's opinions, thoughts, and ideas shall be listened to and treated with respect regardless of age. Survivors should be treated with respect and not experience "blame the victim" attitudes. Children and adolescents have a right to participate in decision-making that impacts their lives based on their level of maturity and age.

Privacy and Confidentiality:At all times the privacy and confidentiality of the survivor and their families shall be respected. Services should be provided in quite, private easily accessible rooms near toilets. Information about survivors should be collected, used, and stored in a confidential manner.

In a small facility or where there is limited space, healthcare providers shall create a private space to ensure privacy and confidentiality. VAC survivors' identify should not be shared or discussed in any meeting inside or outside of the health facility without the survivor's permission. This means sharing only the necessary information as agreed by the survivor with those involved in providing medical assistance. Any discussion of the case for medical consultation should leave out the person's identity. Disclosure of medical information may be allowed with the survivor's consent to:

- Other treatment providers involved in the care of the survivor;
- The person in charge at the court or police if the survivor; and
- Other people requested by the survivor.

If mandatory reporting is required for cases of VAC under local law, inform the child and caregiver immediately.

Non-discrimination:All survivors are equal and shall be treated the same and have equal access to services. There shall be no discrimination or different treatment for anyVAC survivor based on gender, ethnicity; religion; disability, social class, or other factors.

Consent: Consent shall be obtained for specific procedures and services. Options for consent shall be explained to the non-abusing parent or guardian and the VAC survivor based on age and level of maturity See Consent and History Taking. The non-abusing parent or guardians survivor's decision to consent to either a, b, or c shall be respected.

d) Physical examination and treatment only
e) Physical examination, treatment and forensic examination
f) Physical examination, treatment, forensic examination, police investigation and legal justice

3.2 Integrating VAC Services into Existing Health Services

Comprehensive management of VAC survivors at different levels of the healthcare system demands minimum standards for staffing, health care facility settings, materials, equipment, drugs, medical supplies and administrative supplies.

3.2.1 National Health Infrastructure

Ministry of Health (MoH) is responsible for health policy and planning, while facilitating multi-sectoral coordination and external aid.**Provincial Department of Health (PDOH)**is tasked with connecting the central MoH to the operational districts through the implementation of policies in the health sector plan via the annual operations plan. ***Operational Districts (OD)*** are based on population and cover a population

of 100,000 to 200,000 population and comprise referral hospital and a network of health centers. ODs therefore act as the primary entry point of the population into the health system through their service delivery. ***Health Centers*** are geographically located to serve a catchment area of between 8,000 and 12,000 people. Services include initial consultations and primary diagnosis, emergency first aid, chronic disease care, maternal and child care (including normal delivery), birth spacing advice, immunization, health education and referral. ***Referral Hospitals*** are located at the National Level, the Provincial Level and the Operational District Level. The Referral hospitals are expected to support primary care and have resources and expertise available for health centers. There are 3 Complementary Package of Activities (CPA)s at referral hospitals, CPA1, CPA2 and CPA3. CPA 1 Referral Hospitals have no large scale surgery, but have basic obstetric service; CPA2 has emergency care and large scale surgery; and CPA3 have all services at CPA 1 and 2, and have specialize services such as blood transfusions, , ear nose and throat, and others.

3.2.2 Key Entry Points for VAC Survivors

Key entry points for survivors of VAC survivors in the health system are:

- Emergency Departments
- Antenatal Care, Neonatal Care and Postnatal Care Services
- Emergency Obstetric and Newborn Care Services
- Child Immunisation Services
- Child Nutrition Programs
- Voluntary Confidential and Counseling and Testing (VCCT)
- Prevention of Mother-to-Child Transmission (PMTCT)

3.3 Minimum Standards for Management of VAC Survivors

3.3.1Minimum Package of Services

The minimum package of services that all health care facilities should provide is:

- Reception and First-Line Support;
- Ensuring confidentiality and obtaining informed consent for selected medical and forensic procedures;
- Immediate clinical management (history taking, physical exam), treatment for all injuries that the health facility has the capacity to treat;
- Provision of or immediate referral for HIV Post Exposure Prophylaxis (PEP within 72 hours) (in case of sexual violence);
- Provision of or immediate referral for Sexually Transmitted Infection Screening and Treatment (in case of sexual violence);
- Provision of or immediate referral for Emergency Contraception (EC) (in case of sexual violence);
- Provision of or an immediate referral for a Forensic Exam (based on consent of Survivor and Non-abusing Parent or Guardian Consent)
- Referral of survivors to higher level facilities for additional medical care; and
- Referral to other services available for VAC such as psycho-social support, safe shelter, legal, aftercare or rehabilitation, reintegration or other services.

