Health Sector Response to GBV

National Guideline on providing care and prevention for Health Care Providers

Health Protection Agency
Ministry of Health

Supported by:

UNFPA

National Guideline on providing care and
prevention For Health Care Providers

By
Health Protection Agency
United Nations Population Fund in Maldives

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Foreword

Gender-based violence (GBV) is increasingly being recognized around the world as a grave challenge for public health and development and as a violation of human rights. This gross act causes substantial mortality and morbidity due to mental, physical, sexual and reproductive health impacts, leading to increased risky behavior. Sadly, despite the fact that GBV and interpersonal violence are preventable, we have not been able to eradicate these atrocious acts from communities.

GBV is a breach of the fundamental right to life, liberty, security, dignity, equality between men and women including non-discrimination and physical and mental integrity. While GBV is directed against both women and men, the prevalent risk factors, patterns and consequences of violence reinforce inequalities between men and women. This fact is reinforced in the land mark study (Women's Health and Life Experiences Study) conducted in the Maldives in 2004 that revealed that 1 in 3 women aged 15-49 have experienced some form of physical or sexual violence at some point in their lifetime. The violence in the said study portrayed intimate partner violence, sexual violence by family members, colleagues at work and strangers as well as childhood sexual abuse.

Health Sector's role and its response to gender based violence is therefore very important. It is the health care providers who can safely identify and effectively treat survivors of violence, confidentially document cases, provide necessary referrals to needed services and support. It is of utmost importance that the security/protection sector, the legal/justice sector and the health sector to work together within a well-coordinated mechanism to reduce the harmful impacts and prevent further injury, trauma and harm. Therefore, holistic and collaborative efforts must be taken to engage the community to challenge the discriminatory norms and stigmatize attitudes that perpetuate violence. Platforms and guidelines must be created to meaningfully respond to survivors immediate and long-term needs and reintegrate them back into society as confident people capable of managing themselves if the need so arises.

Development of this practical guide and manual for health care managers is in that sense a very important step towards improving the health care response to violence against survivors. It is designed to help entire organizations or clinics to improve their response to gender based violence. The guide focuses on information that managers might need to develop feasible and appropriate strategies, policies and evaluation plans, as well as the guidance it provides for the individual health care professionals to care for survivors are noteworthy.

I take this opportunity to call upon on health care professionals and managers to make full use of this manual and guide; and be a partner to end gender based violence. My appreciation goes to those organizations, institutions and individuals who have contributed towards eliminating GBV and who continue to be engaged in this cause. It is with utmost gratitude that I acknowledge the significant role played by UNFPA (United Nations Population Fund in the Maldives) in facilitating generous technical and financial support from the initiation of this project; which resulted in this document. This this regard, UNFPA's commitment to eliminating GBV in the Maldives is greatly appreciated.

I am also very appreciative of the contributions made by Indira Gandhi Memorial Hospital, Faculty of Health Sciences, Family Protection Authority and Maldives Police Services who kindly came onboard and shared their expertise in this area. A great deal of credit must go to the rest of the stakeholders who were involved in the various meetings and workshops while developing this document.

Ministry of Health and Gender envisions that survivors of GBV/DV will be provided with secure and supportive environment through appropriate support and sheltering services and safely guide them towards a better and a hopeful future.

Dr. Mariyam Shakeela
Minister of Health and Gender
April 2014

Message from UNFPA Country Director

UNFPA, the United Nations Population Fund, advocates against gender-based violence as a human rights violation and a public health priority in line with the mandate entrusted to us by the Programme of Action of the International Conference on Population and Development (ICPD). As lead UN agency on sexual and reproductive health, UNFPA plays a vital role in addressing the health consequences of violence against women and girls which often have a long-lasting impact.

In the Maldives, UNFPA began its support towards addressing gender-based violence in 2002. In partnership with the Ministry of Women's Affairs and Social Security a qualitative study in 2004 on Gender based violence in the Maldives: What We Know So Far and the National Study on Women's Health and Life Experiences in 2007 were produced. These researches showed the prevalence of violence against women is a harsh reality for many women in Maldives. The survivors face severe or long lasting health consequences. As one such response, UNFPA supported the first ever government run Family Protection Unit at the Indira Gandhi Memorial Hospital established in August 2005 to provide one stop support to the survivors.

UNFPA now takes a multi sectoral approach in addressing gender-based violence in line with Domestic Violence Act (2012). Partnering with the Ministry of Law and Gender, the Health Protection Agency and the Family Protection Authority, UNFPA helps to integrate prevention and management of gender based violence including domestic violence. A key strategy is building capacity of the health sector to respond effectively to gender based violence survivors.

To this end, UNFPA provided technical support, under the leadership of the Ministry of Health to develop the National Action Plan for health sector response: Addressing Gender Based Violence including Domestic Violence in the Maldives; Report on the Health Sector Response to Gender-Based Violence Maldives: Training of Trainers Workshop on the National Guideline on Providing Care and Prevention and the Health Sector Response to Gender-Based Violence: National Guideline on Providing Care and Prevention For Health Care Providers.

UNFPA wishes to sincerely thank the technical team and the policy leaders in the Ministry of Health, Health Protection Agency and the panel of experts who have been instrumental in developing the resource package, and for the technical expertise provided by Dr Lakshmen Senanayeke.

Mr. Alain Sibenaler
UNFPA Country Director Maldives

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List of Abbreviations

A&E	Accidents and Emergency
AIDs	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
DNA	Deoxyribo Nucleic Acid
DV	Domestic Violence
EC	Emergency Contraception
FCSC	Family and Children Service Centre
FGM	Female Genital Mutilation
FP	Family Planning
FPA	Family Protection Authority
FPU	Family Protection Unit
GBV	Glenda Based Violence
HCP	Health Care Provider
HIV	Human Immune Virus
ICU	Intensive Care Unit
IGMH	Indira Gandhi Memorial Hospital
IPV	Intimate Partner Violence
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
PCU	Post Care Unit
PEP	Post Exposure Prophylaxis
PNC	Postnatal Care
PTSD	Post Traumatic Stress Disorder
RCH	Reproductive Child Health
SHE	Society for Health Education
STIs	Sexually Transmitted Infections
TT	Tetanus Toxoid
UK	United Kingdom
UN	United Nation
UNFPA	United Nation Population Fund
UNHCR	United Nations High Commission Refugees
USA	United States of America
WDC	Women's Development Committee
WHLE	Women's Health and Life Experience
WHO	World Health Organization

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Rationale and Objectives

1. **Why were the Guidelines developed?**

Gender –based Violence (GBV), which is a gender neutral term by definition, but affecting mostly women, and cutting across all strata of the society, widespread both in the developed and developing world and Maldives is no exception[1].

The land mark study (WHLE Study) conducted in 2004 showed that 1 in 3 women aged 15-49 have experienced some form of physical or sexual violence during their lifetime. This includes intimate partner violence, sexual violence by family members, colleagues at work and stress, as well as childhood sexual abuse.

One of the earliest responses from the Maldivian government was the setting up of a dedicated service point by the name of Family Protection Unit (FPU) at the Indira Gandhi Memorial Hospital (IGMH) by the Ministry of Gender with the collaboration of the Ministry of Health, IGMH and the UN Agencies in 2004. Although it was started as a pilot project initially, it continues to provide the services to survivors of GBV, both women and children, as the single state supported center[2] dedicated for survivors of GBV. This exercise included training and sensitization of staff with a development of a comprehensive guideline for the functioning of the FPU[3].

Incorporation of addressing GBV in the health policies such as Health Master Plan (2006- 2015)[4], and draft National Reproductive Health Strategy (2008-2010)[5] was an important component of the health sector response.

An assessment of the Health sector response to GBV in the Asia Pacific Region conducted by UNFPA in 2010 recognized the health sector response made by Maldives as significant among the countries in the Asia Pacific Region[6].

Although much progress was not made in the last few years, service provision was sustained at the FPU at IGMH with the services of two counselors being made available by the hospital on a permanent basis.

Another milestone in addressing GBV, the enactment of the Domestic Violence Bill 2012, generated

1 Emma Fulhu : Maldives Study on Women's Health and Life Experiences (WHLE), Published by Ministry of Gender and Family - ISBN 99915-95-01-5
2 Protocol for the FPA /IGMH
3 IGMH Guidelines and Protocols for responding to cases of gender-based violence or child abuse.
4 Health Master Plan 2006-2015. Ministry of Health, 2006
5 National Reproductive Health Strategy. Maldives (2005-2007). Ministry of Health, November 2004
6 Health Sector Response to Gender-based Violence an Assessment in the Asia Pacific region.
UNFPA, Asia Pacific Regional Office ISBN.978 974680 673 4 Published 2010

much interest in this issue and the Act recognized the importance of the health sector response in addressing GBV and defined the roles and responsibilities of the health care providers.

With the intention of enhancing the health sector response and to fulfill the obligations described in the Domestic Violence Act[7] A Plan of Action for the Health Sector was developed by the Ministry of Health and Gender in June 2013.

One of the crucial activities included in the said Plan of Action is the development of the National Guidelines for Health care providers in order to streamline and ensure a high quality health sector response in Maldives.

These national guidelines will support healthcare providers in providing high-quality and comprehensive services to survivors of GBV and also to prevent GBV in the community. The guidelines will provide medical providers with direction to manage GBV survivors.

This guideline is developed as a National document, its scope limited to the Health Sector, but, having in mind the possibility of being an integral component of a National Guideline for Maldives on addressing GBV in the country, covering all sectors, to be developed at a future date.

1.2. Whom are they intended for?

The guideline is intended to provide guidance to all categories of health staff, but primarily for Doctors, Nurses, and Primary health care workers considered as the health care providers directly involved in providing care to survivors of GBV as the first contact person in the health sector.

However the guideline will be a valuable resource for guidance to any other category of health staff such as physiotherapists, laboratory technicians who may have to provide supportive services to these persons.

This guideline will assist healthcare managers and programmers to understand the needs and plan the provision of GBV services in facilities and in the community.

With the guidance provided here, healthcare providers will be better equipped to handle the medical aspects of GBV care and referral to other services such as counseling, police or legal systems.

7 Domestic Violence Act : Act Number 3/2012

1.3. Objectives of the Guidelines.

The guidelines are designed to assist the health care providers to deliver holistic, effective, and comprehensive medical care, including emotional support to survivors of GBV, respecting their rights, needs and sensitivities.

1.4. Primary Objective.

To streamline and enhance the quality of the health sector response to survivors of GBV in order to enable the delivery of required interventions and conducting preventive activities by the Health care providers (HCPs) within the health sector.

1.5. Specific Objectives.

- To describe the roles and responsibilities delegated to Health care providers under the Domestic Violence Act Number 3/2012.
- To guide the HCPs to respond and assist the survivors in a uniform and effective manner within the health sector.
- To strengthen the medico legal services by updating the knowledge of the HCPs.
- To describe the referral pathways for providing services within the health sector, and the instruments for documentation and identify relevant non health service providers who could assist the survivors.
- To provide guidance on screening for GBV among care seekers in the health sector.
- To provide guidance on medical management of the survivors while adhering to ethical principles.
- To provide guidance on documentation, data management and research on GBV related issues.
- To understand the importance of guiding principles for helping survivors of sexual violence.
- To provide a basic understanding of international human rights provisions relating to gender-based violence, and identify national legal and justice mechanisms and services for protection to survivors.

GBV and Health

2.1 What is GBV

The term gender is not merely a biological concept, but a term indicating the incorporation of social norms inclusive of roles, responsibilities and expectations from, male and female members of the society, affecting them throughout their life in many different ways. It is also seen that some members of the society, mostly males, use these gender "norms" as a basis to perpetrate and justify violence, often sexual in nature, mostly on women. Such acts based on gender are collectively known as Gender –based Violence.

GBV violates most, if not all, human rights and affects Sexual and Reproductive Health:

- by limiting choices and decision making
- By curtailing the rights of women and girls across their life cycle to access RH, including FP services and safe abortion services where it is legal
- by limiting protection from STI and HIV and unwanted pregnancy
- By causing direct harm and mental health consequences

Gender based Violence is well recognized as a gross human rights violation, an issue cross cutting all components of reproductive health a major public health problem with social, cultural, legal, economic and psychological dimensions. It is not limited by any of the social, educational, cultural, religious or racial stratifications. It is mostly perpetrated by men on women affecting them throughout their life cycle leading to harmful, sometimes fatal, health and non-health consequences.

Gender based violence can be classified as physical, sexual, emotional/economical or social but there is a considerable overlap of the type of violence the woman experiences within the relationship, often resulting in the same survivor suffering many types of violence concurrently.

Specific forms of GBV such as intimate partner violence, female genital mutilation, rape may be predominantly seen to be perpetrated on a particular age group, but it is justifiable to say that women suffer from GBV from womb to tomb.

Root causes of GBV are gender discrimination and gender inequality, abuse of power by one group of the society, mostly men in this instance, and the lack of respect for human rights.

Along with root causes there are contributing factors are that perpetuate GBV or increase risk of GBV, and influence the type and extent of GBV in any setting.

The impunity with which many societies treat GBV is possibly the most important supportive factor for the propagation of this menace, and provides an "excuse and an escape route" for the perpetrator.

