PATHFINDER

Integrating Gender-based Violence First Line Response into Sexual and Reproductive Health Services

AN IMPLEMENTER'S TOOLKIT

ACKNOWLEDGEMENTS

We give thanks to the many survivors who bravely came forward to ask for help and share their stories, and whose journeys informed all the work on which this toolkit is built.

Pathfinder gives thanks to the World Health Organization (WHO), JHIPEIGO, UNFPA, UN Women, and the many people who have contributed to understanding and evidence on what works to integrate first line response and GBV responsive services into primary SRHR care.

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Introduction

For more than a quarter century, the global community has recognized gender-based violence (GBV) as a human rights violation as well as a complex social challenge that presents in multiple forms and contexts. The 1993 United Nations (UN) Declaration on Elimination of Violence Against Women defines GBV as "any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering *[on the basis of gender]*, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life." In November 2019, more than 170 countries renewed commitments to address, prevent, and respond to GBV at the Nairobi ICPD+25 Summit.

Nonetheless, GBV remains a global issue that is frequently and consistently exacerbated in times of stress and crisis. Humanitarian emergencies, economic hardship, natural disasters, and disease outbreaks such as the ongoing COVID-19 pandemic invariably result in spikes in myriad forms of GBV. Global estimates by the World Health Organization (WHO) and other UN agencies indicate that one in three women, and one in ten men, will experience sexual violence in their lifetime. As many as two in three women will experience intimate partner violence, and as many as 30% of girls have a non-consensual sexual debut. It will require intersectoral, persistent, and courageous action to overcome this reality and bring about a world in which people of all gender identities can lead lives free from violence, discrimination, and coercion—enjoying their right to full bodily autonomy and reproductive agency.

Since 2016, the WHO has outlined clear evidence, strategies, and entry points for the health sector response to violence against women and girls. Notably, the Global Plan of Action for Health System Response to Violence Against Women and Girls[1] highlights the unique role that health providers—particularly sexual and reproductive health (SRH) care providers—play as an extra-familial, professional point of contact. Furthermore, the report highlights that globally, those most affected by violence are more likely to need and use health services. Yet, SRH providers and service managers are often ill-supported and undertrained to recognize violence; build confidence and competence in discussing violence; and provide first-line response to clients in need of help.

Furthermore, functional integration of SRH services remains inconsistent at global level with many national health systems offering family planning (FP) & contraception, MNCH, HIV & STI, and GBV services under different departments, and even in separate facilities. To bring essential services under one umbrella, maximize efficiency of health system resources and expand access to first line response for people living with GBV, SRH primary care providers and SRH primary care systems should be supported to integrate GBV services at multiple levels.

1 The global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children. World Health Assembly, Resolution 69.5, May 2016 Online at: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_9-en.pdf WHO Department of Reproductive Health and Research.

PURPOSE

The GBV-SRHR Service Integration Toolkit was developed as a practical guide and resource compendium for health system managers, program managers, and civil society groups working to strengthen quality of and access to health sector-based GBV response services. This toolkit provides practical tips, implementation tools, and provider job aids. This toolkit provides resources and guidance for integration of GBV and SRH at multiple stages. It can be used across a range of contexts—ranging from those where integration is being introduced for the first time to contexts where GBV-SRH service integration has begun and faces challenges in operationalization. The 2022 edition is focused on enabling integration of GBV disclosure and first-line response across primary SRH services. For guidance and tools specific to advanced medico-legal and/or forensic services, users should access the WHO's Strengthening the Medico-Legal Response to Sexual Violence Toolkit.

HOW TO USE THIS GUIDE

This guide is modular, such that users can easily locate tools and resources relevant to their current challenge and/or to the phase of programming design and implementation in which they find themselves. The table of contents is navigable; click on the section or tool of interest to be taken directly to its starting page. Users can also move between modules via the navigation bar found at the bottom of each page. This toolkit is not intended to be used front-to-back. All tools are provided as open, printable resources. We do ask that acknowledgment and proper citation be used.

Indicates printable resource

MODULE 1:

First, Do No Harm

There is a common and understandable instinct to do everything possible to respond to GBV once one becomes aware of this hidden pandemic and its myriad negative impacts on the health and wellbeing of individuals, families, and communities. However, confronting GBV too aggressively (e.g., launching universal screening without proper referral channels; confronting known or suspected perpetrators in community settings; or requiring women who share experiences that constitute GBV to receive legal or medical services) can do more harm than good. Community and or service provider actions that threaten exposure of a perpetrator and/or which lead a violent partner to feel their control is being threatened frequently cause escalations in violence. In addition, the psychological risk taken by disclosing violence is significant and encouraging disclosure without ability to offer adequate response may cause further emotional harm[2]. When embarking on new initiatives or activities to address GBV, it is essential that all stakeholders and programmers begin with clear guidelines to ensure interventions are, at worst, neutral.

GBV RESPONSE: DO NO HARM PRINCIPLES

1. **Always protect and promote privacy and confidentiality.** GBV is most often perpetrated within the survivor's home.
2. **Always validate that a survivor has a right to feel and be safe.** She is never responsible for the violence she is experiencing or has experienced.
3. **Never pressure or force a survivor to speak about their experiences with violence.** Proactive screening to determine whether an individual is experiencing violence is not recommended. Proactive screening should never be conducted unless minimum requirements for frontline worker training and availability of referral resources are in place.
4. **Only ask the minimum information** required to provide appropriate health care.
5. **Minimize the number of contacts a survivor must experience** to receive comprehensive medical, psychosocial, and legal services.
6. **Ensure minimum standards are in place** for each level of service/response you aim to provide. Use guidelines for first-line response, comprehensive health sector response, and advanced medico-legal service to determine whether each context, service site, and project can safely support the related service package. *See Pathfinder decision tree when in doubt.*

PILLARS OF TRAUMA-INFORMED PROGRAMMING

Safety

Choice

Collaboration

Trustworthiness

Empowerment

2 Mannell, Jenevieve, Iran Seyed-Raeisy, Rochelle Burgess, and Catherine Campbell. "The Implications of Community Responses to Intimate Partner Violence in Rwanda." Edited by Andrew R. Dalby. PLOS ONE 13, no. 5 (May 2, 2018): e0196584. https://doi.org/10.1371/journal.pone.0196584.

7. **Stay within defined scopes of practice.** Only individuals who have been trained in comprehensive clinical response for GBV should provide these services.

8. **Uphold the autonomy and agency of the survivor** throughout provision of services. Apply principles of informed consent and client-centered care. This extends to and should always include informed consent and client-led decision making around whether to report and/or take judicial action, or other forms of punishment against the perpetrator.

9. **Do not pressure or lead a survivor of intimate partner violence into leaving the relationship.** The largest percentage of partner homicides occur at the time a survivor tries to leave the relationship. She will know best if she can and is ready to leave.

10. **Confront provider bias and prejudicial social norms** that may result in decreased standard of care or discrimination against marginalized groups (e.g., adolescents, ethnic, religious, or sexual orientation minorities, people with disabilities).

11. **Aim for universal coverage of positive prevention messaging and support for service seeking.** Sharing charged messages about GBV or emphasizing harmful traditional norms may lead to community backlash and/or increases in violence. Such backlash can target survivors and/or health workers. Assume GBV is occurring—one in three women globally experience GBV—and integrate information about community resources and prevention messages into other SRH information, education, and communication (IEC).

Please see following page for a printable pocket card.

GBV RESPONSE: DO NO HARM PRINCIPLES

1. Always protect and promote privacy and confidentiality.
2. Always validate that a survivor has a right to feel and be safe.
3. Never pressure or force a survivor to speak about their experiences with violence.
4. Only ask the minimum information.
5. Minimize the number of contacts a survivor must experience.
6. Ensure minimum standards are in place.
7. Stay within defined scopes of practice.
8. Uphold the autonomy and agency of the survivor throughout provision of services.
9. Do not pressure or lead a survivor of intimate partner violence into leaving the relationship.
10. Confront provider bias and prejudicial social norms.
11. Aim for universal coverage of positive prevention messaging and support for service seeking.