3.3.3.1 Response Available at Different Health Care Provider Levels

Responses	Health Center	Referral Hospital CPA1	Referral Hospital CPA2	Provincial and National Referral Hospital CPA3
Receive and triage for appropriate care	√	√	√	√
Provide first-line support ensuring confidentiality	√	√	√	√
Take history, obtaining consent and undertake examination using forms		√	√	√
Manage minor injuries	√	√	√	√
Manage major injuries			√	√
Provide Post Exposure Prophylaxis (PEP)				√
Provide Emergency Contraception (EC)	√	√	√	√
Provide Tetanus Toxoid Vaccinations (TT Vaccination)	√	√	√	√
Treat STIs	√	√	√	√
Psycho-social services				
Establish good interpersonal relationship with survivor	√	√	√	√
Link survivor with other VAC Services	√	√	√	√
Follow Up	√	√	√	√
Forensic Services				
Collect and document findings from forensic-related investigations		√	√	√
Document findings related to forensic history and physical examinations		√	√	√
Complete Forensic Medical Examination Form		√	√	√
Referrals and Linkages				
Refer complications to higher level facilities	√	√	√	√
Educate, orient, and provide information about other VAC services	√	√	√	√

3.3.2 Minimum Medical and Administrative Supplies by Level of Provider

Health Center	Referral Hospital
Medical Supplies and Medications	
-Supplies and equipment for preventing and controlling infections -Sterile stitches and dressing trays -Sanitary supplies -Pregnancy test kits -Syphilis test kits -Tetanus Toxoid -Analgesics -Local Anesthesia for suturing -Antibiotics -Emergency contraception -Treatment of STIs	Supplies at Health Center Plus -Post Exposure Prophylaxis (PEP) (CPA 3) For Forensic Exam *Forensic Exam Kit that includes:* -Syringe -Speculum -Empty sterile bottles -High vaginal swab -Paper bags for storing clothing -Digital Camera (if possible) -Lubricant -Additional clothing, sanitary pads or other comfort supplies -Materials to work with children including puppets, toys, paper and colour pencils
Administrative Supplies	
Consent Form VAW/C Medical Form Resource and Referral Information	Consent Form VAW/C Medical Form Resource and Referral Information Forensic Medical Examination Form

3.3.3 Minimum Training of Health Care Personnel

All health care facilities should provide a minimum package of services for VAC survivors listed below. In order to provide the minimum package of services health care providers should receive specialized training on:

- Relevant laws related to VAC;
- Dynamics of VAC and challenges with disclosure;
- Signs and symptoms of VAC;
- Engaging Survivors and providing First-Line Support;
- Using Medical Protocols including providing post-exposure prophylaxis, emergency contraception and other health care services as required;
- Understanding and Conducting the Forensic Examination and Legal Requirements for Documentation (at the Referral Hospital Level);
- Knowledge and Referral to Community Resources;
- Using a child friendly approach; and
- Other topics as appropriate.

3.4 Guidelines for Management of Survivors of VAC in Health System

3.4.1 Identification of VAC

- Children that have experienced VAC are sometimes identified by voluntary disclosure by the child, by a report from a third party who witnesses or suspects the abuse. There is no universal reporting law on VAC, however, Cambodian law does require that crimes should be reported to the relevant authorities.
- In most cases, admission is recommended for sufficient time, depending on the condition of the survivor, to perform a thorough medical assessment and organize placement if necessary.
- The child survivor of VAC should be assessed in a separate room in a quiet child friendly environment.
- Involvement of the DoSVY social worker, and Police is important for investigations to start while the child is in a safe place.

Interviewing with Adult Present

If you suspect the person that has brought the child to the health facility is the abuser do not permit the person to be in the interview and examination.

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

You may suspect a child has experienced violence if she has any of the following:

Type of Violence	Physical Signs	Behavioral Signs
Physicalviolenceincludes many forms such as pinching, shoving, kicking, forcing children physical activity punishment (difficult work, kneeling, "exercise"), beaten by hand or with objects like a stick or whipping, burned or threated with a weapon.	- Unexplained bruises, cuts, burns or fractures, - Delayed treatment of injuries	- Avoids home - Inappropriate explanation of injuries - Wary of adult contact
Sexual Violenceranges from rape, unwanted touching, attempts at sexual contract, and non-contact sexual abuse including threats, luring and tricking into sexual contact, exhibitionism and verbal harassment. Sexual VAC also involves coercion into exploitative practices – particularly prostitution and pornography. Coercion includes children receiving gifts or favours in exchange for sexual activity.	- Unexplained genital injury - Vaginal or penile discharge - Difficulty walking or sitting - Pain on urination - Urinary Tract Infection - Anal complains such as pain, bleeding - Presence of Sperm - Pregnancy	- Regression in behavior - Problems in school, - Inappropriate sex behaviors - Acting out - Drug use - Suicide attempts - Threatened by physical contact - Depression - Low Self-Esteem
Emotional violence or abuse is any behavior that is designed to control and subjugate another person through the use of fear, humiliation, and verbal or physical assaults. It can include anything from verbal abuse and constant criticism or intimidation, manipulation	- Rare	- Self-comforting behaviors such as sucking, rocking or biting - Self-injurious behaviors such as cutting in adolescents - Anti-social or destructive behavior - Substance abuse - Developmental Delays
Neglectis the inability to provide for children's basic needs. Neglect may be intentional or from the lack of resources to care for the children.	- Always hungry - dresses inappropriately - poor hygiene - unattended medical or educational needs - delayed physical development	- Regularly tired or falls asleep - Begs or steals food or other basic items such as clothes - Frequently misses school - Extreme need for affection - Developmental delays