As the factors leading to GBV are complex and multiple it is essential to have a multi pronged response to address GBV with all sectors of the community and the state, participating and collaborating with each other.

The negative economic impact of GBV which is considerable, could be due to costs directly incurred because of domestic violence, including but not limited to medical expenses, crisis services, legal services and indirect losses which include impacts on the productivity and earnings of women who are abused, productivity loss from early death or days out of the workforce due to injury.

A national survey in USA showed that physical abuse alone in women undergoing intimate partner violence made them lose 7.2 days on average amounting to 8 million working days for the country and if women undergoing rape and stalking was added it amounted to 13.6 million days of productivity[8]

2.2. Definitions

2.2.1. Violence Against Women

The term violence against women means any act of gender based violence that results in or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

2.2.2. Gender –based Violence

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

8 National Center for Injury Prevention and Control CDC. Costs of Intimate Partner Violence Against Women in the United States. Atlanta (GA): Centers for Disease Control and Prevention; 2003.

Gender –based Violence

Any harm that is done against a person's will based on their gender and that has a negative impact on that person's physical and psychological health, development, and identity (UNHCR 2003)

2.2.3. Domestic violence

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

2.2.4. Intimate Partner violence

The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse[9].

2.2.5. GBV Response

The reaction and support of stakeholders in initiating strategies and activities towards supporting GBV survivors is called the GBV response.

2.2.6. Perpetrator:

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

2.2.7. Survivor

Survivor/victim is a person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred because it implies resiliency[10] and thus used in this document.

2.2.8. Sexual abuse:

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

9 Center for Disease Control and Prevention USA http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/definitions.html
10 Guidelines for Gender based violence in humanitarian settings IASC, http://www.humanitarianinfo.org/iasc/publications/asp

2.2.9. Sexual coercion

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

2.2.10. Sexual exploitation

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

2.2.11. Sexual harassment

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

2.2.12. Sexual violence

Sexual violence takes many forms, including rape, forced prostitution, forced pregnancy, forced abortion sexual exploitation and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that results, or is likely to result, in physical, psychological, and emotional harm.

2.2.13. Socioeconomic violence

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

2.2.14. Rape:

The invasion of any part of the body of the survivor by the perpetrator with a sexual organ or of the anal or genital opening of the survivor with any object or any other part of the body by force, coercion,

taking advantage of a coercive environment, or against a person incapable of giving genuine consent[11] (1998 Rome Statute of the International Criminal Court. Efforts to rape someone which do not result in penetration are considered attempted rape.

2.2.15. Marital rape

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

2.2.16. Female genital mutilation (FGM)

FGM comprises of all procedures that involve partial or total removal of the external female genitalia, or other injury inflicted to the female genital organs for non-medical reasons.

2.2.17. Forced marriage

An arranged marriage is usually against a woman's, a girl's, man's or a boy's wishes and, exposure or threat to expose to violent and/or abusive consequences if she/he refuses to comply.

11 1998 Rome Statute of the International Criminal Court. http://untreaty.un.org/cod/icc/STATUTE/99_corr/cstatute.html

2.3. Global and Regional Overview of Gender-Based Violence

GBV is a global pandemic and an estimated one in three women worldwide has been beaten, coerced into sex, or otherwise abused in their lifetime. According to the UN Population Fund, almost 50 percent of all sexual assaults worldwide are against girls 15 and younger.

Although statistics on the prevalence of violence vary, the scale is tremendous, the scope is vast, and the consequences for individuals, families, communities, and countries are devastating[12].

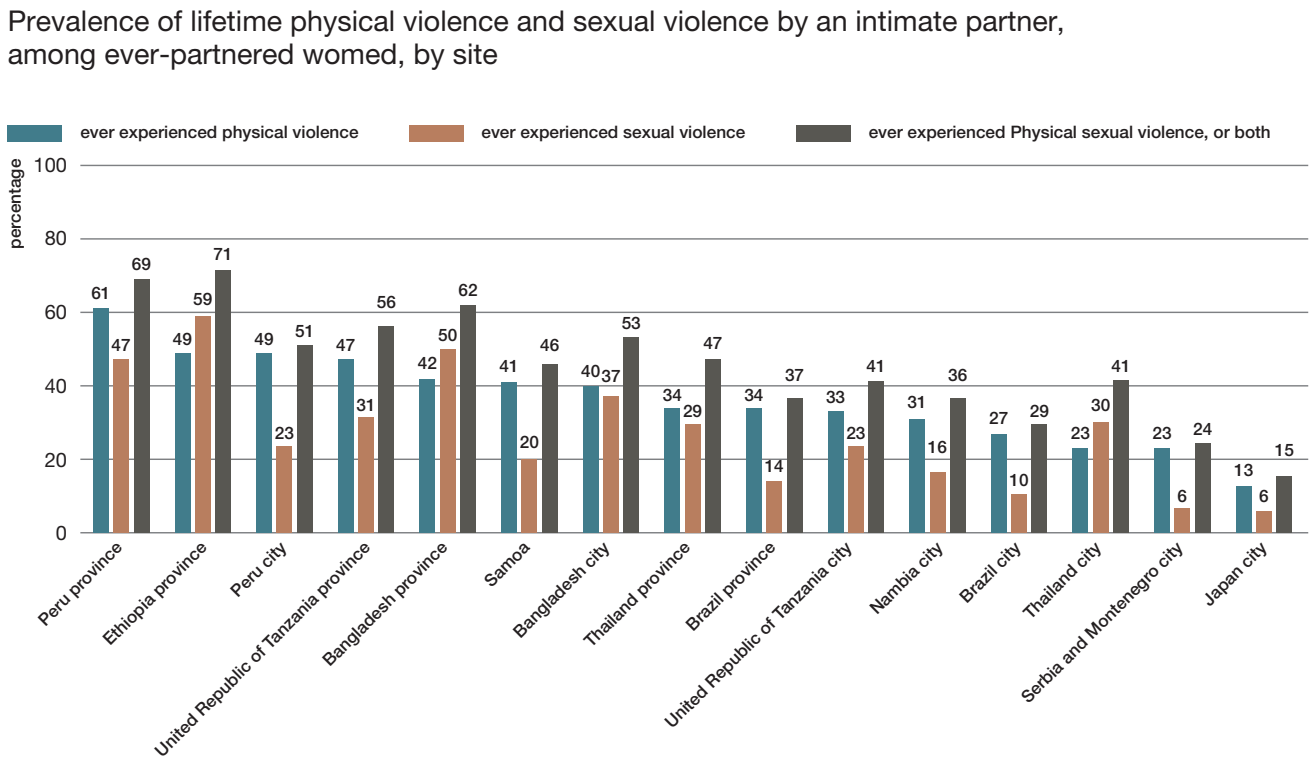


Figure 1 Prevalence of intimate partner violence. Source: WHO[13]

The WHO Multi Country Study which covered 24,000 women from low and middle income countries and from urban and rural settings[14] found that:indings showed a wide variation with Japan recording a low value 13% of and Peru recording a high value of 61% with most countries falling between 23% and 49%.

> "The beating was getting more and more severe….In the beginning it was confined to the house. Gradually he stopped caring. He slapped me in front of others and continued to threaten me…Every time he beat me it was as if he was trying to test my endurance, to see how much I could take"
>
> Woman, 27 year old graduate from Thailand

12 United States Strategy to Prevent and Respond to Gender-Based Violence Globally USAID http://www.usaid.gov/sites/default/files/documents/2155/GBV_Factsheet.pdf
13 Summary Report on Multi Country Study on Womens Health and Domestic Violence on women WHO Geneva2005
14 Claudia Gracia-Monero et al.WHO MultiCountry Study on Women's Health and Domestic Violence against Women WHO 2005

- The range of lifetime prevalence of sexual violence by an intimate partner was between 6% and 59% most falling between 10% and 50%.
- Sexual violence was usually accompanied by physical violence.
- Intimate partners who are physically or sexually violent also tend to have a highly controlling behavior.
- A pattern of increased violence among younger men was documented in Canada, USA, and several developing countries. This pattern may reflect in part the fact that younger men tend to be more violent.
- With regard to partnership status women who were separated, divorced generally reported a higher life time prevalence of all forms of violence than currently married women
- Women who were living with a partner but were not married reported a higher life time prevalence of violence than did married women.
- Lower educational level was associated with increased risk of violence in many sites. The protective effect of education does not appear to start until women achieve the very higher level of education i.e. beyond secondary education.
- There were significant differences between different countries not primarily attributable to socio-demographic variables.
- It is estimated that one in four women and one in eight men in Australia experience sexual assault during their lifetime, though many instances of sexual assault are never reported[15].

Regional situation

South Asia is home to 1.7 billion people, most populous and densely populated regions of the world with a marked diversity in terms of ethnicity, education, political and economic systems. Women's empowerment is low and they are subjected to many forms of GBV. The practice of antenatal sex selection, dowry related deaths, forced suicide of widows still occur despite the laws enacted by the respective governments to curb these practices. Honor and shame complexes with high value given for virginity and sexual purity contribute to domestic violence in many relationships. One of the higher rates of prevalence was recorded from Nepal where 80% of women reported psychological violence with 32% reporting physical violence and 10 % reporting sexual violence6

2.4. Situation in Maldives

The Women's Health and Life Experience Study conducted in 2004 in Maldives brought to light many facts on GBV in and was instrumental in highlighting the magnitude of the problem and served as a launching pad for a response from the state and other concerned organizations.

15 Medical Responses to Adults Who Have Experienced Sexual Assault : an Interactive Educational Module for Doctors The Royal Australian and New Zealand College of Obstetricians and Gynonaecologists

Key findings of the study were

- Approximately 1 in 5 women aged 15-49 (19.5%), who had ever been in a relationship, reported experiencing physical and/or sexual violence by an intimate partner.
- More than 1 in 4 ever-partnered women aged 15-49 (29.2%) reported experiencing emotional abuse by an intimate partner.
- Reports of intimate partner violence were highest in central and southern regions and lower in Male' and the North.
- Women were more likely to experience severe forms of physical partner violence such as punching, kicking, and choking or burning rather than just moderate partner violence.
- The experience of physical and/or sexual partner violence tends to be accompanied by highly controlling behavior by intimate partners.
- There was a significant overlap between physical and sexual partner violence with most women who reported sexual violence also reporting physical partner violence.
- Women who are younger (aged 25-29), have lower levels of education and have been separated or divorced appear to be at increased risk of partner violence.

Different types of violence suffered by women is given in Figure 2

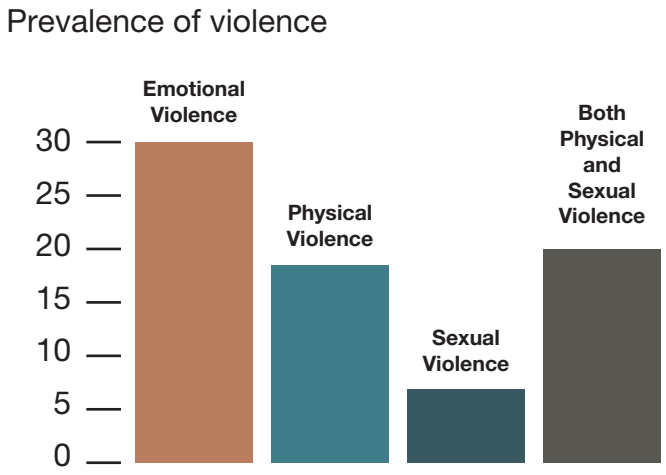


Figure 2 Percentage of women aged 15-49, who have ever been in a relationship; reporting different types of intimate partner violence1 Source WHLE

The level of non-partner violence at the national level was 13.2%. Similar to intimate partner violence, sexual violence was less common than physical violence in this group.

However, non-partner violence was generally found to be higher in Male' than in the atolls, which is the opposite finding in intimate partner violence.1

Childhood sexual abuse (sexual abuse before the age of 15) was found to be relatively common in the Maldives. At the national level, we found that 12.2% of women aged 15-49 had sexually abuse before the age of 15.1

2.5. GBV and providing Health Care

GBV is a major, but preventable problem affecting the health of individuals, mostly that of women. WHO document on Preventing intimate partner violence[16] ,while accepting that other approaches such as human rights approach, approach through gender perspective ,and criminal justice approach are important components , different and overlapping in addressing GBV ,the public health approach which is a science driven, population based, intersectoral possibly is the most effective and successful in primary prevention of GBV.

> "Physical or sexual violence is a public health problem that affects more than one third of all women, globally …….
>
> These findings send a powerful message that violence against women is a global health problem of epidemic proportions"
>
> Dr. Margret Chan Director General
> WHO 2013

In addition health sector has a major and undisputable role in responding to survivors of GBV by providing medical, medico-legal and emotional support in collaboration with justice and social services.

Health care system is unique in that it provides multiple opportunities for women to interact with a HCPs at some point in their lives, as when seeking antenatal care, coming for the delivery bringing her child for check-up or immunization. Health Care providers (HCPs particularly those in some settings such as maternity care, outpatients departments(A & E) family planning services have a critical role to play in detecting, empathetically listening, caring and referring for relevant services.