FOLD

GBV RESPONSE: DO NO HARM PRINCIPLES

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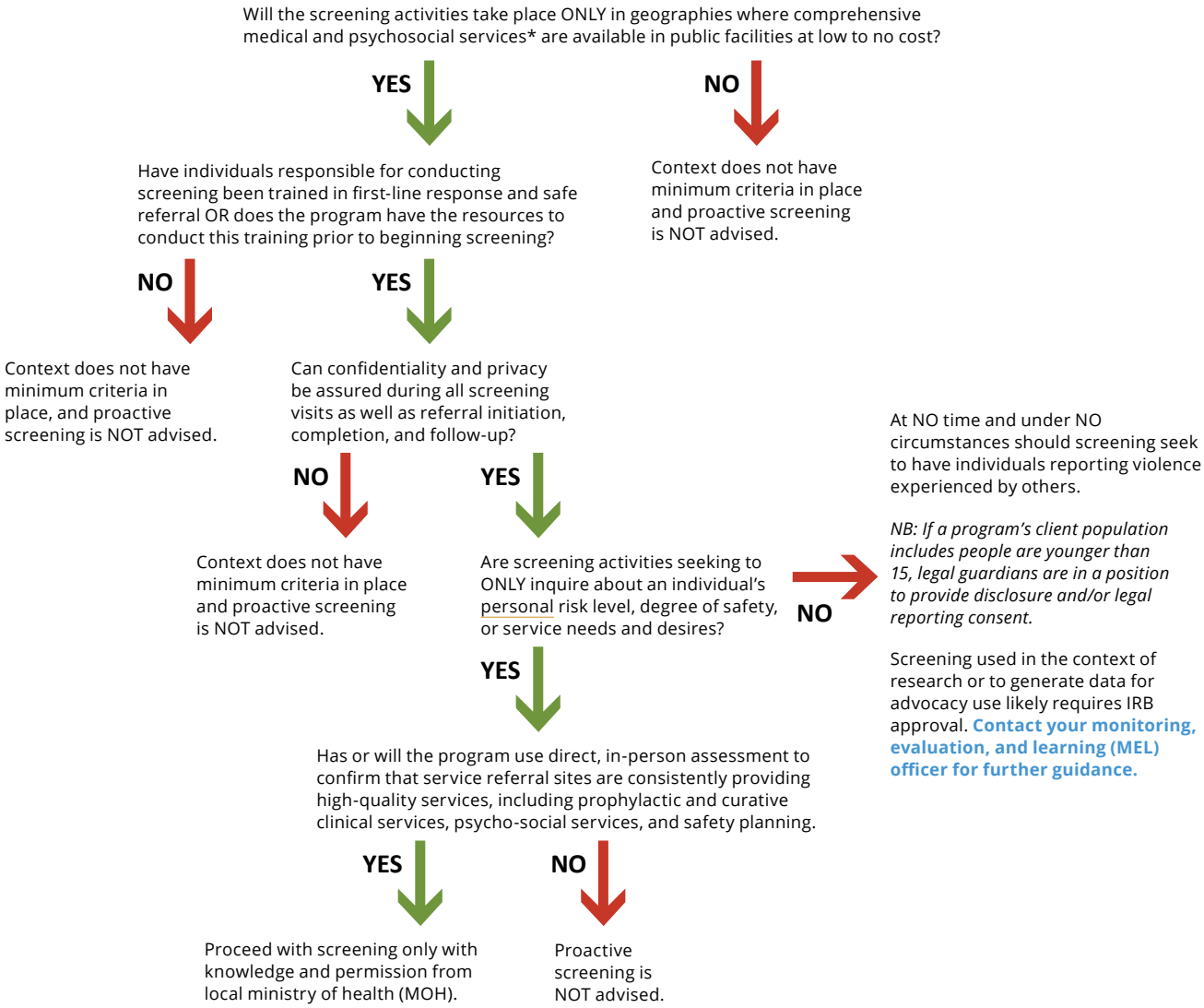
DETERMINING WHETHER TO INTRODUCE UNIVERSAL SCREENING

Universal screening refers to the practice of routinely asking all clients questions to solicit disclosure of gender-based violence and/or to maximize identification of gender-based violence. While empirically useful, the practice is not always what is best for those living with gender-based violence and should only be instituted when provider skills, referral systems, and other response capabilities are in place. The following decision tree can be used to determine whether a given context has the needed enabling elements to support universal screening that is client-centered and trauma-informed.

Decision tree for whether or not to support/implement GBV screening activities



*Psycho-=social services include psychological first aid, safety planning support, and referral to community organizations that support individuals living with or recovering from GBV. Specialized psychiatric services are not required and are commonly unavailable in rural and low-resource contexts.

WHAT TO DO WHEN VIOLENCE OCCURS IN YOUR PROGRAM AREA

Programs that raise awareness of GBV often see an increase in reporting and disclosures as community members become more knowledgeable about the resources available and the safety and protection to which they have a right. Despite all efforts to mitigate risk, integrating GBV messaging and/or first line response into the scope of services provided by CHW or facility-based SRH providers, can inadvertently lead to new incidents or escalations of violence, particularly if perpetrators feel threatened by the program content or objectives.

Violence will not be eradicated overnight, or even within a matter of years. Adhering to Do No Harm principles means being prepared to monitor for new or escalating violence in your program communities and having a plan for what to do when violence does occur.

STEP 1 Follow best practices to mitigate risk of triggering new or escalating violence. Use gender-synchronized approaches to GBV prevention. Ensure all program staff and service providers are trained on Do No Harm principles. Train all staff with direct contact to communities on disclosure response.

STEP 2 Ensure all program staff and service providers are equipped with referral options and familiar with referral procedures for medical, psychosocial, and case-management services. Proactively prepare a list of quality-assured services, inclusive of location, contact information, and details regarding whether walk-in services are available.

STEP 3 Provide standard language to all facilitators, trainers, and anyone else who will be speaking to groups about GBV prevention or response. This language should be used at the opening of all meetings, workshops, trainings, and community dialogues. The following key points may be used as is, or refined into more conversational language:

- GBV is a sensitive and deeply personal issue. It affects many people and likely has or will impact someone you know. It may be affecting your life.
- The most important principle to remember is that all people deserve to feel safe, regardless of life circumstance or personal choices.
- You should never feel pressured to speak or share, and never pressure someone else to speak or share experiences.
- You should never feel pressured to interact with a perpetrator of violence, and you should never pressure someone else to interact with a perpetrator of violence—even if you are working toward forgiveness or reconciliation.
- If you need support, have questions, or would like to talk with someone, resources are available. Any request for information will be treated confidentially.

STEP 4 Know that incidents of violence are happening and will continue to happen in the program's communities of focus. GBV is not eradicated in a matter of years. Have a plan, train staff on the plan, and follow the plan.

STEP 5 When violence is disclosed by a survivor, or a friend of the survivor, focus on connecting the survivor to quality first-line response in a timely manner. Health services are the most common need following a GBV incident. Judicial and legal response are not always desired by the survivor. THIS IS OKAY. Mandatory reporting is not encouraged or supported by global evidence. If local laws stipulate mandatory reporting, pursue advocacy to change such requirements.

When violence is disclosed by the perpetrator, commend them for acknowledging their actions and reinforce new positive behavior messages. DO NOT encourage perpetrators to confront, reach out to, or contact their survivors. Such interactions require highly specialized facilitation and are beyond the scope of SRHR programs.

STEP 6 Follow a systematic process to debrief and review severe incidents once the survivor and/or perpetrator have been connected with appropriate long-term services. Characteristics of an incident that warrant program team debrief include:

- The perpetrator and/or survivor is an active participant of a prevention group or training.
- The incident resulted in hospitalization or death.
- There was a suspected or known safeguarding violation.
- The incident was directly connected to a program activity (e.g., occurred on the outskirts of a meeting site and/or as a participant was on their way home).

The following are standard questions for use during debrief:

- What is known about the chain of events leading up to the incident?
- What, if anything, could have been done differently that might have prevented the incident?
- Is there anything the program team should do to further support quality response?
- Has the incident been anonymously reported into the health management information system (HMIS)?
- Contingent on survivor consent, are the appropriate local authorities and/or health providers aware of the incident?
- Do any compliance, safeguarding, or other misconduct violations need to be reported?

STEP 7 Provide space for program staff to decompress and ask any questions. It is distressing to confront a GBV incident, particularly when the team is working hard to prevent such occurrences. Non-GBV focused discussion, team-building time, and other "breaks" are important to quality programming.

TRAUMA-INFORMED PROGRAMMING

Trauma and trauma-informed care have become buzzwords. What do they really mean, and what are the implications for GBV-SRH service integration? Put simply, trauma is the experience of a harmful event or series of events beyond what an individual can rationalize or comprehend, leaving lasting psychological impacts. Global evidence strongly indicates that repetitive events have a cumulative effect on severity of impact. Trauma-Informed care or programming recognizes and makes a proactive effort to learn the pervasive nature of trauma, particularly the most common traumatic experiences of a specific client population. It promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize.[3]

The intention of trauma-informed programming is to provide services in a way that is accessible and appropriate to those who may have experienced trauma; avoid or change methods of service provision most likely to exacerbate trauma symptoms and retraumatize individuals; and provide the survivor with a new experience that empowers rather than reinforces harm or violence experienced in the past. **Safety, choice, collaboration, trustworthiness, and empowerment** are pillars of trauma-informed programming and service delivery. Recognizable as pillars of all person-centered, rights-base care, these facets of service delivery become critical for achieving our goal of GBV-responsive SRH services and systems.

3 Harris, Maxine, and Roger D. Fallot. Using Trauma Theory to Design Service Systems. San Francisco: Jossey-Bass, 2001.

MODULE 2:

Getting Your Program Started

STEP 1 ASSESSING YOUR SERVICE PROVISION ENVIRONMENT

Understanding the policy and health service delivery environment is critical to determining a feasible, appropriate scope and model for integration. If embarking on GBV-SRH service integration in a new geography, it is critical to make time to map the legal framework, and map and define referral pathways.