3.4.2 Receiving the VAC Survivor

a child has disclosed violence, he or she is often more concerned about the reaction of the person they are disclosing to than his or her physical injuries. The healthcare provider shall provide services with compassion and support and show concern about the well-being and safety of the child. The first response to a child disclosing abuse can often make a significant difference. **Immediately refer patients with life-threatening or severe conditions for immediate emergency treatment.**

3.4.3 Providing First Line Support to Children

First Line Supportfor children involves a few simple tasks: *Listen, Belief, Inquire about needs and concerns, Enhance safety, Ensure confidentiality, and Support.*[21]This is the most important care you can provide. Even if this is all you can do you have greatly helped the patient. First Line Support helps people who have been through various upsetting or stressful events, including children subjected to violence. Remember you are not responsible for solving the survivor's problems and the child's privacy and confidentiality should be respected at all times.

[21] Adapted by UNICEF from First Step and WHO Guidelines

Listen	**Listen to the child closely, with empathy, and without judging;** allow the child to express his/her emotion in his/her own time
Believe	**Reassure the child that you believe him/her and take it seriously.** Assure the child that he/she is not to blame. Offer reassurance and support by using statements such as:" You were very brave to talk about this"; "I am glad you are telling me about this"; "I am sorry that this happened to you";"I will do everything I can to help you"
Inquire about needs and concerns	Assess and respond to various needs and concerns, emotional, physical, social and practical*
Enhance Safety	If there is an immediate risk of safety, ask the child what he/she needs to make him/her feel safe.
Ensure confidentiality	Respect the child's right to confidentiality and not tell other people who do not need to know. Only make promises that can be kept. Do not agree, for instance, to keep what the child said a secret. Explain, in such a case, that some secrets must be shared in order to get help, or to keep people from being hurt. Tell the child the information will be shared only with people who are trying to give help and protection.
Support	Encourage the child to access support from safe people who might be helpful. Support the child by helping to connect him/her to services and social support

3.4.4Consent and History Taking

3.4.4.1 General Considerations

Every effort should be made to minimize the number of times the child is interviewed. If a facility has a socialworker he/she should be present during the interview.

- Introduce yourself to the survivor.
- For adolescents, they should be asked if they want to be alone or with a trusted adult. Ask if the child survivor wants to have a specific support person present.
- Limit the number of people allowed in the room during the examination; if others are present, explain their role and get permission from the child survivor.
- Explain in a language that the child survivor can understand that he/she is in control of the pace, timing, and components of the examination.
- Reassure the survivor that the examination findings will be kept confidential (or what will happen to the results).
- Explain what is going to happen during each step of the examination – why it is important, what it should tell you and how it will influence the care you provide.
- Have the survivor/guardian/parent sign the consent form.
- After the consent form is signed undertake the examination as soon as possible.
- Do not force the child to do anything against his/her will.
- Keep identifying yourself as a helping person.

3.4.4.2 Informed Consent for Children

Prior to conducting a physical examination on a child, the health care provider shall explain to the child (and his/her parent) the process of care and treatment, including the interview and medical examination. Consent for each part of the healthcare and treatment shall be obtained at every step. For a child survivor, a consent form is signed by the child's parent or caregiver, unless the child's parent is the suspected abuser. If the parent is the suspected abuser, a consent form may be signed by a representative from the health facility.

The most crucial aspect in consent, however is while legally children cannot give consent to examination and services, they shall not be compelled or forced to undergo an examination or treatment unless it is necessary to save the life of the child.

- Children 16 years old and older are generally sufficiently mature to provide significant input to in decisions.
- Children between 14 and 16 are presumed mature enough to make a contribution by sharing their views related to decision-making.
- Children between 8 and 14 can meaningfully participate in the decision-making procedure but maturity must be assessed on an individual basis.
- Children younger than 9 have the right to give their opinion and be heard. They may be able to participate to a certain degree, but caution shall be advised to burdening them by giving them the feeling of having to take responsibility for making decisions.
- Ultimately, however the recommendation is that the views of the child shall be weighed and decision on a case by case basis depending on his/her age, level of maturity, and developmental stage and cultural, traditional and environmental factors and that the best interest of the child should be most important in all decisions.