In addition appropriate interventions by the HCPs can mitigate the potential long term and short term negative impacts both health and non-health of GBV. The WHO recognizes GBV as an important public health issue. As well as being a direct cause of injury, ill health and even death it affects women's health indirectly too, through unwanted pregnancies and their attended risks, unsafe abortion, mental health and suicidal ideation and sexually transmitted diseases including HIV/AIDS[17].

16 Preventing Intimate Partner Violence against Women; Taking action and generating evidence WHO and London School of Hygiene and Tropical Medicine 2010
17 Gender-Based Violence Edited by Geraldine Terry with Joanna Hoare Oxfam. http://policy-practice.oxfam.org.uk/publications/gender-based-violence-115394

2.6. Health consequences of GBV

Recent research suggest that health consequences are spread over a wide a range and of a greater magnitude than commonly perceived by the HCPs or the public.

Figure 3 attempts to illustrate this.

Figure 3 Magnitude of some health impacts *Source: WHO*[18]

Health consequences could cover a wide range and is given in Figure 4. Although we recognize them as different entities it should be noted that a survivor often suffers more than one health impact in a single act of violence or within a single relationship.

Health Consequences of Intimate Partner Violence (VAWG)

Physical	Sexual and Reproductive Health	Psychological and Behavioral	Fatal
Abdominal /Thoracic Injuries	Gynecological disorders	Alcohol and drug Abuse	AIDS related mortality
Bruises and welts	Pregnancy complications	Depression and Anxiety	Maternal mortality
Lacerations and abrasions	Miscarriages/low weight births	Eating and sleep disorders	Homicide
Fractures	Pelvic Inflammatory Disease	Feeling of shame and Guilt	Suicide
Eye injuries/blindness	Sexual Dysfunction	Phobias and panic disorders	-
Eardrum injuries/ deafness	STIs/HIV/AIDS	Physical activities	-

18 WHO Global and Regional estimates of Violence Against women . http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/index.html

Burns	Unwanted Pregnancy	Poor self esteem	-
Chronic pain syndrome	Unsafe Abortion	PTSD	-
Disability	-	Psychosomatic disorder	-
Gastrointestinal disorders	-	Suicidal behavior and self-harm	-
Fibromyalgia	-	Smoking	-
Reduced physical functioning	-	Unsafe sexual behavior	-

Figure 4 Health consequences of intimate partner violence Source WHO[19]

At an individual level, violence occurring in childhood and younger years, health impacts particularly on the mental health t may affect that individual and their family for the rest of their lives. This can lead to negative consequences in many spheres of life such as unsafe sexual practices, increased uptake of health –risk behaviors such as use of alcohol and illicit drugs and perpetration of intimate and sexual violence.

2.7.1. Health risk behaviors associated with child abuse

Childhood sexual abuse and witnessing domestic violence in both females and males is known to be associated with increased heath risks and health risk behaviors. Some of the known effects include

- Stuttering
- Sleep disruption
- School problems
- Being terrified
- Aggressive behavior toward others
- Delinquency
- Runaway episodes
- Suicidal ideation
- Alcohol/drug experimentation
- Continuation of violence in adult relationships
- Expansion of violence in the community

19 World Report on Violence and Health WHO Geneva 2002

2.7.2 Health risk behaviors associated with adults

GBV in adults, in addition to direct injuries and disability, can lead to a variety of health problems such as:

- Stress induced somatic complaints such as headache, backache, painful menstruation.
- Substance use and abuse.
- Lack of fertility control and use of contraception leading to unwanted pregnancy and unsafe abortion.
- Lack of personal autonomy leading to inability to negotiate safe sex and risking STIs and HIV/AIDS. Studies on HIV infected women show a higher incidence of intimate partner violence.
- Mental disorders, depression and anxiety.
- Post Traumatic Stress Disorder (PTSD).
- Sexual dysfunction which in turn aggravates the violence.
- Social Phobia.
- Women subjected to intimate partner violence is likely to report poor or very poor health, emotional distress and their children poor health and educational outcomes.

2.8. GBV and pregnancy

The proportion of women in the WHO Multi country Study reporting physical violence during at least one pregnancy varied markedly among countries and fell between 4% and 12%. These rates were not parallel to the overall rates of GBV indicating that the cultural values towards pregnancy within a particular community has an influence on the prevalence of GBV in pregnancy and in some communities violence may be less accepted than in others.

> “He (my husband) tied me up face down on a bed with woven rope. I was 8 months pregnant then…I had to stay like that for 4 hours. When he untied me, my hands and feet were swollen and cut. My tummy hurt really badly because I was tied face down…I cried. I had a still birth and the midwife told me that it was probably due to the violence from my husband”

In this study 13% to 50% said that they had been beaten even before the pregnancy.

A research done in UK showed that nearly one third of pregnant women who experienced violence were beaten for the first time in pregnancy.

The WHLE study in Maldives showed that among women who had ever been pregnant, 6.3% reported being beaten during pregnancy. Of those who reported being beaten, 39% had been punched or kicked in the abdomen. In most cases, women who were physically abused during pregnancy had been beaten prior to getting pregnant; however a significant number (38.3%) reported that the beating had actually started during pregnancy[20].

Adverse outcomes of pregnancy are related to:

- Direct effect battering
- Late entry to antenatal care
- Frequently repeated pregnancies, Lack of social support
- Tendency to follow risky behaviors alcohol abuse
- Depressive symptoms will influence the mother's perceptions, tolerance and the responses to onset of symptoms which in turn may potentially affect her health seeking behavior
- Recorded complications attributable to Domestic Violence during pregnancy include:
    - Abortions, both spontaneous and unsafely induced
    - Higher incidence of pre term labor, being more for severely abused women[21]
    - Abruption of the Placenta and ante partum haemorrhage
    - Pregnancy psychosis and depression. A prospective cohort study on post-partum depression found that of the 16% of women who had depressive symptoms, 40% had undergone Domestic Violence[22]
    - Low birth weight babies
    - Intra uterine deaths
    - Failure of breast feeding

The U.K confidential inquiry in to maternal deaths 2006-2008 found 11 deaths that were homicides and of them 7 women were killed by their partners and the report recommends "not to consider women who suffer from DV as low risk".

2.9. The survivor

Survivors (formerly known as victims) of GBV, mostly women, and a lesser number of men, come from all strata of society. Although association with some risk factors has been recorded it must not be erroneously considered as GBV being limited to these so called "at risk" groups.

20 The Report of the Task force on the Health Aspects of Violence Against Women and Children, March 2010.U.K
21 Shumway et al. journal of Maternal and Fetal Medicine 1999,8:76-80
22 Wool house H, Gartland D, British Journal of Obstetrics and Gynaecology 2011.doi: 10.1111/j.1471-528.2011.03219.x.

Survivors are:

- Often fearful of the partners
- Often not allowed to gain access to family, friends or get assistance by the perpetrator
- Often experience reduced freedom and/or when they exercise autonomy, there are abusive consequences
- Often feel guilty or think that they are to blame for their partner's violence
- Can often articulate what precipitated specific incidents or the progression of violence if she is given time and the care provider is patient
- It is a fact that most survivors want the violence to end, but not the relationship. Unfortunately this does not materialize most of the time and the violence continues.
- The commonly mentioned reasons for not leaving an abusive relationship are:
  - Fear of further violence for herself or the children
  - Lack safe options such as shelters
  - Lack of continuous and sustained family or community support
  - Concern about the future welfare of the children
  - Social stigma attached to a single parent or separated woman
  - Lack of economical empowerment and being dependent on the perpetrator
  - She still loves him
  - Think that perpetrator will one day stop violence

"

Perpetrators of GBV come from every: Age group Religion Ethnic/ racial group Socioeconomic level Educational background Sexual orientation"

2.10 Perpetrator

Perpetrators of GBV mostly men and a much lesser number of women, come from all strata of society[23] and often are known to the survivor specially in child abuse and have a "protective" role given to them such as with the teachers, priests, step fathers who are looked upon as custodians of children.

- Sometimes health care providers can be misled because the batterer does not "look like" a vicious or a cruel person (For example, the batterer may be elderly, upper class, charming, or a professional)

23 Improving the health care response to domestic violence A Trainer's Manual for Health Care Providers ;Published by Family Violence Fund 1998. http://www.fvpf.org

- The one defining similarity among all batterers is their use of tactics of control, but not their demographic or other characteristics.
- Both men and women may perpetrate violence. In heterosexual relationships it is often the male. In same sex relationships it could be either gender.
- Irrespective of who is doing it to whom, health care professionals need to address this issue seriously.
- If the perpetrator accompanies the survivor or he is working in the health system the clinician may hear denying, minimizing, lying or blaming herself by the survivor.
- There is strong evidence that crime levels and conflict in society more generally are not only correlated but causally linked with higher levels of violence against women[24].

24 Ministry of Planning and National Development (2007). Seventh National Development Plan 2006-2010. -Creating new opportunities.

Health policies and legal situation regarding GBV in Maldives

3.1. Health Policies and regulations relevant to addressing GBV

Constitution of Maldives: Article 13 of the Constitution of the Republic of Maldives, guarantees equal treatment for both men and women.

7th National Development Plan (2007): A national policy that calls for the adoption "of an integrated, zero-tolerance approach to gender based violence" and "advocates for the elimination of violence against children" and recommends the establishment of support services for vulnerable children and women.

> "
>
> There should be no place for violence in any relationship.
> Violence is always the responsibility of the perpetrator.
> Never blame the abused woman – it's not her fault.

Action Plan to combat violence against women was developed as a follow up of the WHLE by the Ministry of Gender was set up by the MGF to implement the recommendations of the study[25]

In the 3rd and 4th reports to CEDAW in 2007, the Government of Maldives expressed its commitment towards the establishment of a multi-sectoral support system to help survivor of GBV[26].

Action Plan on implementing CEDAW recommendations 2007-2009 was formulated in consultation with relevant stakeholders covering the period. The Plan includes violence against women among its key issues and, in particular, calls for: 1) the development of professional guidelines on addressing GBV for service providers in each relevant sector; 2) training and sensitisation on GBV for health professionals and policy makers within the health sector[27].

Health Master Plan (2006-2015): The integration of GBV care for women and girls into health services has been included among the strategic actions of the plan[28].

National Reproductive Health Strategy (2008-2010): Prepared by the Department of Public Health, contains a special thematic area on GBV, whose goal is to provide adequate and appropriate health services to all survivors of GBV at any level of care[29].

25 Action Plan to combat violence against women in the Maldives. Based on Women's Health and Life Experiences Survey Findings.Ministry of Gender and Family, December 2006.
26 Ministry of Gender and Family, Second and Third Combined Periodic Report of Maldives to the CEDAW Committee.2007.
27 Draft Action Plan on implementing CEDAW in Maldives (2007-2009). Ministry of Gender and Family.
28 Ministry of Health (2006). Health Master Plan 2006-2015.
29 Draft National Reproductive Health Strategy. Maldives (2008-2010).Department of Public Health

Family Act 2000: This Act makes provision in respect of the principles to be followed in the Maldives with regard to certain other matters of family life and recognizes the cruelty to the wife as an unacceptable and grounds for divorce

3.2. Domestic Violence Act 2012[30]

In accordance with Article 92 of the Constitution, the "Domestic Violence Bill" passed in the 5th sitting of the first session of the People's Majlis held on Monday the 9th of April 2012, has become law and has established a duty of care for the health sector.

Under this Act "domestic violence refers to commission of any act described as an act of violence under this Act, by the perpetrator against the survivor, provided such persons are bound by a domestic relationship". The Act identifies 17 actions that can be considered as domestic violence;

Physical Abuse	Verbal and psychological abuse
Sexual abuse	Economic or financial abuse
Impregnating the spouse, without concern to her health condition	Impregnating a women, who is trying to remove herself from a harmful marriage
Deliberately withholding the property of a person	Intimidation
Harassment	Stalking
Damage to property	Entry into, and being present thereafter at the survivor's residence without consent
Any other act which may be described as controlling or abusive behavior	Confining the survivor to a place or restricting their movement against their will;
Attempting to commit any of the foregoing acts or causing apprehension of such acts	Causing a minor to witness or hear an act of domestic violence
Coercing, intimidating or forcing the survivor to commit an act which such person would not have consented	

Figure 5 Acts considered as Domestic Violence under the DV Act 2012

3.3. Roles and responsibilities of HCPs as identified in the Domestic Violence Act.

This Act clearly identifies the role and responsibilities of the health sector at individual and professional level.

Section 8.a. on reporting mentions that "Cases of alleged domestic violence pursuant to Section 8 a) may be reported by any of the following persons: Employee of a health or social service provider ..."

30 Domestic Violence Act : Act No.3/2012

Section 9. on health care mentions that "A duty of care is hereby established on health professionals and social workers to report suspected cases of domestic violence ... Health professionals and social workers shall further provide full support during the investigative and court stages ..."

Section 12. mentions that "A health professional that has been notified by the Police that an act of domestic violence may have been committed on a survivor...must carry-out the following:-

1. Examine the suspected survivor to the highest possible degree...
2. Assist the survivor in seeking psychiatric or counselling support...
3. Prepare a written report based on the examination of
4. Submit the report prepared under Section 12(d) (2) to the Police and Authority"

While accepting that the Act defines the roles and responsibilities of the health care providers it must be mentioned that it is the responsibility of the administrative sectors such as Health Ministry, Health Protection Authority and Justice Ministry to provide adequate facilities and training and strengthen the relevant areas of care provision in order to ensure satisfactory implementation of the Act.