Legal framework mapping

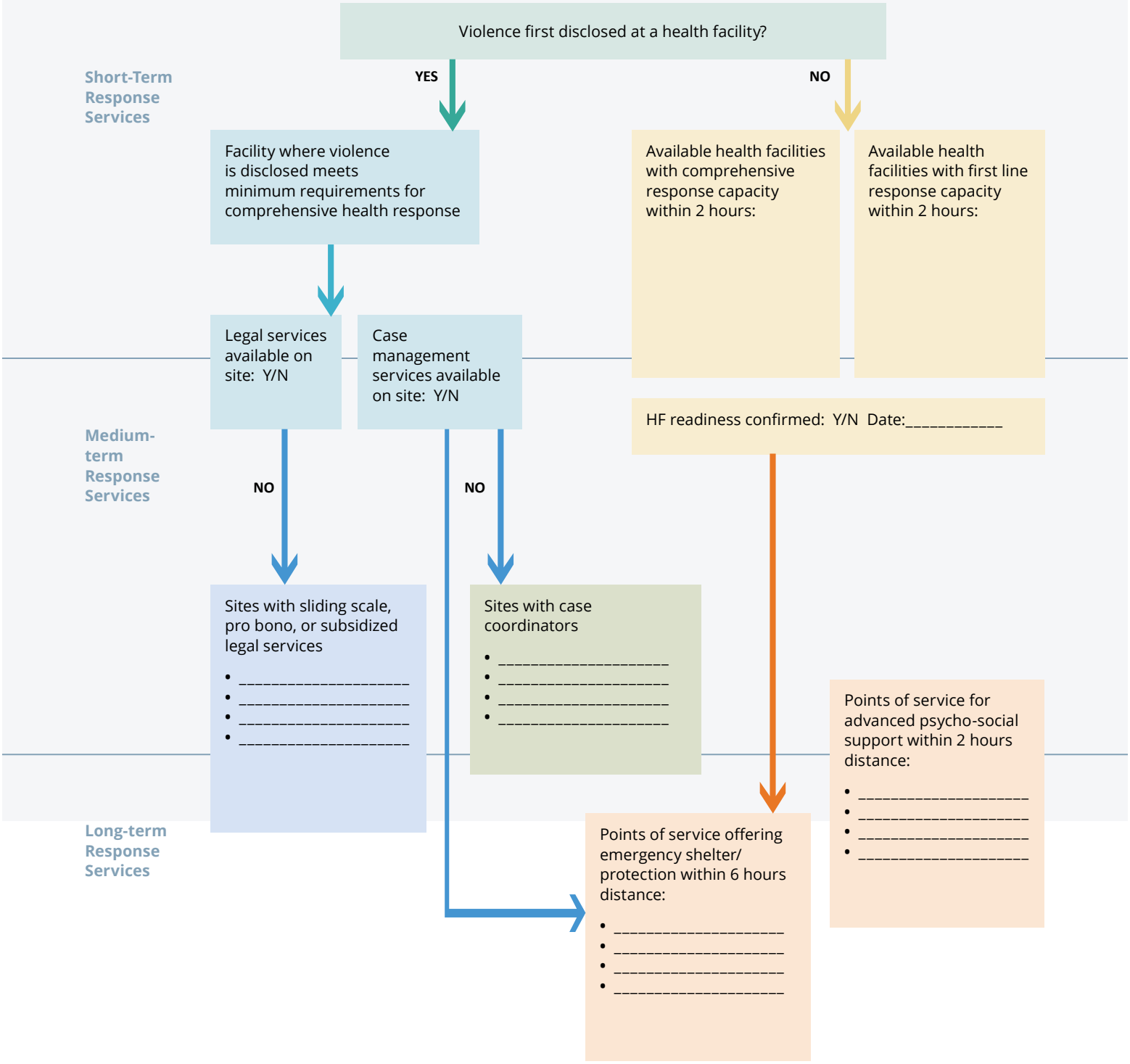
Know your national laws. These vary widely, but have significant implications on implementation, intervention selection, specific content for health worker training, and the application of Do No Harm principles. Completing the table below and sharing with all frontline and technical program staff can help ensure GBV-sensitive programming.

Regulatory Question	Program Context	Notes
Are there mandatory reporting laws? If yes, are there age thresholds for these laws?		*Ensure health workers know any mandatory reporting obligations they do or do not have; and the requirement to disclose this obligation to clients at the outset of any GBV-related conversation.*
What is the legal age of marriage?		
Is there legal recognition of marital rape?		*Consider the implications for abortion access and permissibility as well as potential influence on child, early, or forced marriage or union (CEFMU) patterns.*
Are there legal exoneration precedents or statues for marriage following sexual assault or rape?		*If yes, this is a top priority for advocacy, as it is often a driver of CEFMU.*
Is abortion permitted in instances of rape? If yes, what documentation is required to meet the legal criteria?		*Critical for providers of clinical management of rape to know.*
Is there legal recognition of wife beating as physical assault? Are there regulatory distinctions of severity (e.g., must break the skin or cause fracture)?		
Can a survivor of any age independently file a complaint/request for prosecution? If not, at what age are survivors considered legally independent to choose to press charges?		
Are forensic exams required to file a formal complaint or charge with police?		*Not recommended due to near globally universal challenges in ensuring equitable access to forensic exam services.*

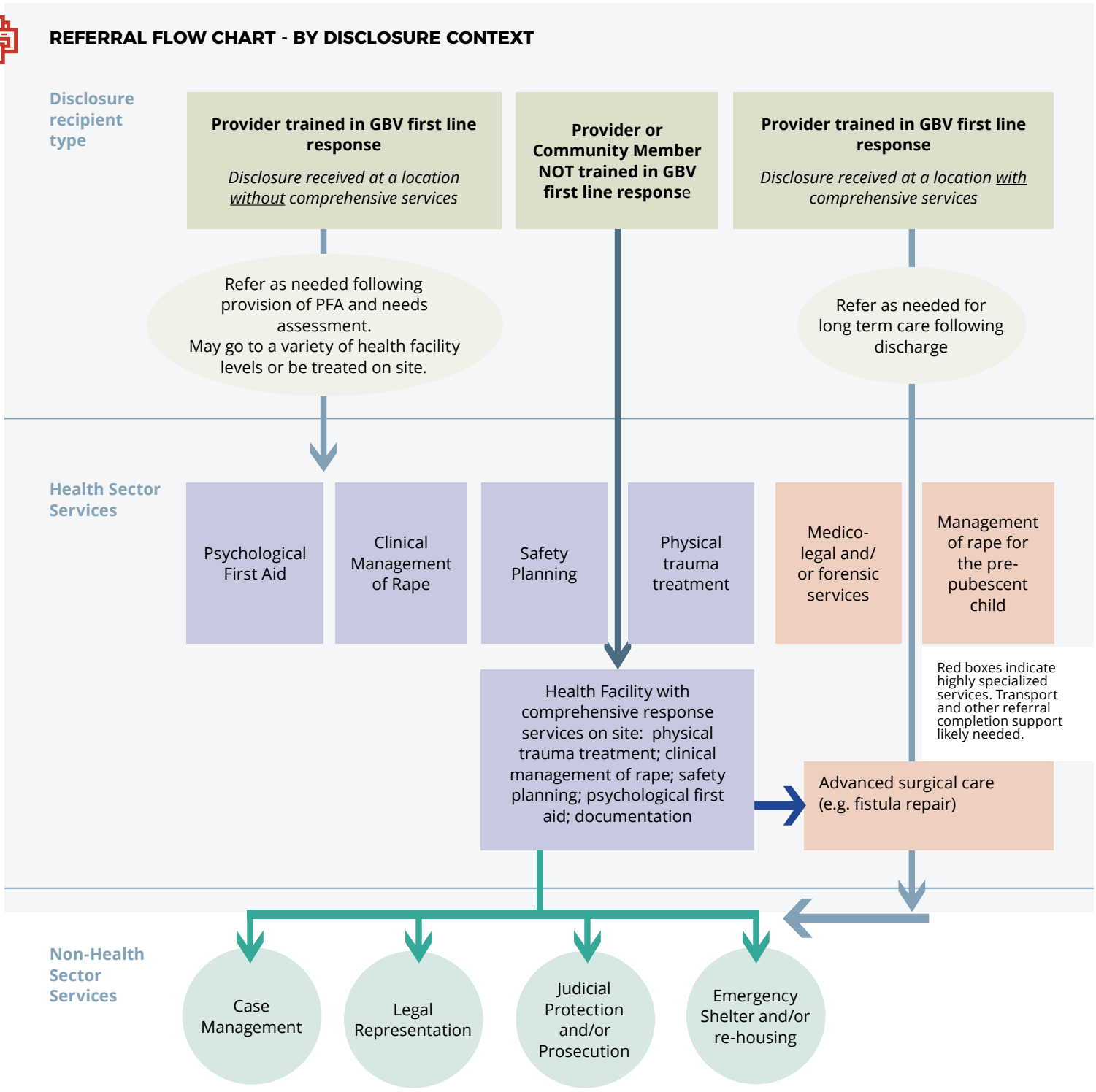
Referral pathway mapping

Programs are encouraged to complete referral maps for each health administration zone in their geographic areas of implementation (e.g., district, local governance area). Health facility managers and providers will need detailed information on proximate referral sites to provide quality care to survivors. The following pages provide templates for referral mapping and referral job aids. These can be printed and used as is, or modified for local context.