Consent regarding children and adolescents occur at three levels:

A. Consent for medical management only
B. Consent for medical management and forensic management
C. Consent for medical management, forensic management and police referral.

Child Friendly Communication Guide

Taketimetogettoknowthechild;establish rapport with the child by discussion things other than the reason for their visit (e.g. school, hobbies, siblings); adaptyourstrategyaccordingtoage(playwithyoungerchildren;drawandtalkwitholder children and adolescents).

Adjustyourselftoheightofthechild(sit so you are not higher than the child to talk to them, getdownandplayonfloorwithveryyoungchildren,sitonfloororonalowchair withyoungchildren,etc.)

Wordsmaynotalwaysworkwithchildren;findalternativewaysofcommunicating(drawing,artmaterials,playing);discovertheformofcommunicationthatworksbestwiththechild.

Somechildrenfeelmorecomfortable withcaregiversbeingpresentinthero omuntilthechilddevelopstrustinyou.

Neverrushachildtoexpresshim/herself;it is common for children to give a small piece of information first to see how adults react and provide more details when they feel safe;alwaysbesurvivor-centeredandallowthechildtoexpresshimself/herselfinhis/herowntime.

Alwaysgivethechildnecessaryinformationinanage-appropriatemanner;avoidkeepinginformationfromthechild.

34.4.3 History-taking for Children

History-taking is not the same as interviewing the child about allegations of abuse. History taking is to gather information for medical treatment, and to collect forensic examination. Ideally, history should be obtained from a caregiver, or someone who is acquainted with the child, rather than the child directly, however this might not always be possible. Older children, particularly adolescents are often shy or embarrassed when asked to talk about matters of a sexual nature. It is a good idea to ask if the child wants an adult or parent present. Adolescents tend to talk more freely when alone.

When gathering information from a child, start with a number of general non-threatening questions before moving on to cover the potentially more distressing issues.

- “What grade are you in school?”
- “How many brothers and sisters do you have?”

If possible the detailed History Taking below should be completed. But the minimum obtained should be the questions in the ***Essential Medical History for Children***

3.4.4.3.1 Generalinformation

- Name address, residence, telephone number, sex date of birth (or age in yeas)
- General health
    - Tell me about your general health?
    - Have you seen a doctor or nurse recently?
    - Have you been diagnosed with any illnesses
    - Have you had any operations?
    - Do you have any infectious diseases?
    - Do you have any allergies?
    - Are you currently taking any medications

3.4.4.3.2 DescriptionoftheIncident

It is important that the health care provider understands the details of what happened in order to check for possible injury:

- Describe what happened and note the date, time and place.
- Obtain information about the perpetrator (male, female, age, location).
- When did the assault take place?
- Was there penetration (oral, vaginal or anal?)
- Did the assailant use physical or psychological force?
- Did the assailant use physical object? How many assailants were there?
- Was it a single assault or was it repeated over hours or days?
- Did the child lose consciousness, and was the assailant known to the survivor?
- What did the child do after the incident? Ask if the child has bathed, urinated, vomited, etc. since the incident. This may affect the collection of forensic evidence.

Essential Medical History for Children

The following pieces of information are essential for medical history:

- When did this happen? When is the first time you remember it happening? Young children do not have an accurate sense of time
- Threats that were made to you?
- What area of your body was touched or hurt?
- Do you have any pain in your bottom or genital area?
- Is there any blood in your underwear or in the toilet?
- Any difficulty or pain with voiding or defecating?
- First menstrual period and date of last menstrual period (for girls)?
- Details of prior sexual activity (explain why you need to ask about this)
- History of washing or bathing since the assault (if it was sexual)

3.4.4.3.2GynecologicHistory (For post-pubertal children)

- Obtain the date of the first day of the last menstrual period.
- Obtain history on prior sexual encounters, as well as whether they were consensual. Find out if the survivor has a sexual partner (s)
- Determine the last time he/she had sexual intercourse prior to the incident if sexually active;
- Determine if the child has had an STI before and if she/he was treated.
- Determine if the child has ever tested for HIV and her/his HIV status.
- Determine if the child has been pregnant before. If so what was the outcome.
- Determine if the child uses contraception. If so, the type, since when they have used it and whether they have used it consistently.

3.4.5Physical Examination

3.4.5.1 Head to Toe Examination for Children

The physical examination of children can be conducted according to the procedures outline for adults in section 3.6.2 above (Head to Toe Examination).