3.4. Policy on services available and minimum standards for GBV services by level of Health Facility

Providing comprehensive, holistic and survivor centred care for survivors of GBV requires defining the minimum services to be made available and minimum standards for staffing, facility infrastructure, materials, equipment, drugs, and administrative supplies.

Healthcare providers need to adhere to minimum standards for service provision at different levels of health institutions. The minimum standards need to be defined according to the existing capacity of the health system in order to realistically institutionalize GBV care[31].

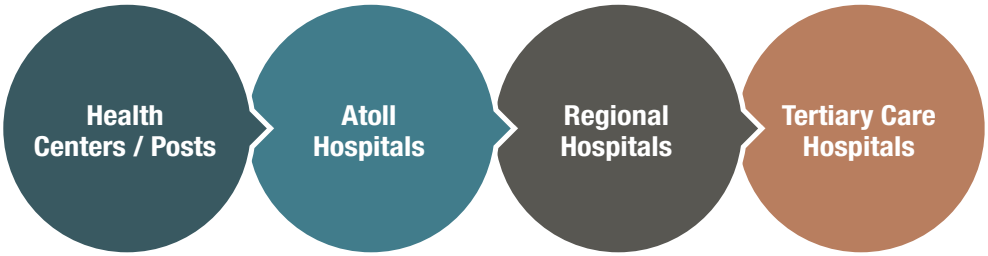


Figure 6 State health care delivery system Maldives Courtesy Dr. Sheeza

31 National management guidelines for the health sector response to and prevention of gender-based violence (gbv) Ministry of Health and Social Welfare Te United Republic of Tanzania 2011

3.4.1. Minimum services available

Minimum services are described according to these levels of care as given in Figure 7

Services Medical services	Health Centers/ Health Posts	Atoll Hospitals	Regional hospitals	Tertiary Care Hospitals
Receive the survivor in a dignified manner	x	x	X	X
Provide empathetic listening and counseling	x	x	X	X
Take a history & basic clinical examination	x	x	X	X
Conduct relevant examination	x	x	X	X
Conduct specialized examination and in-depth investigations			X	X
Take sample for DNA Examination to send Forensic Services at police		x	X	X
Manage minor injuries	x	x	X	X
Manage possible major injuries including surgical interventions		x	X	X
Provide Emergency contraception immediately /on selected sites	x	x	X	X
Provide tetanus prophylaxis	x	x	X	X
Provide STI Prophylaxis	x	x	X	X
Provide HIV Prophylaxis (PEP)	x	x	X	X
Psychosocial Services				
Establish a good rapport with the survivor	X	X	X	X
Reduce anxiety and make her / him comfortable	X	X	X	X
Provide empathetic listening	X	X	X	X
Provide basic counseling	x	x	X	X
Referral for other services	x	x	X	X
follow up if required	x	x	X	X
Medico legal services				
Document history and examination for medico legal perspective	x	x	X	X
Collect samples for relevant laboratory examinations	x*	x	X	X
Complete medico legal forms and submit to relevant authorities	x	x	x	X

Provide Medical expert opinion in legal cases		x	x	X
Referrals and Linkages				
Referrals to a higher level health care institution(if needed)	x	x	x	X
Referral to Police Action	x	x	x	X
Notify aggregated report to FPA	x	x	x	X
Provide information on legal redress available .such as the health sector response in line with the Domestic Violence Act 2012	x	x	x	X

*** Grade 1 level**

Figure 7 Minimum services that should be available at different levels of health institutions

3.4.2. Minimum standards

Minimum standards for providing medical care would include:

3.4.2.1. Location, Furniture, and Setting

GBV services should be integrated into all healthcare points of entry including emergency departments, Out-patients Departments, Reproductive and Child Health/Family Planning (RCH/FP), HIV, Antenatal (ANC) and Post Natal Care (PNC) and at a minimum, survivors will be selectively screened at critical point of entry.

- Written guideline or a protocol must be available
- GBV services should be provided in private, easily accessible rooms preferably with easy access to toilets.
- In a small facility or where there is inadequate space, healthcare providers shall create a space within their power to ensure privacy and confidentiality.
- The examination room should have chair(s)/sofa, curtains, an examination table, sufficient light preferably fixed (a torch may be threatening for children), infection protection equipment and supplies for collecting specimens, magnifying glass and a weighing scale for children.
- Basic resuscitation facilities must be available but if the survivor collapses should be taken immediately to PCU/ICU where skilled personnel and equipment are available.
- In a large facility, there should be at least designated area for clinicians, nurses, social welfare officers, and counselors, depending on the level of the health facility and availability of space.

- Whenever possible, separate child-friendly rooms with toys, drawing materials, colorful walls, and posters.
- Prescribed forms for documentation and a lockable cabinet for storing them.

3.4.2.2. Skilled health care providers

All health care facilities need to have HCPs who could provide minimum services for GBV survivors. This includes immediate medical management (history taking, physical exam), treatment for all injuries that the facility has the capacity to treat, informed consent, HIV PEP, STI screening and treatment, basic psycho-social assessment and counseling, referral of survivors to higher level facilities for additional medical care, and referral to other community services available for GBV survivors.

> “Looking in to a clinic in Laos with a very low attendance found that a promised partition to be built in a corner for women to talk in privacy was not provided for a long time”
>
> UNFPA Paper on Addressing GBV
> (UNFPA Gender, Human Rights and culture Branch)

In addition, selected healthcare providers from each facility who are providing medico legal services should receive adequate training on engaging survivors, collecting forensic evidence, and documenting and reporting on survivors and perpetrators and dealing with survivors with challenging concerns such as suicidal/homicidal survivor, angry/aggressive survivor, drug or alcohol abusing survivor, and mentally disturbed survivors. If caretaker is not available when survivor presents at health facility in GBV cases then this support needs to be provided by relevant government authority e.g., Ministry of Law and Gender.

Medical supplies

All health facilities must have the supplies necessary to provide the minimum standard of care for GBV survivors.

- A GBV kit that includes items for collecting forensic evidence (syringe, speculum, proctoscope, empty sterile bottle high vaginal swab, comb for collecting foreign matter from pubic hair); sterile gloves; sterile swabs; magnifying glass; and medication for symptomatic conditions.

Post-exposure prophylaxis (PEP; emergency contraception (EC); This can be assembled locally ensuring that they confirm to WHO guidelines and may be made available at selected health facilities initially.

- In the absence of a pre-prepared GBV kit, a health facility should collect these items on a tray.
- Supplies and equipment for preventing and controlling infection antiseptics and antibiotics.
- Sterile stitches and dressing trays.
- Extra clothes for survivors whose clothes may be collected for evidence.
- Sanitary supplies.
- Pregnancy test kits.

3.4.2.3. Medications

- Treatment for STIs
- Post Exposure Prophylaxis (PEP)
- Emergency contraception, such as combined oral contraceptives, " morning after pills"
- Tetanus Toxoid (TT)
- Analgesics
- Anxiolytics
- Sedatives
- Local anesthesia for suturing (lignocaine)
- Antibiotics

3.4.2.4. Minimum medico legal services

Different levels of health institutions should provide the services as described in Table 1

3.4.2.4.1. Medical services

Nurse

- Receive the survivor warmly in a dignified manner and arrange for appropriate care
- Provide initial listening and basic counseling while ensuring confidentiality
- Medical specialist or medical officer (wherever available)

- Take a history
- Conduct physical examination including vaginal and rectal examinations when indicated
- Mental state examinations (if skilled); if not refer
- Request or perform investigations as indicated, depending on nature of GBV
- Manage minor and major physical injuries, including complicated conditions and major operative procedures (depending on the availability of specialists) if not refer
- Provide GBV survivors with time-sensitive PEP and EC (of sexual assault) and TT
- Provide STI, HIV Prophylaxis
- Address anxiety or other trauma as needed (according to the competency of the HCP)
- Laboratory technician, radiologist, pathologist (when available)
- Perform the tests requested by the medical specialist/medical officer and assistant medical officer and perform analyses of tests done and provide a report.
- Medical administration will plan for and facilitate procurement of all medical equipment and medication necessary for survivors wherever possible and assist survivors in obtaining prescribed medication(s) in a timely manner.
- Psychologist, psychiatrist or counselor or any other HCP trained in this area (where available) They will provide emotional support and psychosocial care for the survivor and if needed for the perpetrator
- Establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on guiding principles
- Provide survivors with
    - Reassurance
    - Individual counseling based on their needs
    - Post-traumatic counseling (if skilled)
    - HIV pre- and post-test counseling (if skilled)
    - Adherence counseling
    - Linkage with other GBV services
    - Follow-up care

3.4.2.4.2. Forensic (medico legal) services

Services are provided by a number of HCPs but where a doctor is in attendance, the primary responsibility lies with the medical specialist or the medical officer according to the level of health institution. They include medical specialist, medical officer, nurse, and laboratory technician, if applicable. HCP should assist the police in collecting the required samples for forensic investigations.

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

If medical doctor is not in attendance in that facility, then other HCPs need to collect samples according to the level of facility and type of GBV case. Samples will then be received by the relevant forensic authorities for further investigation.

Guiding Principles: Human Rights and Ethics relevant to GBV care

In addressing GBV in the health system the HCP may have to interact and intervene with three individuals with three different interests and mindsets: the survivor, her/his children and the perpetrator. In this difficult exercise HCP has to ensure the safety of the survivor his/her children as well as that of the safety of HCP. Therefore special attention needs to be given to some aspects of ethical and moral issues in addition to the clinical aspects of care. In addition, unlike most of the clinical conditions seen in the routine health care provision, GBV care entails other dimensions such as societal attitudes, safety issues for the survivor and her children, perpetrator and his pressure on the care provider, as well as the attitudes and the past experiences of the care providers themselves.

The following guiding principles need to be adhered to.

- Confidentiality
- Privacy
- Safety
- Nondiscrimination
- Respect

4.1 Guiding Principles

4.1.1 Confidentiality and privacy

All medical and health status information related to adult survivors should be kept confidential and private, including from members of their family unless the survivor expresses a desire otherwise.

With respect to children and minors the parent who is with the child or the legal guardian serves as the decision maker and needs to be informed and consulted.

Disclosure of medical information may be allowed in the following situations but after informing the survivor

- Other treatment providers involved in the care of the survivor
- Healthcare service payers (medical insurance agencies)
- Officials of the court of law/justice
- Officials investigating the case
- A person requested by the survivor.

It is imperative to recognize the importance of maintaining confidentiality at all points of care provision pathway from the point of entry at the reception to the point of exit from the health facility. This is more important than maintaining documents and records. It is advisable to maintain a filing system under lock and key identified by the number only with a master list of care receivers kept by one person, the officer in charge[32].

If any reports or statistics are to be made public, all potentially identifying information should be removed and only aggregate numbers and data made public. And such reports need to be communicated with the program at HPA and endorsed by program before disclosure to media or public. These records will be maintained by HPA program.

In meetings, there may be times when a specific GBV case is mentioned. Ensure that no identifying information is revealed, to protect the confidentiality of the survivor.

Domestic violence survivors have high needs for privacy, as they are already the target of an abuser, and often need to keep the information reaching the abuser. For a domestic violence survivor ensuring privacy amounts to guaranteeing physical safety.

4.1.2 Safety

All actions taken on behalf of a survivor needs to be aimed at restoring or maintaining safety. The facility should have room with a door that could be closed and locked to discuss issues with the survivor in confidence and safely[33]. Supportive services to be given by the health facility until FCSC personnel take over.

In addition, there needs to be a clearly stated and printed clinic policy that ensures privacy when survivors are being asked about GBV. It could be explained to the partner or the person accompanying the survivor that each survivor is seen alone for part of their visit If the examining HCP is of different gender to the survivor then health professional or health employee of same gender as survivor will accompany the HCP during clinical examinations of survivor.

Asking a survivor of domestic violence about GBV in front of her partner during screening can put her in danger therefore caution must be exercised in phrasing the question and the body language of the HCP and if HCP senses it is dangerous, issue needs to be raised in private consultation or depending on case, raising the issue could be postponed to another time.

32 Gender –based Violence Information booklet for health care providers : Family health bureau Ministry of Health Sri Lanka 2012

Safety and security of the people who are helping the survivor, such as family, friends, and health care providers/GBV workers need to be taken into consideration.

4.1.3 Being non-judgmental / non discriminatory

All survivors of GBV have the right to receive respectful and high quality healthcare, regardless of their race, sex, age, national or social origin, marital status, religion, or socioeconomic status.

All members of the society including the doctors and other health professionals have past experiences, opinions, views and attitudes towards gender and GBV instilled in their mind. It is very important that these should not be allowed to influence the way they provide care to the survivors.

It is common to be judgmental towards the survivor and blame them when caring for survivors of rape or GBV based on societal "gender norms" unless the care provider takes a special effort to dissociate from such notions and provide nondiscriminatory care.