COMPLETE AT THE DISTRICT LEVEL OR EQUIVALENT HEALTH ADMINISTRATION ZONE



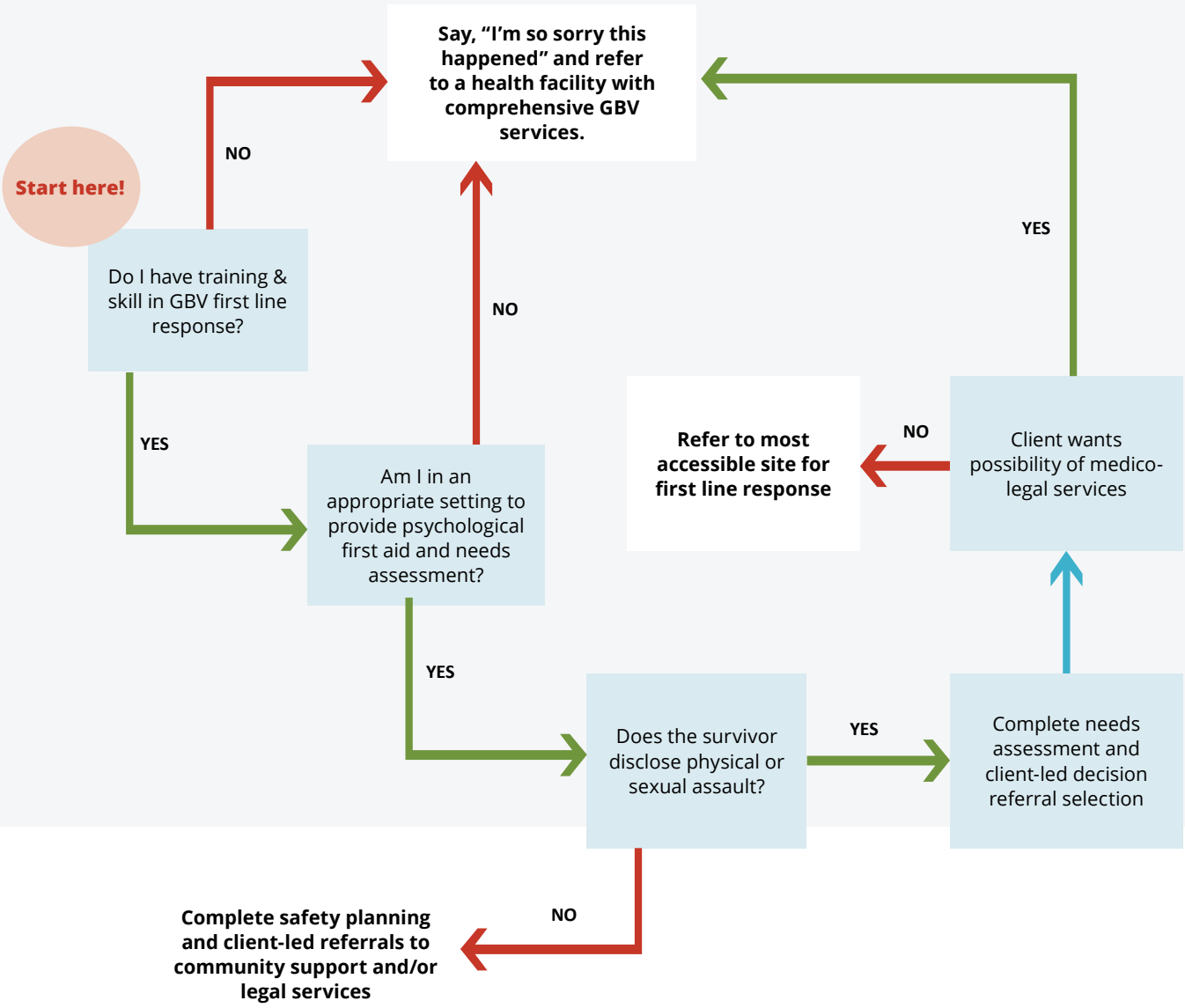
Essential Referral Offerings by Context of Disclosure Setting



Regardless of an individual provider's skill and training, determination of when to directly provide care versus when to refer is also dependent on the setting and resources available at the time of disclosure. Ensure that community health workers and other community-based SRH service providers receive information and guidance on when and how to refer in cases of disclosure by a client experiencing GBV. Ideally, non-provider health facility staff will also receive orientation on how to respond to disclosures of violence.

REFERRAL JOB AID – COMMUNITY AND FACILITY-BASED STAKEHOLDERS

Reminder! If you encounter or are approached with a life-threatening emergency, provide stabilizing treatment and/or facilitate the survivor reaching emergency medical services as quickly as possible before any other action is taken.



STEP 2 ASSESSING HEALTH FACILITY READINESS

Assessing Health Facility Readiness is a complete health facility assessment (HFA) tool available upon request from Pathfinder and online to anyone with access to the Pathfinder Atlas. It spans readiness assessment across many service areas. An extracted GBV service-readiness assessment tool is provided in Annex 1. The tool is designed to distinguish between health facilities ready for provision of first-line response and more specialized facilities with capacity to provide comprehensive GBV response services such as case management; surgical repair of cervical lacerations; or medico-legal services. It is important to note the headers within the assessment tool and follow the skip patterns designated for the level of health sector response you aim to support.

STEP 3 FUNCTIONAL INTEGRATION OF SERVICES

With baseline information about the policy and referral environment, and facility readiness, you can make evidence-based decisions about what level of GBV integration to introduce. In large-scale programs, this often entails definition and establishment of service tiers based on facility size or health system designation. Following determination of service packages and competencies to be offered by each point of service tier, program designers and health system managers will need to select an integration model. Available global evidence suggests that while system integration of GBV and SRH services is important[4], this integration can be effective through multiple models (i.e: integration of services offered by individual providers; integration of services offered within a single facility; or integration of services across facilities through coordinated referral networks). The table below presents core benefits and risks for each model of integration.

Integration Model	Core Principles	Pros	Cons
Provider-level integration	The same provider offers a range of services during one consultation. Must include physical, psychosocial, and legal response	High degree of case management and trust-building for the client. Well-suited to specialty clinics, such as stand alone One Stop Centers or Women's Crisis Centers	Requires a high degree of training and specialization on the part of providers. Feasible only with limited case load per provider. Not well-suited for integration into small, narrow scope SRH service clinics.
Facility-level integration	A range of services is available at one facility but not necessarily from the same provider. Can be provided at general health facilities or at specialty stand-alone facilities (One- Stop Centers)	Reduces travel times, # of visits, and points of contact for clients. Can enable closer collaboration among providers from different sectors and/or specialties.	Can be difficult to extend first-line response services to last-mile populations where facilities only have a couple of providers, and none with GBV expertise. Requires multi-sectoral/ multi-agency coordination and budgeting.
Systems-level integration	There is facility-level integration as well as a coherent referral system among facilities to ensure comprehensive response.	Enables maximum coverage of entry-points to care. Able to leverage specialist providers when few are present in any given country.	Can increase # of visits, travel times, and points of contact for clients. Requires strong, effective, equitable referral system. Increases potential for record confidentiality breaches; record- and data- sharing protocols should be rigorous.

4 Dockerty 2017

Service package tiers

	Initial Disclosure Response	Comprehensive Health Sector First-line Response	Medico-Legal Services[5]
Minimum elements of care	• Psychological first aid • Client-consented referral to treatment and support services • Protection of client privacy, confidentiality, and autonomy	• **All elements of Disclosure Response, plus:** • Post-exposure prophylaxis (PEP) for HIV; sexually- transmitted infection (STI) and other infection prophylaxis and/or treatment (including tetanus) • Emergency contraception • Comprehensive abortion care (CAC) (within extent of the law and including postabortion family planning (PAFP) & postabortion care (PAC) at a minimum) • Treatment for physical injuries (including fistula, lacerations, and broken bones) • Safety planning • Follow-up psychosocial support • Participation in multisectoral coordination and communication • Consistent, confidential documentation of client needs, services provided, and referrals issued	• **All elements of comprehensive first-line response, plus:** • Forensic examination and laboratory-assisted evidence collection • Formal documentation and evidence presentation in alignment with local and national legal standards • Medical testimony as part of legal prosecution or other incident-related legal proceedings (e.g., divorce proceedings)
Minimum standards for service readiness	• Defined service package agreed to by implementing partners and local leaders • First-line response providers have received competency-based training in survivor-centered response to disclosure of violence • Written protocols and standard operating procedures (SOPs) are in place and followed to ensure client confidentiality, survivor agency and consent in referrals, and safe storage of records and data	• Defined service package by point-of-service level agreed to by implementing partners and local leaders • Providers have received competency-based training that covers physical and psychological care. • Designated sites for comprehensive clinical care for assault have 24/7 availability of trained, competent providers. • Essential commodities and supplies are budgeted and stocked. • Psycho-emotional support and care is available onsite or through referral to a nearby service site. • Written protocols and SOPs are in place and followed to ensure client confidentiality, survivor agency and consent in referrals, and safe storage of records and data.	• **All standards required for health sector response, plus:** • All providers have been trained through competency-based methodologies for the following areas: » Forensic examination; » Care, storage, and documentation of forensic samples; » Laws and policies governing GBV in their geography; » Laws, policies, and burden-of-proof standards governing physical evidence of crimes in their geography; and » Risk recognition and alert systems in the event of coercive pressure to alter evidence.