- Note the general appearance of the child
- Take vital signs
- Record the height and weight
- Examine the upper limbs for any signs of injuries
- Inspect the face, eyes and ears
- In the mouth/pharynx note petechial of the palate or posterior pharynx, and look for any tears to the frenulum;
- Examine the scalp for any injuries and signs of inflammation
- Examine the neck for bruises and life-threatening assaults
- Examine the breasts and trunk for bites or other injuries
- Record the child's sexual development and check the breasts for signs of injury.
- Do abdominal and chest examinations for any internal injuries/pregnancy
- Examine the lower limbs thoroughly
- *If doing the forensic medical exam collect any specimens as you examine the survivor as described above*

3.4.5.2 The Genito-Anal Examination for Girls (if sexual assault or rape)

Remember that in most cases, a speculum exam is not indicated. It is only indicated when the child may have internal bleeding arising from a vaginal injury as a result of penetration. Explain the procedure to the child, providing details of each step.

- Examine the external genitalia
- Examine the labia and other related structures
- In this case, a speculum examination should be done under general anesthesia if possible;
- Examine the anus, look for bruises tears or discharge. Help the child lie on her back or on her side;
- For small girls, a pediatric speculum is recommended.

Whenever possible do not conduct a speculum exam on girls who have not reached puberty. It might be very painful and cause additional trauma.

3.4.5.3 The Genito-Anal Exam for Boys (if sexual assault or rape)

- Check for injuries to the skin that connects the foreskin to the penis;
- Check for discharge at the urethral meatus (tip of penis);
- In an older child, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child;
- Examine the anus. Look for bruises, tears, or discharge. Help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated;
- Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

3.4.6 Laboratory Investigations

Laboratory investigations are done to help address medical problems as a result of the violence and to collect evidence. The forensic evidence may be used for medical and legal

3.4.6.1 Laboratory investigations for clinical management of the survivor

- Urine
    - Urinalysis-microscopy
    - Pregnancy Test
- Blood

- HIV Test
- Haemoglobin Level
- Liver Function Tests
- VDRL

3.4.6.2 Laboratory investigations for Forensic Medical Examination

- Urine analysis for epithelial cells;
- High vaginal swab for evidence of spermatozoa

3.4.7 Treatment

3.4.7.1 Treatment of Physical Injuries

- All VAC survivors should be treated as an emergency and should not be allowed to wait;
- Refer severe conditions for emergency treatment;
- Treatless severe physical injuries according to standard protocols;

With any physical injuries resulting in breach of the skin and mucous membranes, immunize with 0.5 mls. of tetanus toxoid according to the schedule in the table below.

Dosing Schedule	Administration Schedule	Duration of Immunity conferred
1st TT Dose	At first contact	Nil
2nd TT Dose	1st month after 1st TT	1-3 years
3rd TT Dose	6 months after 2nd TT	5 years
4th TT Dose	1 Year after 3rd TT	10 years
5th TT Dose	1 Year after 4th TT	20 years

Tetanus toxoid should be given to all survivors of sexual violence (all sexes and all ages) if there are any physical signs of injuries to the skin and/or mucous membranes.

3.3.7.2 Preventive Treatments

Based on age, individual experience of the child and if she is menstruating, children should also be provided preventive treatments for injuries, HIV, STIs, and pregnancy prevention.

3.3.7.2.1 Guidelines for Prevention of HIV

Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. PEP is recommended for children at risk of HIV infection. Talk to the woman or child (parent/guardian) about whether HIV PEP is appropriate in their situation. You should consider PEP if:

- The perpetrator is HIV-infected or unknown status;
- The child is not known to be HIV positive;
- The child has been exposed to blood or semen;
- The child has experienced oral, vaginal and/or anal penetration;

Guidelines for PEP should be based on the current national guidelines for HIV and AIDs management. For children the same drugs can be used but must be given according to weight and/or surface area. Remember the longer it takes to start administering this preventive measure for HIV, the lower the efficiency of the procedures.

- PEP should be initiated within 72 hours.
- HIV pre- and post-test counseling should be done before and after the HIV test is done, respectively.

- If test is negative give PEP for 28 days; provide adherence counseling for PEP before administering the drug; inform the survivor that PEP only reduces the changes of acquiring HIV; inform the survivor about potential side effects, how to deal with them, including that they will diminish with time.
- If the result is positive, discontinue the PEP, as this shows survivor had HIV prior to VAC incident and refer appropriately.
- Blood should be monitored for Hemoglobin, Alanine Amino Transferase and Spirate Amino Transferase.

3.3.7.2.2 GuidelinesforPregnancyPrevention

A girl under 18 that has started menses who has been raped is likely to worry if she will get pregnant. The health care provider should ask if she has been using an effective contraceptive method such pills, injectable, implants, IUD or female sterilization. If so it is not likely she will get pregnant. If she has not been using effective birth control, Emergency contraceptive (EC) should be offered to non-pregnant, females of child bearing age.