Common expressions coming from care providers such as "no wonder you get molested when you wear such clothes" "If you go around at night you are inviting trouble" indicate the biases that make HCPs though unintentionally damage the morale and the rehabilitation of the survivor . It is the right of each and individual to receive non-judgmental care irrespective of the provider's personal values[33].

4.1.4 Respect

Opinions, thoughts, and ideas of adult survivors who are adults shall be listened to and treated with respect.

Adolescents (under 18) are under the guardianship of their parents but needs to be treated with respect in order to strengthen their self-esteem and self-respect. The decision making will be by the parents as there is no legal concept of evolving capacity incorporated into the legal system of Maldives. Decisions on the examinations will be made by the social service personnel depending on the relationship between perpetrator and the survivor.

GBV survivor has undergone a very traumatic, degrading and humiliating treatment from the perpetrator treating her with respect and dignity is very important for her recovery, apart from it being her right.

The prior sexual history or status of virginity of the survivor is not an issue that is relevant to this incident of violence. Objectively examining the survivor and presenting the findings is the role of the

33 Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines WHO 2013

care provider without personal values and biases influencing them.

As far as possible avoid requiring the survivor to repeat her story in multiple interviews.

The body language and words used by the care provider is very important to gain the confidence of the survivor which is essential in order to help her/him. Irrespective of the background of the survivor or the views and beliefs of the care provider it is essential to show respect to the survivors.

4.2 Human Rights and GBV

GBV has been recognized as a violation of survivor's human rights including their right to freedom from discrimination, to life, to integrity and security of the person, to the highest attainable standard of health.

UN Committee on the Elimination of all forms of Discrimination Against Women (CEDAW) states that state parties should ensure the following:

- Women centered care is offered in the health services. "The services are delivered in a way that ensures that a woman gives fully informed consent, respects her dignity, guarantees confidentiality and is sensitive to her needs and perspectives[33]."
- Policies protocols and hospital procedures that address GBV should place "gender perspectives in the center of all policies and programmes"[34].
- Adequate gender –sensitive training be offered to HCPs be ensured by including "comprehensive and mandatory gender sensitive curricula"[34].

GBV violates most, if not all, human rights and affects Sexual and Reproductive Health:

- by limiting choices and decision making
- By curtailing the rights of women and girls across their life cycle to access RH, including FP services and safe abortion services where it is legal.
- by limiting protection from STI and HIV and unwanted pregnancy
- By causing direct harm and mental health consequences

4.3 Ethical considerations in managing GBV

It is important for the care provider to realize that under the human rights principles, every survivor who is an adult has a right to decide. Survivor has the right to choose what kind of care they want. Survivor may decide to stop telling their story or stop the examination at any time. The survivors have

34 Ethical Guidelines for counseling women facing domestic violence Center for Enquiry in to Health and Allied Themes CEHAT

the right to decide whether they want legal or any other services, the health facility offers.

However the Domestic Violence Act 2012 has made it the "duty of care and the responsibility" of the health care providers to report acts of DV and child abuse to Police and the FPA and this needs to be explained to the survivor and the legal obligations fulfilled.

Ethical principles governing counseling survivors of GBV are[34]

- Principle of autonomy: Survivor has a right to make decisions about all spheres of their life and circumstances. It is the responsibility of the counselor to enhance the ability of the survivor act autonomously and enable her to promote her well-being.
- Principle of non – maleficence: It is the counselor's duty to cause no harm to the survivor by way of an act of commission or omission The intervention needs to be informed by a sound analysis of the consequences of every action and should be based on a risk benefit analysis.
- Principle of beneficence: It is a counselor's duty to do good and actively work towards the best interests of the survivor.
- Principle of veracity and fidelity: The survivor should not be misled about expectation and no other interests come in the way of survivor's interests.
- Principle of justice: Counselor should be fair and not discriminate on any basis.

4.4 Issues related to consent

Recommended Consent form is given as Annexure

In case of adults

- In obtaining informed consent, the healthcare provider makes correct and adequate medical information available to the survivor and ensures that the survivor has understood the available treatment options and the decisions he/she will have to make (e.g. compliance to treatment and choices of treatment options).
- Due to the medico-legal aspect of GBV, it is important that the survivor signs the consent form after the provider has ensured that she/he has fully understood the information provided.
- The healthcare provider will explain to the survivor that when he/she consents to forensic evidence collection and police involvement that the information gathered during an examination may be presented in court.

- The healthcare provider shall inform the GBV survivor that she/he has the right to refuse consent to all or some aspects of medical consultation and treatment[32].

4.4.1 In obtaining consent

- Provide information on availability of Emergency Contraception (EC) and HIV testing
- Provide information on the medical consequences related to GBV, risk of an STI, HIV, and pregnancy
- Explain the procedures for gathering forensic evidence and that any evidence gathered may be used to provide evidence in court
- Explain adequately the non-health aspects will be dealt with by police, social welfare officer and legal system
- The importance of documenting the medical examination for the survivor's records

In the case of children, in addition,

- Promote the child's best interest at all times
- Comfort the child
- Treat every child fairly and equally
- Promote the child's resiliencies
- Accept that the child is unable to communicate about the act of violence

4.5 Avoiding conflicts with the survivor and their relations and safety issues of the staff.

Predisposing factors:	Precipitating factors:
• Rudeness	• Adverse outcomes,
• Delays	• Iatrogenic failures,
• Inattentiveness	• Mistakes,
• Miscommunication	• System errors
• Apathy	
• Male Doctors 60% more likely to be sued	

Figure 8 Why are doctors sued?

Care seekers come in to conflict with the providers because of unexpected outcome (often adverse) unexpected cost and unmet expectations. In providing medico legal services in Maldives in the state sector cost is not a determining factor and medical unexpected outcome such as seen in clinical disciplines is not common.

Therefore it concerns mostly unexpected expectations of the care seeker which is often beyond the care provider and built up on the inadequate or erroneous information and knowledge of the care seeker. However the care provider may unwittingly contribute to the conflict by generating animosity in the care seeker on the basis of behaviors given in Figure 8

Realistic expectations	Unrealistic expectations
• Adequate time	• Service available 24 hours during the week
• Doctor interest	• Office staff will do all paperwork
• Helpfulness/attentiveness of office staff	• All treatments will be 100% successful with no side effects
• Doctor's competence	• Unlimited time
• Treated respectfully	• All issues will be addressed at one consultation
• Survivor will be listened to	

Figure 9 Expectations of the survivor

While accepting that all expectations cannot be fulfilled by the provider every effort must be made to provide comprehensive, survivor sensitive and survivor centered care and friendly services.

This is also significant in cases of child abuse where the parents are anxious, often agitated and genuinely worried about the child which may be beyond the medical concerns the provider is focusing on. In this situation it is essential to be survivor empathetic and understanding towards the parent or the guardian. In USA where litigation is rampant only 12% of adverse events that occur in hospitals result in a law suit. Some of them were settled out of court by the defense organizations.

Tips to avoid conflicts resulting in law suits

- Prevention of litigation begins the moment a professional relationship is established with a survivor –treat survivor and caretakers with respect and dignity throughout the care process
- Involve the survivor and family (if the survivor so desires) directly in the care as much as possible – Explain all steps of procedure
- Communicating with the survivors and caretakers is a key issue in preventing litigation - Use appropriate communication skills and build a good rapport
- Words mean different things to different people. Avoid medical language -Choose words carefully respecting the local customs and sensitivities
- Avoid criticizing another HCP's management with words or gestures - You too may be blamed one day

- Prepare survivors for any pain, discomfort, they can reasonably expect before examination or procedure- Let them know. Do not expect them to know
- Telephone numbers of the Police to be available so that assistance could be sought in case of a situation that poses a risk to the HCP's
- Assistance may be sought from the FPA to resolve situations that may arise as a result of providing care and fulfilling medico legal obligations by the HCP's
- Make sure that there is adequate documentation and record keeping

Medical management of GBV (over 18 years old)

5.1. Introduction

A person who has suffered GBV such as rape has experienced trauma, physical and psychological and may be in a state of agitation or withdrawal. They often feel fear, guilt, shame and anger or often all of them. Health care worker should understand this and prepare her/him, obtain the consent, for the examination and carry it out in a compassionate, systematic and complete manner and document it adequately and accurately. Medical management of GBV survivors involves treating potentially life threatening injuries and potential infections that may occur as a result of the violence. The management of medical emergencies and injuries should be a priority, but at the same time, the time-dependent preventive treatments should be provided.

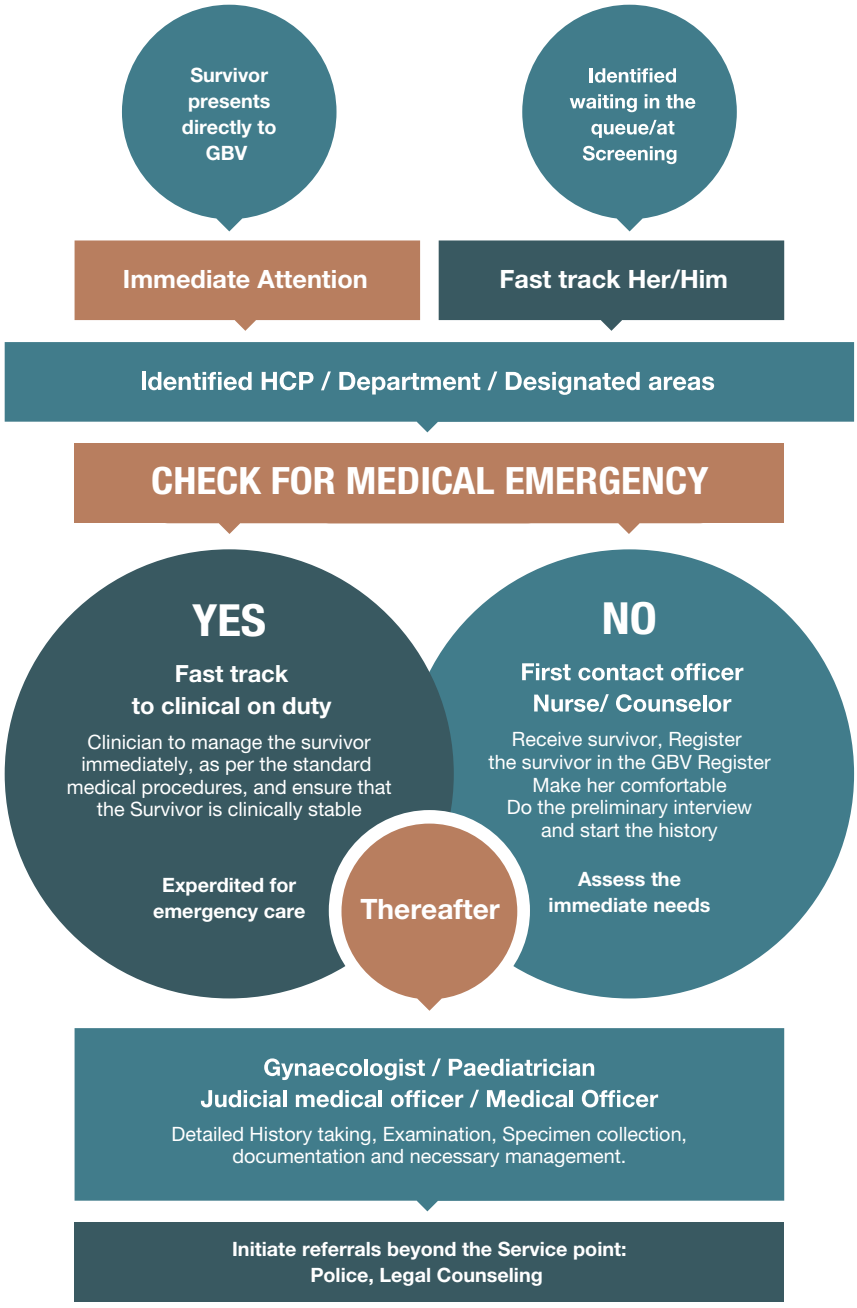
Obtaining consent as described earlier from adult survivors and guardian of children should not be ignored even though a legal request has been made by authorities.

5.2. Receiving the Survivor

- Greet the person by their preferred name
- Introduce yourself
- Ask if the survivor wants to have a specific support person present.
- Ensure that a chaperone of the same sex as the HCP is present
- Explain the procedure and what to expect. (guardian in case of children)
- Ensure the adult survivor that she/he can interrupt, ask questions or stop the procedure if they feel so[35].
- Ensure that the confidentiality will be maintained as well as the legal obligations that the HCP will have to fulfill
- Get the survivor/guardian to sign the consent form

35 Clinical Management of Rape Survivors; developing protocols for use with refugees and internally displaced persons WHO,UNFPA and UNHCR

Pathway of care within the hospital



5.3. History taking

Let the survivor tell the story the way he/she wants to and the clarifications and questioning should be done gently and at the survivors own pace. Avoid questions that suggest blame such as "What were you doing there alone"[36]

Do not rush her/him to answer your questions

If the incident has occurred recently enquire whether he/she had bathed or washed herself or douched.