5 Medico-legal services carries a specific burden of responsibility and legal obligation/risk. Standard medical records can and sometime are used as evidence in a legal proceeding. However, standard procedures and documentation are less likely to hold up in a court of law, and may be insufficient – thus requiring secondary examination to be tolerated by the survivor. Contrary to the focus of many government strategies, it is recommended to abstain from this tier of response unless system capacity and competency is carefully assessed and can be confirmed.

As noted in this module, psychological first aid and safety planning are core competencies that all SRH providers should have to optimize integration. In addition, SRH providers--particularly contraception service providers--should be mindful of the intersection of family planning and GBV. Sample job aids for these services are provided below.

JOB AIDS for Facility-Level Integration of GBV & SRH Services

1. Safety planning worksheet

CLIENT CODE: _____

Date:

STEP 1 Introduce safety planning to the client:

"Your safety is important to me. I want you to know that what is happening to you is not your fault. You may not always be able to avoid or prevent a dangerous situation, but there may be ways to defuse it, or to protect yourself from greater harm. I have a list of questions that we can go through together to help us think about ways to increase your level of security during difficult times. We can stop any time you would like, either to take a break, or to stop all together. This plan is just for you. I will not share it with anyone else.

Would you like to continue?

If yes, would you like a copy of this plan kept in your locked file? Y/N

Would you like a copy of this plan to take with you? Y/N

STEP 2 Review the following discussion questions with the client. Take brief notes in the space provided.

Security Measures	Notes
Have you confided in someone about what you're going through? Is there someone you'll feel comfortable talking to about this? You deserve to be supported.	
Once you have identified a supportive person, is there a way for you to warn them that you are in danger? How? What about at night? How?	
Where are you most worried about experiencing violence? What is the physical environment like? Is it an enclosed space? Are there sharp objects or weapons that can be used to hurt you more? Are there locations in the environment that could be used to trap you? Are there objects or locations that you can use to separate yourself from the perpetrator (e.g. a large table, a lockable bathroom door)? Can you stay away from those objects and/or put a protective object (e.g: a table)	

Security Measures	Notes
Reiterate: I want you to remember that you are never responsible for acts of violence committed against you. THEN, Are there patterns of behavior or verbal cues that a common situation is becoming violent (for example, your partner coming home drunk)? Do you have techniques that help de-escalate the situation (e.g., send the children to play at a neighbor's home until the perpetrator passes out)? **NB: This can include extremely hard decisions such as submitting to unwanted sex to avoid physical violence. Reinforce for the survivor that she is making strong choices to protect herself and you support her looking out for her own safety.** How might you remove yourself from the environment when you notice these warning signs? Where would you go? Is that space safe? Does it provide an option for reaching out for support (e.g., there is cell signal, it is a supportive friend's house, it is your own home)?	
Do you have children? Are they ever with you at times when you worry about violence taking place? Have you talked with your children about where they can go to be safe when violence occurs? Who are the safe adults they can get to without you? Do your children know how to reach those adults?	
If you must leave your home, can you identify at least two places you could go? During the day? At night?	
If you leave your home, what important personal belongings will you need to take with you? (e.g., money, identification, contact details, mobile phone, legal documents) Where can you keep these items so they are easily reachable and protected?	
Are there any health services that you worry will trigger or increase your risk of violence, such as using a contraceptive method at home, sharing results of a pregnancy test, or disclosing an STI? Would you like help choosing a contraceptive method that is not easily detectable? Would you like to bring your partner to the health facility and/or have support from a community health worker so that you are not alone when sharing health information?	
Sadly, there is a universal pattern that controlling or violent partners often escalate their violence when they feel their control is threatened. This makes the times when you might reach out for help (getting health care, making a police report, ending the relationship) particularly important for having a safety plan in place. If you needed to quickly leave you home in the middle of the night, where would you go that the perpetrator is unlikely to find you or unable to gain admittance? Would you need to bring your child(ren) with you? What will you need ready for them? *Explain to the survivor that, if possible, they should have a "go bag" already stored at their safe destination or somewhere in the house the perpetrator is unlikely to find it.*	

2. LIV(ES) Pneumonic Pocket Card *[Adapted from: WHO 2018]*

Listen closely, with empathy, not judgment.

Ask and assess her needs and concerns—emotional, physical, social, and practical. Respond in order of her priorities, not your own.

Show that you believe and understand her.

Discuss how to protect her from further harm. Explore actions she can take for herself.

Help connect her to services, social support, and follow-up care.

FOLD

Listen

Inquire about needs and concerns

Validate

Enhance safety

Support and refer

SIGNS OF IMMINENT RISK

- Tried to strangle her
- Beaten when pregnant
- Reports fear of being killed*
- Threatened with a weapon
- Escalation of violence over past 14 days
- Client younger than 13*

*Seek help from a GBV specialist before concluding visit

Asking about violence

You might say:

- Many women experience problems with their husband or boyfriend, but it is not acceptable for them to hurt you or make you feel afraid.

You might ask:

- Have you been forced into sex when you didn't want it?
- Are you afraid of your husband (partner)?
- Has he or someone else at home threatened to hurt you? If so, when?
- Does he try to control when you go out of the house or have access to cash?
- Does he or someone else at home bully or insult you?
- Has he threatened to kill you?

3. GBV-Responsive Contraceptive Counseling Guide

Method	Pros	Cons	Discussion Points
Injectables	• Leaves no sign on the skin • No supplies to keep in your home if provider administered • May have a self-administration option (if DMPA-SC is in use) • Often lightens or leads to cessation of monthly bleeding	• Often lightens or leads to cessation of monthly bleeding • Frequent, repeat service visits are required to maintain injections and contraceptive protection	• **Are you concerned that a partner or other family member is tracking your periods?** • **Can you reliably come to the health facility for repeat injections, on time?**
Implants	• Maintains contraceptive protection for several years,usually no follow-up required • No supplies to keep in your home	• Sometimes can be felt and seen under the skin of the arm • May cause off-cycle spotting or other changes in menstrual bleeding (often short-term after insertion)	• **Are you concerned that a partner or other family member is tracking your periods?** • **Are you concerned about a partner or family member noticing a new mark on your arm?**
Intrauterine contraceptive device (IUCD)	• Maintains contraceptive protection for several years, usually, no follow-up required • No supplies to keep in your home	• Copper IUD often increases menstrual flow and intensity of menstrual cramping • Hormonal IUCD often lightens or leads to cessation of monthly bleeding • String ends of the IUCD may be felt at the cervix during intercourse • May create a pathogen route for STI to enter the uterus	• **Do you have concerns about your partner feeling the strings during intercourse? Would you like the strings cut shorter or left longer for hiding within or behind or the cervix?** • **Do you have elevated risks for STIs?**
Oral contraceptive pills	• Leaves no sign on the skin • Little effect on menstrual bleeding • Well-suited to community distribution, does not always require repeat visits to a health facility	• Must be taken every day around the same time • Pills must be properly stored in the home and are susceptible to moisture damage or sabotage by a partner or other family member • Usually dispensed with no more than three months' quantity	• **Are you worried a partner or family member will try to throw away or damage your pills?** • **Do you have a dry, safe place to store them?** • **Will you be able to take your pills every single day?**
Female (internal) condoms	• Can be inserted several hours in advance of intercourse • Offers protection against HIV/STI • Placed by the female partner • Well-suited to pharmacy procurement or community distribution	• Will be felt and noticed by your partner • Requires correct insertion and removal to maintain protection, ideally with access to proper hand-washing before and after	• **Are you concerned your partner will object or become angry if they notice condom usage?** • **Are you comfortable with internal placement/insertion?**

MODULE 3:

Continuous Quality Assurance and Improvement

The United Nations' Sustainable Development Goal (SDG) 3.8 focuses on universal health coverage (UHC) and demands that countries to move toward ensuring that all people and communities receive **quality** essential health services. As such, integration of GBV response into primary SRH services requires a focus on provision of quality care and the use of continuous quality improvement (CQI) and assurance (CQA) processes. In 2022, Pathfinder developed an evidence-based CQI/CQA framework that articulates seven core elements of quality health care as defined by the National Academy for Medicine.[6]

SAFE care minimizes risk and harm, avoids preventable injuries, and reduces medical errors.

EFFECTIVE care ensures that evidence-based health services reach those who need them.