- A baseline pregnancy test should be done first, though this should not delay the dose of EC
- EC is most effective when given within 120 hours (5 days) of assault
- Another pregnancy test should be given 6 weeks after the incident at the follow-up visit, whether or not they took EC after the rape.

Alternative EC Regimes and Doses

Progestin only pills	Postinor 2	1 Tab 12 hours apart (total 2 tabs) or 2 tabs at one time
Progestin only pills (1.5 mg Levonorgestrel)	NorLevo	1 Tab (single dose)
Combined oral contraceptive pills with high dose of oestrogen (50 µg)	Euginon	2 Tabs 12 hours apart (total 4 tabs)
Combined oral contraceptive pills with low dose of oestrogen (30 µg)	Nordette Microgynon	4 Tabs 12 hours apart (total 8 tabs)

Note: The Survivor can be given any of the above three regiments.

3.3.7.3.3 Prevent Sexually Transmitted Infections

Childrenwho have been sexually assaulted should be given antibiotics and treat the following sexually transmitted infections (STIs) – chlamydia, gonorrhea, trichomonas, and if common in the area syphilis.

- Offer treatment immediately
- These is no need to test for STI before treating
- Give preventive antibiotic treatment for STIs

Drugs used for STI Prophylaxis

Children	Amoxycillin	15 mg/kg TDS one week
	Erythomycin	10 mg/kg QDS one week

3.4.8FollowupCare,andReferral

3.4.8.1 Follow Up Care

After the examination, diagnosis and treatment health care providers should:

- Plan follow-up with the child survivor based on time sensitive treatments.

- Make a referral and follow-up plan for the child to obtain police and legal services
- Refer the child survivors to other services.
- Follow-up on medical, legal and forensic evidence

3.4.8.2 Referral of Survivors for Legal Intervention and Multi-Sectoral Services

3.4.8.2.1 Legal Response

A child that has experience VAC should be reported to the local authorities (respecting confidentiality). The options for reporting the crime are to the:

- Commune Committee for Women and Children
- Commune Police
- District Anti-Trafficking Police
- District Military Police
- Village Chief, Commune Chief
- DoSVY Social Worker
- Judicial Police Officer of MoWA
- Prosecutor at the Provincial Court

In serious cases when the family or care-takers of the children have been confirmed to be or are the suspected perpetrators, the child may not be able to return to the family. In those cases, family-based solutions should be sought as a first option and residential care should be avoided and only used as a last option and for short periods of time.

3.3.8.2.2 Other Community Services and Supports for VAC Survivors

Experts have identified that women and children survivors of violence require a myriad of resources and supports based on their individual situation and the type of violence experienced. These services can include crisis services, psycho-social support and counseling, aftercare and rehabilitation, and re/integration.

Some services are provided by the Government and some services by NGOs. The Health Care Facility should collect resources available in their province, district or commune on the available referral resources. It is best to have formal referral agreement with services providers and a system for how the survivor obtains the service.

Some examples of services are:

Commune Committee on Women and Children (CCWC) Gender Focal Point: The Focal Point for Women and Children is responsible for responding to and referring women and children that have experienced VAW/C to government or community resources.

District Department of Social Affairs Veterans and Youth Rehabilitation (DoSVY): The District DoSVY social Worker can assist with placement of a child into alternative care and re-integration back into the community.

District Department of Women's Affairs (DoWA): The District DoWA staff can help to refer survivors of VAC to services for VAC including to the Judicial Police for legal advocacy at the Provincial DoWA.

Safe Shelter: Some civil society organizations provide safe shelter for women and children who are victims of VAC. Shelter is usually provided in a central location and survivors can stay for extended periods of time. Shelters typically provide other supportive services such as counseling, legal information, support and advocacy, vocational training, and re/integration services.

Legal Information, Support and Advocacy: Legal information, support and advocacy are provided by the MoWA Judicial Police Agents (Provincial Level), and some NGO service providers. This can be in the form of information, representation or advocacy and support as the survivor goes through a legal process.

Psycho-social counseling and emotional support: A range of psycho-social counseling and emotional support is provided. Some NGOs specialize in different types of psycho-social counseling such as individual or group counseling, and others as a part of other services.

Economic Empowerment: Both NGOs and government ministries such as the Ministry of Labor and Vocational Training and Ministry of Women's Affairs (MoWA) offer vocational training for women survivors, targeted to promoting economic empowerment. Some is offered on site at NGO shelters, others are stand-alone services.

Re-integration: For women and children that have been in safe shelter or residential care some NGOs, and MoSVY offer services to help the survivor re-integrate back into their home community or another community

3.4.9Documentation

The healthcare provider shall ensure that the necessary

- Complete necessary paperwork, including the VAW/C documentation forms;
- The healthcare provider is responsible for safe custody of the documentation forms, medical records and forensic specimens; and
- Health care providers should ensure proper documentation and safe keeping of medical records for purposes of security and for future use.