The main elements of history taking are:

- **General information**
  - Name
  - Address (current)
  - Permanent address
  - ID number
  - Hospital/Health facility number
  - Residence, telephone number
  - Sex
  - Date of birth (or age in years)
  - Date and time of the examination
  - Name(s) of any staff or support persons present

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

Important to get details of exactly what happened in order to check for possible injuries. For example, when and where the assaults took place? Was there penetration (oral, vaginal, or anal)? Did the assailant use physical or psychological force? Did the assailant use a physical object? How many assailants were there? Was it a single assault or was it repeated over hours or days? Did the survivor lose consciousness, and was the assailant known to the survivor? What did the survivor do after the incidence[32]?

Gynecologic history

- First date of the last menstrual period
- Determine the last time the survivor had sexual intercourse prior to the incident. Mainly to interpret investigations
- Determine if the survivor has ever tested for STIs or HIV before and his/her HIV status. To check for possible infection due to the incident
- Determine if the survivor has been pregnant before
- Determine if the survivor uses contraception. If so, the type, since when, and the compliance

- **Emotional /mental health status**

While accepting that most HCPs are not trained to asses mental health status and not in a position to provide expert evidence on such matters basic assessment is done essentially to identify the need for emotionally support the survivor should in no way re-victimize, stigmatize, or blame the survivor

Within the capacity of the HCP look for evidence of the following:

- Depression
- Anxiety
- Mood problems
- Suicidal ideation
- Substance abuse

- **Past medical and surgical history**

Ask about possible medical conditions, allergies, use of alcohol/drugs, vaccination, and previous surgery. These questions should help you to determine the best treatment and offer follow-up healthcare[32.]

5.4. Physical Examination

- **General considerations for physical examination**
  - Confirm that consent had been taken
  - Make sure equipments etc. are ready before starting
  - Look at the survivor explain before you touch
  - Take the basic vital signs at the start
  - Never ask a survivor to be undress completely but conduct the upper body initially and then the lower half or give an appropriate gown[36]
  - The clothes should be collected for forensic examination and put in a paper sheet/ bag when sexual and physical violence has occurred. If the survivor is going to be undressed, she can do this over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs that would support her information about the assault or violence
  - Conduct the examination systematically
  - Wherever relevant collect specimens for testing at the same time

- **Head to toe examination**
  - Examine the upper limbs for any signs of injuries
  - Inspect the face, eyes, and ears
  - Examine the scalp for any injuries and signs of inflammation
  - Examine the neck for bruises and life-threatening assaults
  - Examine the breasts and trunk for bites and other injuries
  - Do abdominal and chest examinations for any internal injuries/pregnancy
  - Examine the lower limbs thoroughly

- **Genital and anal examination (relevant in cases of rape and sexual abuse)**
  - Most women are averse to this part of the examination and the HCP must be patient and considerate. Explaining the procedure adequately in a "non musicalized manner" understandable to the survivor would minimize this
  - Even when female genitalia are examined immediately after a rape identifiable damage to genitalia are found on examination in less than 50% of instances[36]
  - Cultural sensitivities may prevent the survivor consenting for a vaginal, digital or speculum examinations particularly if she is not married and her wishes need to be respected. Systemically examine genitalia in this order and note injuries etc.
    - Mons pubis
    - Inside of the thighs
    - Perineum
    - Labia majora
    - Labia minora
    - Clitoris
    - Urethra
    - Introitus
    - Hymen
    - Anus

Take all the swabs, in the following order:

- External vaginal swab
- Internal vaginal swab
- High vaginal swab and rectal swab
- The other swabs are oral swabs for secretor factors in cases where oral sex is implicated
- Skin swabs when a suspicious seminal stain is present on the skin
- If collecting for DNA analysis take swabs from around the anus and the perineum before the vulva[36]
- Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.

Do speculum and digital examinations

Under no circumstance should this be done prior to taking the swabs Speculum examination on women who are not married and girls cause much pain and may cause injury, so it should only be done when essential (e.g., when the child may have had internal bleeding from a penetrating vaginal

injury) In such situations, examination under anesthesia is preferable in children and girls by use the ear speculum. Or a very small speculum in unmarried adult women.

Use water or saline when introducing but no lubricants.

If and when required do anal examination

- Note the shape and dilatation of the anus
- Evidence of tears, fissures, fecal matter on the perineum, or bleeding
- If traumatic intercourse/gang rape had taken place, look for recto vaginal tears or injuries

- **Documentation**
  - The gynecologist/pediatrician/surgeon shall complete the medical section of the form. In the absence of a specialist the Medical Officer shall fill the medical section of the form.
  - The healthcare provider is responsible for safe custody of the documentation forms, medical records, and forensic specimens till they are handed over to the administration /laboratory or the Police.
  - Use the pictogram to clearly give the location and measurement of the injury but describe it in words.

5.5 Laboratory investigations

The evidence should be collected as soon as possible after the incident to ensure that the time-sensitive aspects of the tests are addressed. They are done:

- To collect evidence that may help prove or disprove contact between the offender and survivor
- To address medical problems as a result of violence
- To identify the perpetrator
- To identify existing conditions

Basic laboratory investigations

- Vaginal smear for spermatozoa
- Vaginal smear for GC
- Blood for Syphilis

Detailed laboratory investigations

- Testing for HIV
- DNA testing on seminal or other samples collected

- Examination of hair nails scrapings etc.

5.6. Treatment of GBV survivors

- **General consideration**
  - All GBV survivors should be treated as an emergency and should not be allowed to queue in the line
  - HCPs should, as much as possible, follow the stated procedures, on taking the history of the survivor, which may be needed in court.
  - Treatment will also depend on how soon after the incident the survivor arrived at the hospital

- **Preventive/prescribing treatment**

If the survivor presents before 72 hours[36].

- STI prophylaxis
- Prevention of pregnancy by Emergency Contraception
- Prevention of HIV by PEP
- Prevention of Tetanus
- Provide wound care

If the survivor presents after 72 hours36.

- If the lab tests are positive or has symptoms of STI treat according to local guidance
- If survivor presents between 72 hrs (3 days) and 120 hrs (5 days) after sexual exposure/ rape emergency contraception is moderately effective and should be given[36] (WHO). Not effective after 120 hrs.
- Tetanus prophylaxis could be given

5.7. Psychosocial Care and Support

- **General Consideration**
  - GBV survivors undergo marked emotional evident immediately, short term or long term.
  - The duration and depth of traumatic effects would depend on the individual and the circumstances of the GBV
  - Listen but do not force her to talk
  - Counselor where available should apply the survivor-centered approach to counseling by strengthening her ability to decide for herself. This approach focuses on “DOING GOOD

and NOT DOING HARM" when counseling the survivors.

- One key principle in providing basic counseling is "not blaming the survivor" for the incident.
- All healthcare providers delivering GBV services should have listening skills and be able to provide basic counseling to GBV survivors, including children
- Clinicians, nurses, and trained social workers should offer counseling services to all GBV survivors, depending on the need
- The counselor should at all times adhere to professional ethics and apply the principle of "doing good and not doing harm" and recognize that survivor is the decision maker[34]

Where professional counselor services are available trauma counseling must be offered when indicated.

5.8 Assisting the male survivor

- Male survivors are less likely talk and are thoroughly embarrassed
- Physical effects may differ from females but psychological effects are similar
- Male survivors must be offered management options similar to female survivors
- History taking and examination would be similar except for the genital examination
- Sometimes when a man is anally raped due to pressure on the prostate he may have an erection and even ejaculate. Reassure the survivor that it is a physiological reaction beyond his control[36] and should not be considered as it is with his consent
- Men need to be[36] informed about and offered HIV test and the option Post Exposure Prophylaxis

5.9. Assessment of Risk/Danger in domestic violence

Of the women who undergo violence, particularly domestic violence only a small percentage present to a health institutions or the police. Often it is the group who undergo more serious forms, or those who fear for their life would come to a health institution or the Police. If an immediate danger is expressed by the survivor or if anticipated by HCP then this case needs to be immediately reported to FCSC or on call number at gender ministry.

> "The most dangerous moment for a woman according to some authorities is when the woman leaves or announces that she intends to leave the abusive relationship"

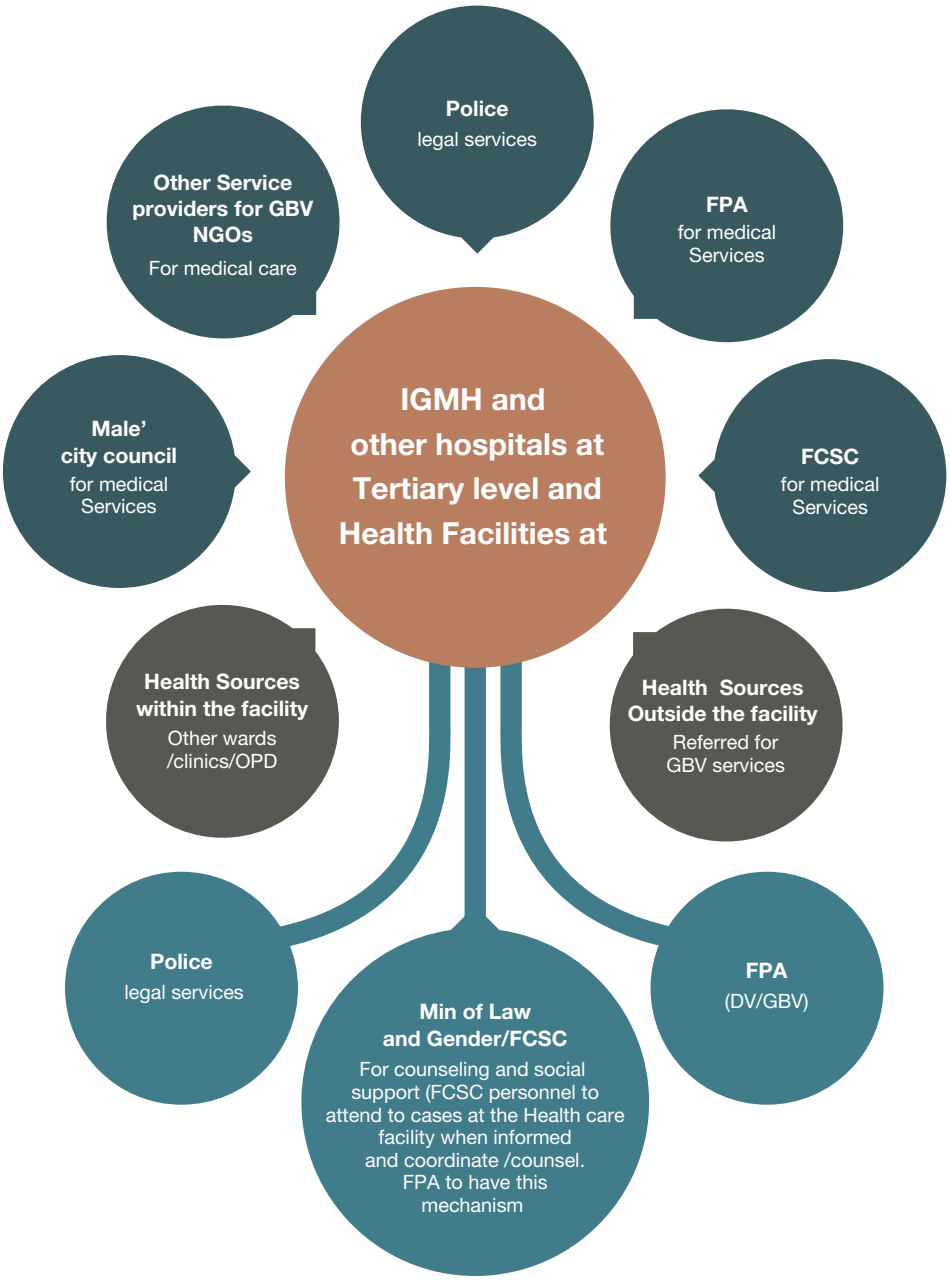
36 Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines WHO 2013

1	If the Partner is unemployed.
2	If perpetrator has access to lethal weapons
3	Recent threats of Deadly Violence such as Shooting, Throttling.
4	Escalation of severity and frequency of Violence in the recent past.
5	History of inflicting severe injuries fractures stab injuries.
6	Severe abuse of alcohol or drugs.
7	Threats or actually having battered or harmed the children.
8	Recently separated or divorced.
9	Recent activities of stalking or closely watching the survivor.
10	Pregnancy or recent birth.
11	When cultural issues are involved.

Figure 10 Risk factors for danger in domestic Violence

- If the care provider feels that there is significant suicidal or homicidal ideation/thoughts the survivor should be kept safe in the facility and counseling and or psychiatric evaluation can be obtained (whereever possible or referred to facility which provides this service).

5.10. Referral Pathways



Survivors of GBV needs to be referred to other service providers when such services are not available in the health institutions This must be done after their specific needs are identified and one is aware of the capabilities of the organizations to which the referral is made.

Assisting the survivors to connect with these resources and following up on them as to whether the survivor used the referral offered and if so their feedback on the quality of care received is important.

Regarding referrals in general following points should be considered.

- Most institutions have to refer and in turn accept survivors between them for providing different kind of services. The Figure above illustrates the fact.