PEOPLE-CENTERED care is respectful of and responsive to individual patient preferences and needs, ensuring that patient values guide all clinical decisions.

TIMELY care minimizes wait times and potentially harmful delays for both those who receive and those who give care.

INTEGRATED care is coordinated across levels and providers and makes available the full range of health services throughout the life course.

EFFICIENT care maximizes resources and avoids waste of equipment, supplies, ideas, and energy.

EQUITABLE care is consistent in quality regardless of client characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status.

The standards recommended below advance and uphold these seven domains of quality for GBV response offered in the context of SRHR systems and service visits.

6 Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academies Press, 2001. https://doi.org/10.17226/10027.

Recommended Quality Standards to Introduce and Monitor

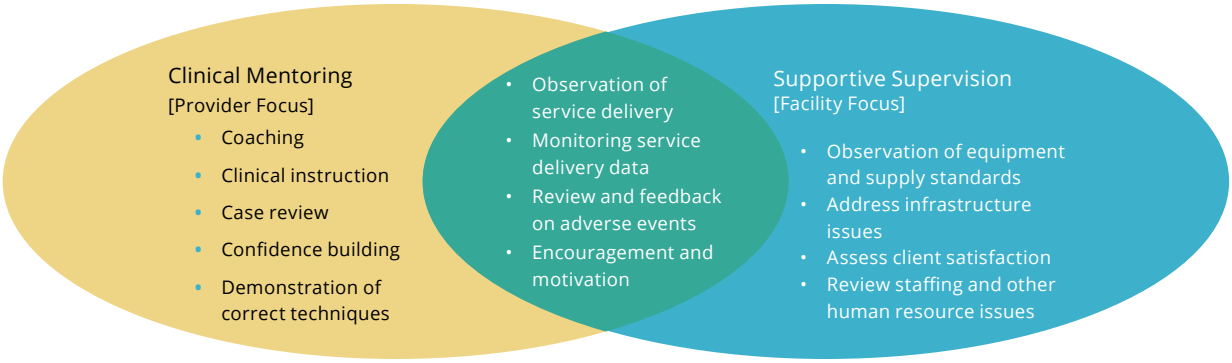
Quality Standards and Dimensions	Operational Definition	Acceptable Minimum
1. Client **informed consent** is sought and obtained prior to any procedures, inquiry, or documentation for medico-legal/forensic purposes.	Informed consent counseling on laws, mandatory reporting, record storage, and statute of limitations, as well as necessary procedures, is provided and written consent obtained or declined for every client at sites with capacity to provide medico-legal services.	Informed consent counseling on laws, mandatory reporting, record storage, and statute of limitations, as well as necessary procedures, is provided and written consent obtained or declined for every client at sites with capacity to provide medico-legal services.
2. **First-line GBV response** is available at all health facilities providing SRH services and accessible to people of all ages and gender identities.	All SRH health facilities can provide client-centered response to disclosure, stabilization of injuries, psychological first aid, and referrals. The response should comply with the three main principles guiding the survivor-centered response services: respect, confidentiality, and safety.	Client-centered response to disclosure and referral to health center or other facility with capacity to provide first-line package of services, regardless of age, marital status, gender identity, sexual orientation, or socioeconomic status.
3. Space for a **and confidential** consultation with audio and visual privacy	GBV wards do not have publicly visible marking, private waiting areas are available upon request, and space or fans are available to establish auditory privacy during consultation and treatment.	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facilities, limit services to first-line response and referral.
4. **Providers** mandated to offer comprehensive GBV services have **proven competency** in the minimum package of evidence-based skills and services required.	All cadres providing GBV services scored at least an 80% on competency assessment for their scope of practice.	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facility, limit services to first-line response and referral.
5. Written **protocols and/ or SOPs** for provision of GBV services are present in service rooms.	SOPs and protocols are printed and present in all GBV service provision rooms (including lab sites). Must include: a. Do No Harm principals b. Clinical treatment protocols, include pyschological and safety planning c. SOP for history taking and physical assessment of adolescents, with specific SOP for very young adolescents d. Client record access protocol e. Mandatory reporting protocols for adults and children f. Decision tree for whether to provide forensic exam and documentation	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facility, limit services to first-line response and referral.
6. **Confidentiality mechanisms are in place for recording information** and maintaining service registers about the survivors' experience of violence and care received.	Policies and procedures are in place that maintain survivors' confidentiality. The point of health service delivery ensures privacy where services are provided. This includes both physical privacy and confidentiality. The layout that is designed to ensure privacy throughout an adolescent's visit. This includes the point of entry, reception area, waiting area, examination area, and patient-record storage area. Separate space or barriers are in place to ensure auditory privacy and confidentiality. Mandatory reporting laws are not recommended based on global evidence and should be discouraged where possible. Reporting to parents is never advised for survivors over the age of 13. For younger survivors, reporting to parents is conditional on assessment of whether a parent is the perpetrator.	Mandatory for all sites offering health response for GBV. Where mandatory reporting laws are in effect, concurrent advocacy efforts to bring the legal framework into alignment with global best practice is recommended.

Quality Standards and Dimensions	Operational Definition	Acceptable Minimum
7. Clients' **agency and choice** are respected and promoted in provision of GBV services.	Promoting individual agency and choice refers to the provider's capacity and willingness to support a client's voluntary informed decisions about care, without pressure to conform to gender and social norms.	Providers do not require a client's spouse, partner, or family member to give consent for services (unless mandated by emergency or government policy). Information and counseling are given to clients to make an informed choice.
8. Availability of essential **commodities and supplies**	Health facilities should be supplied with equipment, consumables, and medicines for at least three months for provision of GBV services. Facility pharmacists will be trained/refreshed on stocks forecasting, management, and reporting using training curriculum and tools validated by MOH or adapted from other organizations. Stocks availability and management will be verified during supportive supervision visits to ensure that no stockout is reported.	If for any reason three month-stocks cannot be secured, each supported health facility should have equipment, stocks of supplies and medicines for provision of GBV for at least one month while a procurement order has been placed. GBV incidents typically increase during crises. Pre-placement of essential supplies and commodities supports uninterrupted provision of the minimum initial service package (MISP) for SRHR.
9. **Referral systems** are in place to link survivors of any gender or age to **psychosocial support**.	Pre-established routes, indications for, and chain of communication between health facilities and psychosocial services	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facilities, limit services to first-line response and referral.
10. **Referral systems** in place to link survivors of any gender or age to **legal services**, if desired.	Pre-established routes, indications for, and chain of communication among health facilities and mental, socio, protection and legal services. Facilities have in-house or established partners for provision of comprehensive GBV case management.	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facilities, limit services to first-line response and referral.
11. **Referral system** in place to link survivors to **acute physical trauma treatment** as needed (e.g., referral to higher-level care facility in the case of severe injury).	Pre-established routes, indications for, and chain of communication among service points for comprehensive GBV case management.	Mandatory for all sites. All facilities receiving capacity strengthening and/or technical assistance related to GBV should have established referral pathways in case a client presents with severe physical and mental trauma requiring secondary- or tertiary-level emergency treatment.
12. **24/7 availability** of GBV health services	At least one provider trained on comprehensive GBV service provision, including clinical management of rape and safety planning [may be available through a call system, if insufficient providers are available onsite for all shifts].	Mandatory for all sites offering comprehensive health response for GBV. If not possible at dispensary or lower health facilities, limit services to first-line response and referral.
13. Facilities have an appropriate **system in place to respond to and/or identify** clients who have experienced GBV.	Facilities have self-designated as an "active case identification" facility OR as a "routine inquiry" facility. Active case identification should be followed when clients present with voluntarily disclosed GBV or active health issues symptomatic of GBV. Routine inquiry involves screening via family planning (FP) and/or antenatal care (ANC) clinics and is only appropriate where quality, comprehensive GBV clinical services are also available at the same facility. **See When to Screen flow chart in module 1 of this toolkit.**	Active case identification is the most appropriate system for identifying cases of GBV in most contexts. At facilities without capacity to offer comprehensive GBV services (see other standards), it is the only mechanism that should be used.
14. **Written protocols** and/or SOPs s for provision of GBV services are displayed in the health facility.	SOPs and protocols for offered services are printed and present in all service provision rooms (including lab sites).	Mandatory for all supported sites offering GBV services.

While defining and disseminating quality standards is an essential foundation step in establishing integrating services, standards in and of themselves are insufficient to achieve quality. Consistent, institutionalized processes for supportive supervision and continuous quality improvement is critical.

SUPPORTIVE SUPERVISION AND CLINICAL MENTORSHIP

Clinical mentoring and supportive supervision are complementary activities that are both necessary to build and maintain a quality system of care and play an invaluable role in quality assurance and improvement for GBV integration into SRH service provision. Although clinical mentoring and supportive supervision overlap considerably, the activities are different enough that they are best implemented by separate teams (See figure below). Clinical mentoring focuses on the professional development of health care workers, and requires mentors with clinical expertise of their own, as well as skillful coaching competencies. Supportive supervision focuses on the conditions required for proper functioning of the clinic and clinical team. District supervisory and management teams often have full-time administrative duties and do not have the time or experience to be effective clinical mentors. Most countries already have functional supervision systems. However, the indicators and monitoring data collected may not provide insight into readiness to integrate GBV-responsive care, nor the quality of that care if offered. Implementation of GBV-SRH integration often requires technical assistance to update and/or pilot new supervision forms that enable monitoring of GBV related standards (see data reporting guidance on page 26.).