4-QUALITYASSURANCE

4.1 QualityAssuranceProcedures

Quality assurance plays an important role in medical services to VAW/C survivors. The purpose is to ensure that VAW/C survivors receive effective and comprehensive response. Continuous monitoring of VAW /C service provision is required. The Health Facility Management is responsible to carry out quality assurance procedures.

1) Regularly Review of the Processes and Documentation:

Health care providers including doctors, nurses and midwifes providing care should review each survivor's VAW/C Consent and Documentation Form and ask the following questions:

- Did healthcare providers use standardized forms?
- Did healthcare provider fill in the forms correctly and completely?
- Did health care providers do tests as per the standards and record the samples taken?
- Did health care providers perform the examination as per the standards?
- Did health care providers administer treatments as per the standards (including EC and PEP)?
- Did healthcare providers counsel as per the standards?
- Did healthcare providers make referrals as per the standards?
- Is there a signed consent form by the survivor (or guardian) in the file? Are other required signatures in the file (from those in possession of evidence or collected it for analysis or for onward transmission to the police/court?
- How was the evidence obtained, sealed, and preserved?
- Was there a chain of custody in place?
- Who documented the injuries and how was this documented?
- Who has custody of the medical and laboratory reports?

2) As a team the Health Facility should discuss the weaknesses and develop an action plan to address them.

3) Meet regularly with VAW/C service providers such as police, court, NGOs, to solve problems and identify gaps and resources in services. Ask for feedback on quality of services.

4) Regularly conduct satisfaction evaluations with survivors asking if they were satisfied with the services and what they liked or did not like.

ANNEX1:CONSENTFORM

Name ofFacility:_____

I……..authorize the above namedhealthfacilitytoperformthefollowing:

	Yes	No
Conductamedicalexamination,includingpelvicexamination.		
Collectevidence,suchasbodyfluidsamples,collectionofclothing, haircombings,scrapingsorcuttingoffingernails,bloodsamples,a ndphotographs.		
Provideevidenceandmedicalinformationtothepoliceandlawco urtsconcerningmycase;thisinformationwillbelimitedtotheresu ltsofthisexaminationandanyrelevantfollow-upcareprovided.		

If minor child list minor's name _____

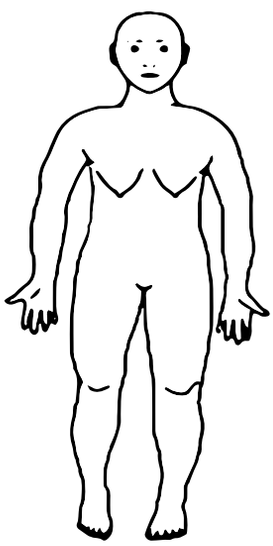
Signature:_____ Date: _____

Witness: _____Date:_____

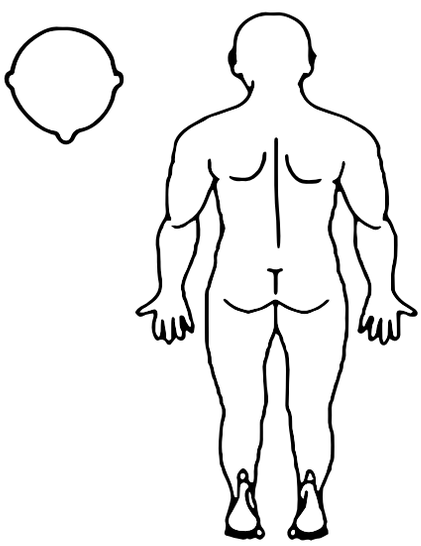
ANNEX2:PICTOGRAM

Sketch of person

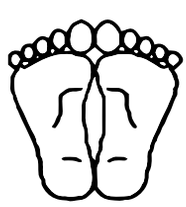
Antertor view



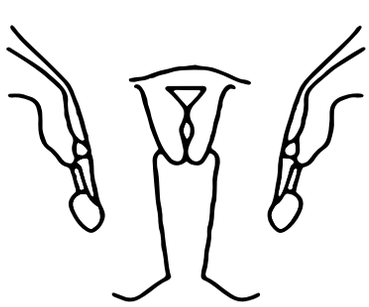
Posterior view

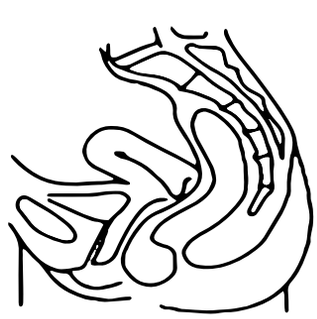


Comments

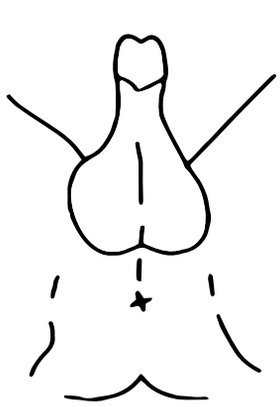


Female Genilalia





Male Genitalia



ANNEX3:VAW/C DOCUMENTATION FORM

GENERAL INFORMATION	Name of Health Facility:
Family Name:	Survivor Registration Number:
First Name:	Parent or Guardian Name (if child)
Date of Birth (MM/DD/Year)	Marital Status: Single ☐ Married ☐ Divorced ☐
Sex: Male ☐ Female ☐	Residence:
Occupation:	Contact Number:
Witness (if any)	Other contact information:

THE INCIDENT

Survivor's Description of the Incident:

PhysicalViolence	**Yes**	**No**	**Describetypeandlocationonbody**
Type(beating,biting,pullinghair,etc.)			
Useofrestraints			
Useofweapon(s)			
Drugs/alcoholinvolved			

Penetration	**Yes**	**No**	**Notsure**	**Describe(oral,vaginal,anal,typeofobject)**
Penis				
Finger				
Other(describe)				
	Yes	**No**	**Notsure**	**Location(oral,vaginal,anal,other)**
Ejaculation				
Condomused				

MEDICAL HISTORY

Afterthe incident, did the survivor	**Yes**	**No**		**Yes**	**No**
Vomit?			Rinsemouth?		
Urinate?			Changeclothing?		

Defecate?			Washorbath?		
Brushteeth?			Usetamponor pad?		

Contraception use					
Pill		IUD		Sterilization	
Injectable		Condom		Other	

Menstrual/obstetrichistory	
Lastmenstrualperiod (dd/mm/yy)	Menstruationat timeofevent Yes☐
Evidenceofpregnancy Yes☐ No☐	Numberofweekspregnant _____weeks
Obstetrichistory	

History ofconsenting intercourse(only if sampleshave beentakenforDNAanalysis)		
Lastconsentingintercoursewithinaweekpriortot heassault	Date(dd/mm/yy)	Nameofindividual:

Existing healthproblems
History offemalegenitalmutilation,type
Allergies
Currentmedication

Vaccinationstatus	**Vaccinated**	**NotVaccinated**	**Unknown**	**Comment**
Tetanus				
HepatitisB				

HIV/AIDSStatus	Known	Unknown

MEDICAL EXAMINATION
Appearance(clothing,hair,obviousphysical or mentaldisability)
Mentalstate(calm,crying,anxious,cooperative, depressed, other)

Weight:	Height:	Pubertalstage(pre-pubertal,pubertal,mature):

Pulserate:	Blood pressure:	Respiratoryrate:	Temperature:

Physical findings

Describesystematically,anddrawontheattachedbodypictograms,theexactlocationofallwounds,bruises,petechial, marks,etc.Documenttype,size,colour,formandotherparticulars.Bedescriptive,donotinterpretfindings.

Headand face	Mouthand nose
Eyesandears	Neck
Chest	Back
Abdomen	Buttocks
Armsandhands	Legsandfeet

GENITAL AND ANAL EXAMINATION

Vulvas/scrotum	Introitusand hymen	Anus
Vagina/penis	Cervix	Bimanual/recto vaginalexamination

Positionof patient(supine, prone, knee-chest,lateral, mother'slap)

Forgenitalexamination:	Foranalexamination:

TREATMENT	Yes	No	Type and Comments
STIPrevention/treatment			
Emergencycontraception			
Woundtreatment			
Tetanusprophylaxis			
HepatitisBvaccination			
Post-exposureprophylaxisfor HIV			
Other			

Any other medication/treatments given?	
Laboratory Investigations	**Comments**
Urine Pregnancy Test	

Microcscopy	
Other	
Vaginal Swab – Sperm	
Culture and Sensitivity	
Blood	
DNA	
VDRL	
Hepatitis B surface antigen	
Full blood picture	
Hemoglobin (HB)	
X Matching	
Blood Chemistry	
Serological test for HIV	
Anal Swab	
Other	
REFERRALS AND FOLLOW-UP	

Generalpsychologicalstatus	
Survivorplans to report to policeORhasalreadymadereport Yes ☐ No☐	
Survivorhas a placeto go to Yes ☐No☐	Hassomeonetoaccompanyher/him Yes ☐No ☐
Counselingprovided:	
Referrals	
Follow-uprequired	
Name of Doctor: _____ Position: _____	Date: _____

ANNEX 4 COMMUNITY RESOURCES

Type of Resources	Services Provided	Location	Contact Information
Safe Shelter			
Crisis Center			
Financial Support or Aid			
Legal Aid or Information			
Psycho-social support			
Mental Health Care			
Primary Health Care			
Income Generation Support			
Other			

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