- The dual role of each institution needs to be understood
- It is important for the HCP to explain to the survivor the purpose of the referrals related to clinical aspects
- The referral should be clearly beneficial to the survivor and is not merely to fulfill a formality
- In the process of referral, due regard to confidentiality (including data protection requirements),respect, sensitivity and the dignity of the survivor must be attended to
- It is important to agree with referring institutions which information is absolutely necessary and the manner in which it can be collected in a way so that minimal harm is done to the survivor in sharing information[37]
- Island Councils play a role distinct from other institutions which provide identified services. Their role is essentially to facilitate by making services available to the survivors in situations such as the need for transport to atolls or Male'. In addition the information on the trends and types of violence may help them to initiate targeted preventive activities. However a Study on the decentralization process in the Maldives conducted in 2013 mentions that Atoll and island Councils played no role in provision in the health services. As the same study mentions that there is a considerable variation between different islands and lack of clarity it is best to be guided by the operational practices in the local context
- FPA provides a dual role by providing counseling services as well as facilitating the provision of services by other agencies
- In addition the FPA by the mandate given by the Domestic Violence Act is expected to assist and oversee the response to GBV by all sectors of the country including that of the health sector

37 Ethical Guidelines for counseling women facing domestic violence Center for Enquiry in to Health and Allied Themes CEHAT

Purpose of the referrals

Referrals TO the Health Center from (Inward)	What purpose / Any criteria if relevant	Referrals FROM the Health Center (Outward)	What purpose / Any criteria if relevant
Police	Medical management & Medico legal examination	Police	For Police Action & Initiate legal response
WDC	Medical management & Medico legal examination	WDC	Support the survivor appropriately Facilitate transport etc.
Island Council	Medical management & Medico legal examination	Island Council	Support the survivor Facilitate transfer / Launch
FPA		FPA	To assist the survivor if there is a need. Facilitate any steps in the care provision. Fulfilling a requirement of the DV Act (For the present collective data to be submitted on a monthly basis Detailed information on Individual survivors To be submitted if Requested by FPA
FCSC	Medical management & Medico legal examination	FCSC	For emotional support Available only at atoll Level Counseling and social Services be provided at the health institution by invitation
NGOs / SHE	Medical management & Medico legal examination	NGOs/SHE	Emotional support and Counseling
NGOs/	Medical management & Medico legal examination	NGOs	Legal advice and assistance- Reports or communication from health facility needs to be shared with police and FPA as per DV act.

Atoll and Regional Hospital level

In addition to the institutions mentioned for the Health center internal referrals from other departments of the health institution such as maternity, surgical pediatric must be considered.

In addition Police will have a role in taking charge of and transporting evidence in the form of samples collected by the HCP.

Counseling services by the Counselors need to be sought and best be provided in the health institution by invitation.

If survivor attends without caretaker this service needs to be provided by Gender ministry or relevant government authority.

Tertiary Level at IGMH

Referral Pathway

The most desirable and logical first contact point which the survivor should access, as early as after the incident, would be the Health Post or the Health center in the islands and Atoll hospital or the Regional hospital at atolls or the FPU at IGMH in Male', in order to provide medical care (if needed) and attend to emergency treatment (if needed) as the initial response.

In case the survivor goes to other organizations (Police, WDC, Island Council, FPA) and comes to the Health institution subsequently she should be accepted and provided medical treatment if required. Any survivor who has suffered GBV such as DV child abuse should be received by the health institution at any level for medical treatment irrespective of the fact that she has been referred or not.

The Police is expected to produce a document requesting a medico legal examination when they produce a survivor as they are doing it as a legal responsibility. It is mandatory to produce MLC form irrespective of police note'

Once such request is made health care providers are required by law (DV Act) to conduct an examination and report to the best of their ability expected from that category of the staff.
Recommended medico legal reporting form is given as annexure 2. (IGMH may use a special form which includes additional information)

Wherever and whenever possible the medical officer should conduct the examination and complete and submit the medico legal report.

However in special situations where a medical officer is not attached to the facility or not available, then the most suitable and experienced staff member should do the examination and attend to first aid and either conduct the examination and submit the Medico legal Report or refer to the atoll hospital where a medical officer is available (after attending to immediate medical needs / and noting down the obvious injuries etc.) If there is a choice a female HCP is desirable for examining female survivors.

A request for a second opinion (Medico legal) should come from Police or Judiciary. If the request for a second is from parents or guardian it should be formerly approved in writing by the Police or the Judiciary and should be addressed to an officer of a higher category (wherever possible). For example if the survivor has been examined by a medical officer in the first instance, then she should be referred to Consultant (Gynecologist /Pediatrician) for the second /expert opinion).

If the survivor has been examined by a Consultant in the first instance then she should be referred to another Consultant (Gynecologist /Pediatrician) for the second opinion.

The criteria for second opinion /expert opinion should be the competence and the category of the HCP (Medical Officer /Consultant) and not the sector he belongs to private or state.

It is expected that the private sector run medico legal services parallel to the state sector and care providers in the private sector take guidance from these guidelines.

Reports or communication from health facility needs to be shared with police and FPA as per DV act. If in emergency or immediate danger then HCP needs to inform FCSCs also. Purpose of report by HCP to police and FPA is to ensure other relevant services are provided to survivor and to link with other services.

Once report is received by FPA-FCSCs or FPA to link with other relevant services or authorities to ensure the complete or comprehensive care is provided to the GBV/DV survivor.

5.11. Follow-up care, treatment and referral

- It is possible that the survivor may not be allowed to come for follow up by the husband and hence it is prudent to provide maximum input during the initial visit as that may be the only visit[36].
- Follow up of survivors of GBV must be optional and left to survivor to decide except in cases of follow up on STIs/HIV or pregnancy
- HCPs should not insist on contacting them at home etc. which may lead to exacerbation of violence in cases of domestic violence and put survivor and the children at risk.
- However the availability of the HCP and the services, in case of a future need must be made clear to the survivor irrespective of the fact that she/he attends follow up or not.

Medical management of sexual abuse of adolescents and children

6.1. Introduction

Managing child sexual abuse is distinct and different in many ways from the management of the same in adults. This section of the guideline attempts to identify such differences from the point of service provision and needs to be considered as a supplementary in order to enhance the knowledge of the HCP's gained in undergraduate studies and training.

- Child sexual abuse in most countries including Maldives needs mandatory reporting to the legal authorities
- As the concept of evolving capacity is not in the legal system, consent needs to be taken from the parents or the guardian in case of adolescents and children. However it is up to the HCP to provide adequate explanation and sensitization on the medical issues relating to care provision depending on the age and the capacity of the survivor
- Even when the parent gives consent every effort must be made to avoid forcing adolescents in particular undergoing the examination but attempt to negotiate agreement with adequate explanation and building confidence
- Therefore the parent or legal guardian should sign the consent form for examination of the child and collection of forensic evidence, unless he or she is the suspected offender. In this case, a representative from the police, community support services or the court may give permission to examine[36].
- Healthcare providers need to recognize children and adolescents as a special group that require timely attention, treatment with empathy, and support and follow-up to the satisfaction of the child, parent, or guardian and acceptable to the sensitivities of the community
- HCPs should be well aware of the facts on growth and development of the child and the anatomical status of children as distinct from the adult

6.2. General Considerations

Any child or adolescent who is raped or sexually assaulted shall be fast tracked from the queue and immediately taken to an emergency room to receive medical treatment

As far as possible the child should be examined in a child friendly environment with toys or colorful pictures etc.

Sometimes admission to the facility may be needed to give adequate time to calm the child and examine and if needed to do an examination under anesthesia.

Involvement of the probation social welfare services, FCSC, and police in early stages is important for management while the child is in a safe place.

Symptoms of severe medical complications[36]

• Convulsions	• Fever
• Persistent vomiting	• Low body temperature
• Strider in a calm child	• Bulging fontanels
• Lethargy or unconsciousness	• Grunting and in drawing, of the chest
• Inability to drink or breastfeed.	• Respiratory rate of more than 60

Figure 11 Evidence of serious medical complications in the child

6.3. Types of Gender-Based Violence in children

Sexual violence in children may include following activities[32]

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

6.4. Perpetrators of Child Sexual abuse

It could be any one from the community and there is no register of offenders available at present. There is no way of profiling the perpetrator and often he is someone known to the child and who is in the capacity of providing "protection" and trusted individual.

Incest or child and adolescent sexual abuse within the family is one of the most invisible forms of violence in some parts of the world, It is usually perpetrated by most often by a father, stepfather, grandfather, brother, uncle, or another male relative in a position of trust. In some cases, mother may deny it to protect the name of the family and that of other children. This has to be dealt with sensitively but is mandatory to report.

6.5. History taking

A thorough and systematic history needs to be taken to obtain the routine background medical information of the child or adolescent survivor, information on the abuse as well as information about any medical symptoms that have arisen or resulted from the violence.

The history taking procedure will depend on the emotional and physical state of the child survivor. In some cases, the interview may be difficult due to the distress, fear and sense of insecurity in the child. In some cases of adolescents, the parent or guardian may be asked to wait outside and the child may be interviewed alone at least part of the time.

A strong alliance and rapport between the counselor, health care provider and the child and the guardian is crucial to successful sessions and in preventing conflicts and resultant legal action against the HCP.

- Introduce yourself to the survivor
- For adolescents, they should be asked if they want to be alone or with a trusted adult
- Explain in words that the child is used to and can understand
- Reassure the survivor that the examination findings will be kept confidential
- Explain what is going to happen during each step of the examination in words that understood by the child and not scared by them
- Have the survivor/guardian/parent sign the consent form
- Stop the interview in case the child is uncomfortable

- In addition the medical history shall cover any known health problems including allergies, immunization status, and medications
- Particulars of the child survivor:
  - Name, address, date of birth, age, sex, address on admission (current address, permanent address, ID number, hospital /health facility telephone number, date and time of examination)
  - Name(s) of any staff or support person present during the interview and examination
- Description of the incident by child, adolescent or the guardian
  - It is important that the healthcare provider understands the details of exactly what happened in order to check for possible injuries
  - Did the assailant use a foreign object
  - Determine whether the survivor has bathed, urinated, vomited, etc., since the incident occurred, as this may affect the collection of forensic evidence
  - In case of adolescents who had attained menarche, the last regular menstrual period, sexual encounters in the recent past; if so the date of the last and whether she had been using contraceptives.

• Unexplained genital injury	• Regression in behavior, school performance
• Recurrent vulvo-vaginitis	• Acute traumatic response such as clingy behavior and irritability in young children
• Vaginal or penile discharge often purulent	• Sleep disturbances
• Bedwetting and fecal soiling beyond the usual age	• Eating disorders
• Anal complaints (e.g., fissures, pain, bleeding)	• Problems at school
• Pain on urination	• Inappropriate sexualized behaviors
• STIs	
• Pregnancy in an adolescent	

Figure 12 Indicators of child sexual abuse (Source Ref.32)

6.6. Examination of the survivor

Guidance on general principles on examining an adult survivor applies in case of the children and adolescent and will not be repeated here.

6.7. Special considerations for children

Special considerations for children in summary are as follows[36]

Examination

(Adapted from Clinical Guidelines for Rape Survivors WHO):

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

of anal penetration, but also of constipation

- Do not carry out a digital examination to assess anal sphincter tone

Laboratory testing

- General principles that apply to adult survivors would apply here
- Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations
- The child presents with signs or symptoms of STI
- The suspected offender is known to have an STI or is at high risk of STI
- There is a high prevalence of STI in the community
- The child or parent requests testing
- In some settings, screening for gonorrhea and Chlamydia, syphilis and HIV is done for all children who may have been raped
- The presence of any one of these infections may be diagnostic of rape, if the infection is not likely to have been acquired perinatally or through blood transfusion)

Screening for GBV

It is well known that only a small proportion of survivors of GBV access services for assistance and a majority continue to suffer in silence.

The medical community can play a vital role in identifying women who are experiencing IPV and halting the cycle of abuse through screening, offering ongoing support.

WHLE study in Maldives[1] showed that 39% of women who had experienced physical and/or sexual partner violence never told anyone about the violence and those who told someone did so only when they could not endure the violence any more or she was badly injured.

Screening can be either asking all women known as "universal screening" or asking selected groups of women based on a clinical condition such as pregnancy, "screening", also known as "clinical inquiry" or "case finding"[34]

WHO guideline 2013 recommends that universal screening/routine inquiry i.e. asking all health care workers should not be implemented but HCPs should ask about intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence. Examples of such conditions are given in Figure 13.

This approach is recommended in this Guideline .Screening survivors at various times is also important because some women do not disclose abuse the first time they are asked.

Most health systems rely on survivor-initiated reporting and service-seeking, developing a proactive approach to identifying survivors for early intervention and care has the potential to improve health and social outcomes for survivors and their families[38] .

38 American College of Obstetricians and Gynaecologistshttp://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Health_Care_for_Underserved_Women/Intimate_Partner_Violence

• Adverse reproductive outcomes, unintended pregnancy, unsafe abortion, delay in attending for antenatal services
• Depression anxiety PTSD
• Suicidal attempts or self-harm
• Unexplained reproductive symptoms, dysmenorrhea or dyspareunia
• Chronic pain
• Traumatic injuries with implausible explanations
• Unexplained headache
• Repeated health consultations with no clear diagnosis
• Intrusive husband at consultations

Figure 13 Examples of clinical conditions associated with IPV and needs to be screened Source WHO[34]

It is also important to consider whether the healthcare provider is able to provide support emotional and other kinds of assistance if she discloses GBV and the facilities available within the health system. Minimum requirements to be fulfilled prior to asking about GBV is given in Figure 14.