Clinical mentorship in health care is based on a mutually beneficial relationship in which an experienced and knowledgeable mentor supports the maturation of a less-experienced mentee. When implemented in conjunction with supportive supervision, clinical mentoring enhances provider competency, builds confidence, and encourages adherence to clinical quality standards and protocols. This is particularly valuable for integration of GBV services in which providers are confronted with distressing and challenging client histories and in which even experienced providers may be providing first line response for the first time. Furthermore, mentorship programs can directly provide data for supportive supervision and quality assurance by:

- Providing aggregate reports of mentee performance to administrators conducting supervision visits;
- Reporting adverse events through supportive supervision, maternal-perinatal death surveillance and response (MPDSR) systems, and other sentinel event surveillance systems; and
- Identifying providers who require evaluation and potential reassignment to a more appropriate role should lack of quality improvement persist through multiple rounds of mentorship coaching.

Annex 2 provides ready-to use checklists for mentorship visits related to GBV-responsive SRH service provision, and primary health center GBV services. Additional comprehensive guidance on establishing a clinical mentorship program is available from Pathfinder upon request[7].

7 For further information or to request the complete clinical mentorship guide and recommended standard operating procedures, please contact info@pathfinder.org.

DATA COLLECTION AND APPROPRIATE REPORTING

Standalone comprehensive GBV response centers such as One-Stop Crisis Centers, or dedicated GBV/clinical management of rape wards within larger hospitals will typically have their own registers and data systems. However, documentation and reporting in SRH integrated settings becomes more complex. Program implementers, health facilities, and health supervision/MIS systems must balance the value of documenting and collecting data with client anonymity and consent. When introducing or strengthening GBV-responsive SRH services, the following principles should guide data documentation and reporting:

REMEMBER!
Protecting client confidentiality is a top priority.

- ☑ In FP, ANC, or postpartum wards, do not include GBV data in routine registers which typically include client identifying information such as name or date of birth. Develop and use separate forms for individual client documentation as well as anonymized incident reporting.
- ☑ Any records containing client-identifying information must be immediately stored in a lockable storage space to which access is limited.
- ☑ Develop and use a coding system to enable anonymized information to be linked back to detailed client records should clinical or legal need arise.

Individual client disclosure forms should include the following information for a standard use form. If no such form is currently available in your program area, use or adapt the sample form provided here.

- ☑ Basic demographic information
- ☑ Consents obtained
- ☑ Anonymous code for use in referral communication
- ☑ Information shared by the client
- ☑ Provider observations
- ☑ Referrals given

Template for documentation of client disclosure of GBV in a primary care setting (e.g., FP, ANC, PP clinic)

Client Name:			**Client Code:**
Report Date*	**Incident Date***	**Provider Name**	**Client Alone or Accompanied?** (circle one) **If accompanied, by whom?** Spouse Other intimate partner Parent In-law Friend Other

Client's Age*	**Sex of Client***	**Client's District of Origin*?**	**Specific Needs / Vulnerabilities*** (check all that apply)
	☐ Female ☐ Male	☐	☐ No ☐ Physical Disability ☐ Mental Disability ☐ Unaccompanied Minor ☐ Other Vulnerable Child

*Adapt for relevant local administrative designation. Most helpful if reported by facility catchment area governance area name.

Details of the Incident

Type of incident/violence*

Please select primary form of violence presenting from the top three options. Additional forms of violence may be checked as all that apply.

- ☐ **Rape**

  (includes gang rape, marital rape)

- ☐ **Sexual Assault**

  (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation)

- ☐ **Physical Assault**

  (includes hitting, slapping, kicking, shoving, etc., that are not sexual in nature)

- ☐ **Forced Marriage**

  (includes early marriage)

- ☐ **Denial of resources, opportunities, or services**

  (includes denial of inheritance, earnings, access to school or contraceptives, etc. Reports of general poverty should not be recorded.)

- ☐ **Psychological / Emotional Abuse**

  (includes threats of physical or sexual violence, forced isolation, harassment /intimidation, gestures or written words of a sexual/menacing nature, etc.)

1. **Did the reported incident involve penetration?**

   If yes → classify the incident as "Rape".

   If no → proceed to the next incident type on the list.

2. **Did the reported incident involve unwanted sexual contact?**

   If yes → classify the incident as "Sexual Assault".

   If no → proceed to the next incident type on the list.

3. **Did the reported incident involve physical assault?**

   If yes → classify the incident as "Physical Assault".

   If no → proceed to the next incident type on the list.

4. **Was the incident an act of forced marriage?**

   If yes → classify the incident as "Forced Marriage".

   If no → proceed to the next incident type on the list.

5. **Did the reported incident involve the denial of resources, opportunities, or services?**

   If yes → classify the incident as "Denial of Resources, Opportunities or Services".

   If no → proceed to the next incident type on the list.

6. **Did the reported incident involve psychological/ emotional abuse?**

   If yes → classify the incident as "Psychological / Emotional Abuse".

Details of Response

Type of Service Provided

- ☐ Psychological first aid
- ☐ Safety planning
- ☐ VCT for HIV
- ☐ Emergency contraception (if within 120 hours of incident with conception possibility)
- ☐ Additional service referrals

Type of Referral Offered	Accepted
☐ Clinical management of rape	Y/N
☐ Legal aid/legal support	Y/N
☐ Specialized psychological care	Y/N
☐ Shelter/Protection	Y/N
☐ Other _____	Y/N

The following consent should be read to the client or guardian in her first language. It should be clearly explained to the client that she/he can choose any or none of the options listed.

I, _____, give my permission for (name of facility) to share information about the incident I have reported to them as detailed below. I understand that shared information will be treated with confidentiality and respect and shared only as needed to provide the assistance I request. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency/focal point listed below.

I would like information released to the following: (Specify name, facility, and agency as applicable.)

Psychosocial services (specify): _____
Health/medical services (specify): _____

Safe house/shelter (specify):_____
Legal assistance services (specify): _____
Other (specify type of service, name, and agency): _____

2. I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared for service management and monitoring. I understand that shared information will be treated with confidentiality and respect.

Signature/thumbprint of client: _____

Signature/thumbprint of guardian if client is below the age of 14: _____

Contact number:_____ Voicemail okay: Y/N SMS okay: Y/N

Provider name or code:_____ Date: _____

A simple addendum or separate register should be present in all FP, ANC, and PP exam rooms to allow for anonymized documentation and periodic review by supervisory staff. Below is a sample register, piloted in Bangladesh.

Sample GBV service register for anonymize documentation of GBV in SRH clinic settings.

Date of visit	Date of incident	Case Code	Client sex	Client age	Type of GBV					Response				
					Physical	Contraceptive Sabotage	Emotional	Sexual (IPV)	Sexual (non-IPV)	Treatment (first aid)	LIV(ES)	Referral Issued	Referral Completed*	Police Report Made
23/9/2022	19/9/22	922-05	F	22		X		X			X	X		N

MODULE 4:

Beyond the Health Sector

COORDINATION WITH JUDICIAL, LEGAL, AND PROTECTION SECTORS

As shown in the referral mapping tools presented in module 2, people living with GBV need access to a diversity of services, including services beyond what the health sector can provide. These include legal consultation and representation services should they choose to explore and/or pursue seek a restraining order, financial restitution, etc. Judicial services include evidence collection, documentation, and prosecution, while protection services range from emergency, short-term shelter to long-term resettlement support. Each of these sectors have their own quality standards and warrant support and strengthening from appropriate specialists. Health sector agencies and programs are advised to focus on health sector integration and to rely on strategic partnerships if funds are available to address gaps in judicial, legal, or protection services.

It is critical that all sectors involved in GBV response coordinate to maximize continuity of care for survivors—reducing the time and cost required for a survivor to access the full range of services she needs. Continuity of care also should reduce the number of providers a survivor must relate their history and experience to, reducing repetitive reliving of violent experience which can increase traumatic impacts. Thus, SRH points of service and SRH providers who seek to integrate GBV services must also ensure processes and mechanisms for institutionalized coordination with judicial, legal, and protection sectors. Several of the recommended elements of GBV-SRH integration detailed in modules 1-3 support this multi-sector coordination:

- Sharing anonymized, aggregate data on prevalence of GBV in a particular district or service catchment area. Use of a reporting form such as the sample show at the end of Module 3 can enable safe sharing of GBV data between health and other sectors.
- Ensuring mutual knowledge of GBV services across sectors to facilitate referral for survivors. As noted in this toolkit, judicial, protection, and legal services should be included in referral services lists housed in SRH service points, as well as included when mapping GBV referral pathways for a given local geography.