• Protocol /SOP
• Training on how to ask ,minimum response or beyond
• Private setting
• Confidentiality ensured
• System for referrals in place

Figure 14 Minimum requirements for asking about GBV Source WHO34

Documentation and data management

Documentation is a very important but often neglected area of GBV care.

Very often the medical records reveal only very limited information regarding abuse. Since such records may constitute the only documentation about the survivor's injuries, they should contain all key facts, including the use of weapons and whether any injuries resulted from their use or was threatened to use. As health records play an important role in addressing GBV it is necessary to keep clear, accurate and detailed notes on the injuries to indicate the harm caused due to violence. This can help the woman to live in a safer environment later on.

Documentation, includes clearly and specifically recording the history, details of the incident and description of injuries, preferably diagrammatically.

To ensure consistency, uniformity and the completeness, it is necessary to developformats for documentation and make them available (such as a medico-legal report).

It is advisable to use:

- Survivor s' own words
- Use body maps and diagrams
- For photo evidence to use Police (when applicable)
- Keep separate notes rather than in the records such as ANC records to ensure confidentiality

It is important to maintain confidentiality by securing the documents till they are handed over to the administrative authorities or legal authorities.

*Incase of a situation where 2 separate medical examinations are done and 2 forms filled then an expert in the field will decide on which to use as expert evidence.

Building linkages and collaborating with other stakeholders

The USAID Guide on health sector programme Officers on addressing GBV states that[39] "While accepting that the main role of health services in the area of gender-based violence is to respond to women who have already experienced violence, to mitigate the negative consequences, and to help them find ways to avoid additional violence. However, health programs should also look beyond their clinic wall in the following ways and for the following reasons:

1. Building referral networks between health, social, and legal services in the community can be an essential way to facilitate women's access to services, reduce duplication of services, and to identify gaps in services for policymakers and donors.
2. By participating in public policy advocacy campaigns, task forces, and other public forums, healthcare professionals and organizations can encourage policymakers to address gender-based violence as a public health problem.
3. By building links and alliances with broader GBV prevention efforts, such as those launched by other NGOs, healthcare organizations can raise their profile as a resource for women who experience violence."

Addressing GBV requires multi-sectoral multi-pronged interventions. Because a single organization sector may not be able to carry out all required actions, sectors need to collaborate to assess the existing situation and decide what piece of the puzzle each one can take on. The inability to undertake all necessary steps should be a motivating factor to collaborate rather than a justification for not addressing the issue.

The World Bank recognizes the importance of strengthening and mentions "Inter-sectoral collaboration, networking and partnership with other ministries, civil society, NGOs (incl. Disabled Peoples Organizations) and the private sector to enhance awareness, prevent, monitor and manage GBV. Effective community and society interventions are based on coordination between the legal, social, health and education system and the work place (Bott et al, 2005). This is often furthered through decentralization:

a. Social services: shelters, child protection, income generating activities, community support and women's groups.
b. Education: Involve the education system in the prevention and management of GBV; promoting

39 IGWG of USAID. 2006. Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers. Washington, D.C 2006

greater respect for girls and women and human rights, as well as nonviolence; enhance school safety (safe latrines for girls); school health education and school health. Include education in GBV in the higher education of health care providers, lawyers, social workers, teachers, police etc.

c. Legal: build alliance with legal system to enhance enforcement of laws related to gender based violence"[40].

Although the MoH had taken the initiative and the leadership in developing a plan of Action to address GBV in the health sector, however other sectors need to collaborate and provide necessary support in order to launch a successful, effective, comprehensive and high quality health sector response.

The Family Protection Unit, Ministry of Law and Gender, Ministry of Justice, Police and NGOs addressing the issue of GBV are few of such organizations that the FPA needs to collaborate with and work together with other relevant authorities/agencies/services/NGOs in order to achieve a successful response.

9.1. Linkages within the health sector

Health Protection Agency is the focal agency responsible for the health sector response with the Director General Health Services and the Secretary Health Services directing and overseeing the activities.

Health Protection Agency being responsible for reproductive health issues addressing GBV which cuts across all RH issues would be the most logical and appropriate arm of the MoH to launch and sustain the health sector response.

It is important to collaborate with the other sectors within and outside the MoH in responding to GBV as identified in the Plan of Action.
Some of these sectors are:

40 Gender –based violence: Health and the Health sector Public Health at a glance .World Bank http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTPHAAG/0,,contentMDK:22421973~pagePK:64229817~piPK:64229743~theSitePK:672263,00.html#Role

Regional and Atoll health administration

Streamlining GBV care services available at these levels of health institution by way of identifying a common reporting form and a mechanism and identifying a health provider who would be the entry point for the pathway of care for the survivor could be achieved with the collaboration of these institutions.

On a future date providing a GBV center dedicated for providing services for survivors of GBV may be envisaged with the collaboration of these sectors.

Private hospitals and practitioners

As some of the survivors access the private sector and the private sector is expected to provide parallel services it is important to reach a consensus and identify the mechanisms for these two sectors to operate complimentary to each other in order to avoid duplication of services and to minimize burden to the state and to the survivors in time and finances.

Interdepartmental linkages within the health institutions such as regional and tertiary hospitals such as IGMH. Collaboration between the dedicated service center such as the FPU and the other relevant departments such as A & E, maternity, psychiatric, and surgical is very important to identify service needs and initiate referrals in one hand and to refer for services on the other hand. Collaboration should extend to sharing experiences success stories through regular communications which in turn helps to build up the image of the service point.

Annexure 1

Consent form

Adapted from WHO Document Clinical management of Rape Survivors

Name of facility IGMH / Regional hospital/Atoll Hospital/Health Center - - - - - - - - - - - - - - - - - -

Instructions to the health provider:

After providing the relevant information to the survivor please read the entire form to the survivor (or his/her parent/guardian), explaining that he/she can choose to refuse any (or none) of the items listed. Obtain the signature or a thumb print with signature of a witness and confirm the fact by your own signature.

I, - , *(name of survivor)*

authorize the staff of the above-named health facility to perform the following *(tick the appropriate response):*

Conduct a medical examination Yes No

Conduct genital / pelvic / anal *examination Yes No

Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs * Yes No

Provide evidence and medical information to the police /courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided. Yes No

I understand that health authorities are obliged to provide information on this examination and investigation to Police /Courts /FPA
I understand that I can refuse any aspect of the examination I don't wish to undergo and am willing to take responsibility for that)

Signature: -

Date: -

Witness: -

I Dr/Mr/Ms. confirm that I have explained in detail ,the contents of this document to the survivor

…………………………………………………….

Signature of the care provider

The following to be printed on the back of the consent form)

Guidance to obtain informed consent

- It is expected that the survivor (or his/her parent(s) or guardian) will receive information on all the relevant issues, to help the survivor /(or his/her parent(s) or guardian) make a decision about what is best for her/him at the time.

- Explain to the survivor or his/her parent(s) or guardian) that her /his lack of consent to any aspect of the exam will not affect her / his access to treatment and care but the lack of information that could be gained may limit the diagnosis and legal opinions expressed .

- Provide information in a language that is readily understood by the survivor or his/her parent/guardian

Explain what happens at examination particularly when doing genital/pelvic /anal/ examinations or lab investigations (as and when relevant)

Annexure 2

Medico legal Record *Adapted from WHO Document Clinical management of Rape Survivors*

(To be used for providing a report on adults and children)

Confidential

Name of the Hospital …….

MLC No.

Hospital No.

General Information					
Name					
Address	Temporary:		Permanent:		
Brought /Referred by : Self/Police/Parent /……..	Name:		Address :		
Sex		Date of birth: ID card number:		Age	
Marital status	Married /Separated /Widowed				
Date and Time of Examination					
In the case of Children	Name and address of the parent /Guardian *(particularly when the history is given by this person)*	In the presence of*(If applicable)* Name ……. …….	Signature ……		
About the incident					
Date of incident		**Time of incident**			
Description of the incident *(in survivor's words) **					
Physical Violence	**Yes**	**No**	**Details**		
Type					

Physical/Sexual etc.				
Use of restraints				
Drugs/alcohol involved				
Penetration	**Yes**	**No**	**Details**	
Penis				
Finger				
Other				
Ejaculation				
Condom Used				
After the incident Did the survivor	**Yes**	**No**	**details**	
Vomit				
Urinate				
Rinse Mouth				
Have a wash / bath				
Change clothing				
Medical History				
Contraception use				
Menstrual History				
Last Regular Menstrual Period			Was she menstruating at the time of incident	Yes /No
Evidence of Pregnancy			Number of weeks Pregnant	
Obstetric History Summary				

History of prior consenting intercourse **Only if samples have been taken for DNA Analysis**				
Last consenting intercourse if within one week	Date			
Existing Medical conditions				
Allergies				
Current medications *(if any)*				
Vaccination	Tetanus		Hepatitis B	
HIV Status	Known	Yes /No	Unknown	
Medical Examination				
Appearance	*(Clothing, Hair obvious physical or mental disability …)*			
Mental State as perceived by the examiner	*(Crying, anxious, agitated, depressed, depressed, cooperative etc.)*			
Weight:	Height:		Pubertal Stage Pre pubertal/pubertal/Adult	
Pulse:	Blood Pressure:	Respiratory Rate:	Temperature:	

Physical Findings*(Use the body maps attached)* *Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae,marks, etc. Document type, size, color, form and other particulars. <u>Be descriptive, do not interpret the findings.</u>*	
Head & Face :	Mouth & Nose:

Eyes Ears:	Neck:
Chest :	Back :
Abdomen :	Buttocks:
Arms &Hands:	Legs & Feet:
Genital & Anal Examination*(Use the body maps attached)*	
Vulva in females /Scrotum in males:	Introitus and Hymen
Vagina in females /Penis in males:	Cervix:
Anus:	Bimanual/ Recto vaginal Examination:
Position of survivor *(supine, prone, knee-chest, lateral, mother's lap:)*	
For Genital Examination:	For Anal Examination :

Investigations Done		
Name of examination	Examined /Sent to Laboratory	Result *(if available)*

Evidence Taken		
Type and location	Send to / Stored at	Collected by / on …….(*date)*

Treatment Prescribed			
Treatment	Given	Not given	Type and Comments
STI Prevention:			
Emergency Contraception:			

Wound care :			
Tetanus Prevention :			
Other *(Specify)* :			

Other Services ,including referrals and arrangement for follow up :
General psychological emotional status as perceived by the examiner :
Details of Counseling /befriending provided :
Referrals for in-depth counseling *(if done)*
Follow up offered : Accepted /Not If yes date of next visit
Summary of the medico legal examination (*The absence of lesions should not lead to the conclusion that no sexual attack took place)* *Certificate prepared on this day and handed over to the person concerned as proof of evidence.*

Name of the Health professional conducting the examination :	
Designation :	
Date :	
Time:	
Signature :	
Name of the person to whom the report was handed over :	
Designation and Signature :	

**** If the survivor is a child, also ask:***

Has this happened before?
When was the first time?
How long has it been happening?
Who did it?
Is the person still a threat?
Also ask about bleeding from the vagina or the rectum, pain on walking, dysuria, pain passing stool, signs of discharge, any other sign or symptom.

Annexure 3

Format for Transmitting information (*details of a specific incident)* **on Instances of Domestic Violence to Family Protection Authority** *(when applicable)*

Domestic Violence Referral Form

Form Number:

Date:

Organization case is referred to:

Case Information:

Reported by:	Reported time:
Phone number:	
Case received by:	Reported Date:
Protection Order: Yes ☐ No ☐	
Has the case been reported to any other organization? Yes ☐ No ☐ If yes, please specify the organization:	

Survivor Information:

Name:	Gender: Female ☐ Male ☐
Permanent address:	Date of birth/Age:
Current address:	ID card / PP number:
If survivor is a child:	
Name and Address of Father:	Phone number:
Name and Address of Mother:	Phone number:
Name and Address of Guardian:	Phone number:

Perpetrator Information:

Name:	Address:
Relation to survivor:	Phone number:

Case Details:

Checked by

Signature
Name

Annexure 4

Format for Transmitting information on Instances of Domestic Violence and GBV to relevant Authorities other than Police *(when applicable)*
Family Protection Authority, Health Protection Agency, Island Councils *(when applicable)*
Sent as a monthly report without identifying individuals and maintaining confidentiality *(when applicable)*
(However details of an specific incident if requested formally needs to be provided accordingly)

Year and the Month		
Name of the hospital		
Name and designation of the officer preparing the report		
Details of GBV survivor by type : Number of survivors seen /reported during the month		
Domestic Violence		
Child Abuse		
Rape		
Incest		
Forced marriage		
Others *(Please name)*……..		
Services provided to survivors during the month *(No. of Survivors provided with the service)*		
Emotional support by a health professional		
Counseling by a professional counseling		
Medical care for injuries		
Providing a medico legal report		
Referrals done		
Police		
Higher hospital for medico legal services		

Health Protection Agency
Ministry of Health

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