In addition, it is critical to facilitate and encourage routine meetings between health and other sectors involved in GBV response. There is no evidence to-date suggesting that one cadence or setting for multi-sectoral coordination meetings works best, but we recommend semi-annual meetings at a minimum. Suggest topics for a standing meeting agenda are:

- **Review of new case data since prior meeting.** Suggested indicators to track include: # of cases of sexual violence, # of cases of physical violence, # of GBV cases resulting in homicide, # of cases resulting in hospitalization, % of total cases reported in which the survivor sought/is seeking legal action; incidence trends year on year.
- **Anonymized case review of sentinel events.** This includes any cases which resulted in the death of a client and/or major adverse event (example: a client reports of fear of being killed during a routine FP counseling visit, but has no shelter options other than returning home. Three days later the client is admitted into the intensive care unit from the emergency department following a severe beating).

- **Alignment of annual workplans and budgets.** Such discussions enable more effective fiscal planning across sectors. Multi-sectoral prioritization planning is also invaluable to inform guidance and requests made to civil society actors, bilateral donors, and other GBV prevention and response partners.

UNDERSTANDING THE ROLE OF RESTORATIVE JUSTICE

Many contexts place emphasis on the role of legal and prosecutorial deterrence, punishment, and justice for GBV. While such services and policies do play an important role in both primary and secondary prevention, over-emphasis can also lead to non-trauma informed mandatory reporting laws or provider bias toward reporting that results in pressure on clients to "go public."

Within the health sector, it is important for managers and individual providers to understand the difference between legal justice and survivor-centered justice. These may result and demand the same course of events, but they may not. Primary care providers (as opposed to medico-legal specialists) should be trained and supported to focus on their mandate to provide client-centered, trauma-informed care, which lays an important foundation for restorative justice, regardless of whether the violence is prosecutable under local laws and regardless of whether a client choose to access legal services.

Legal justice: The restoration of fairness in the eyes of the law. This most commonly focuses on punishment for violation of established laws and equitable process for determining such violations.

Survivor-center or restorative justice: The restoration of balance and a sense of peace following a crime or violation perpetrated against an individual. Systems and methods of restorative justice focus on providing opportunities for healing, reparation, and reintegration.

Restorative justice can take place through carefully designed reconciliation and restitution systems. These are fairly rare and still primarily established in places where mass trauma and/or violence has taken place (e.g., post-apartheid South Africa, post-genocide Rwanda, mass incarceration of black, indigenous, and other people of color in the United States). However, any act that helps restore balance and healing to victim, perpetrator, and community, and helps restore power to the victim is an act of restorative justice. The most recognized frameworks ask that providers, community leaders, and allies seeking to promote this form of justice ask the following five questions before taking action[8]:

1. Does the action help address harms and causes?
2. Is it victim-oriented?
3. Are perpetrators encouraged to take responsibility?
4. Is there an opportunity for dialogue and participatory decision-making?
5. Are all three stakeholder groups (victim/survivor, perpetrator, their community) involved?

Health system managers and primary SRH providers are encouraged to remember these principals when providing disclosure response, offering referral options, or providing comprehensive first-line response/clinical management of rape. Providing physical care, psychological first aid, and an opportunity to choose what happens next is a step toward justice.

8 Zehr, Howard. The Little Book of Restorative Justice. The Little Books of Justice & Peacebuilding. Intercourse, PA: Good Books, 2002.

Additional Resources

- No More Helpline and Service Global Directory. www.nomoredirectory.org
- Health Care for Women Affected by Violence Clinical Handbook – WHO
- Responding to Children and Adolescents who have been sexually abused – WHO
- World Health Organization's Strengthening the Medico-Legal Response to Sexual Violence Toolkit
- Institute of Trauma and Trauma-informed Care at the University of Buffalo. New York. USA. Self-Paced Online Certificate Course.

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"Respect Women: Preventing Violence Against Women." Geneva, Switzerland: World Health Organization, 2019. https://apps.who.int/iris/handle/10665/312261.

Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers. Geneva: World Health Organization, 2017. https://apps.who.int/iris/handle/10665/259489.

Annexes

ANNEX 1

Health Facility Assessment

Readiness to Provide GBV Integrated Services

ANNEX 2

IPV Responsive Care Mentorship Checklist

Disclosure Response to GBV Mentorship Checklist

Clinical Management of Rape Mentorship Checklist

ANNEX 1 HEALTH FACILITY ASSESSMENT

Instructions

Preparation:

The following tasks should be accomplished prior to beginning data collection:

- **Select facilities**. Obtain from the district, county, or other relevant sub-national team a complete list of project-supported HFs and select the facilities to assess. If the team is planning to assess a sample of HFs from a large pool, use a random sampling methodology. At a minimum, the team SHOULD NOT select HFs based on reputation or performance data. Rather, ensure the following considerations are met diversity in geography, facility level, and type, and a balance of rural and urban facilities. Be mindful of the time required to complete each facility's assessment and select an appropriate number for the project's timeline and budget. Each assessment team will be able to assess one facility in a day—two at most if the facilities are in close proximity to each other.
- **Procure and acquire the logistics** and materials needed (for example, transportation, printed materials, digital support, fees).
- **Schedule introductory and planning meetings** with relevant health authorities (such as district health management teams) and consulting firm (if applicable) and agree on roles and responsibilities.
- **Select data collectors, assessors, numerators, and supervisors.** Data collectors and supervisors must be familiar with services provided within the facility and have the relevant technical background.
- **Train data collectors, assessors, enumerators, and supervisors on the data collection process and tool.** Data collectors and supervisors should undergo sufficient training that blends both didactic and onsite experiential learning within nearby health facilities; length of training may vary based on team capacity needs and assessment complexity and length.

Table 1. HFA Module Descriptions

Modules	Purpose
Module 1: Facility services, infrastructure, and capacity	Use this module to collect basic information on individual facilities, including type, organization, and number of services, amount, and profile of human resources available. state and conditions of existing infrastructure; and the immediate physical environment.
Module 2: GBV	Use this module to collect information that relates to organization, provision, and quality of facility based GBV services. This module covers information on human resources available and trained on GBV. availability and condition of infrastructure for GBV services; type services offered to survivors. referral systems; barriers to offering GBV services; requirements for confidentiality and privacy, including protection of clients' personal information; GBV service performance three months prior to the assessment. use of IPC measures, and availability or stockout of medicines for GBV services.
Module 3: Gender-sensitive health services	This module aims to assess whether health facilities follow gender standards and whether providers and facility managers offer gender- sensitive services to clients, their partners, and their families. The module covers existing policies and protocols that define the need for gender equality and non-discrimination. health provider knowledge on gender; and equity in access to health services for all clients regardless of their sexual orientation, age, and marital status.

Step 2. Assessment and data collection

Day before planned assessment day:

- Confirm with the facilities to be assessed that they remain able to receive the assessment team as scheduled.

Day of assessment:

- Data collectors introduce themselves to the facility managers upon arrival and explain the purpose and general methodology of the assessment.
- The facility managers, after responding to questions in Module 1, will introduce the assessors to the providers of specific services to be assessed.
- Data collection methods might include observations and interviews with facility managers, providers of services, and pharmacists. Ensure that mobile devices are charged, as taking photos of signage or commodity stocks may be useful.
- Assessors must ensure they do not disrupt services at the facility, respect service user's privacy always, and take permissions from the facility managers where required. Defer to the facility managers' guidance on the order of rooms to visit and providers with whom to speak.
- Before leaving the facility, assessors may hold a closing meeting to share preliminary findings with the facility management team and ward supervisors. Enumerators should convey any challenges or questions to their supervisors at the end of each day.

Step 3. Data collection and analysis

- HFAs are data intensive. Proactively planning for data collection and analytic tools and systems is important. Although paper-based data collection may be required in certain limited contexts, electronic data collection forms using secure computers, tablets, and open data kit (ODK) data collection platforms or servers will make data cleaning and analysis more efficient. KoboToolbox/ODK mobile is one such example of an application for primary data collection given its ease of use and interoperability with DHIS2.
- Adaptation of the HFA questionnaire may affect scoring/denominators. Therefore, ensure adequate time for setting up skip logic/scoring in Kobo and subsequent analytic software, especially if adapting these modules from their original content.

MULTI-MODULAR TOOL

ENUMERATOR INFORMATION

CODES	QUESTIONS	RESPONSES
	Date of assessment (day/month/year):	
	Name of enumerator	
	Enumerator code	
	Title of the enumerator	
	Institution or organization of the enumerator	

INSTRUCTIONS

INSTRUCTIONS TO ENUMERATOR:
Introduce yourself to the facility manager and begin the discussion based on this questionnaire. After completing module 1 with the facility manager, he/she should be able to put you in touch with other staff or additional resources as needed. Complete the health facility assessment tool by observing services, reviewing necessary documents, talking with staff and physically inspecting equipment, instruments and supplies. Record your comments and other relevant information in the spaces provided. Unless otherwise specified, please circle only one response for each question.

Please use the following text to guide your introductory remarks to, and request for consent from the facility manager:
Hello. My name is [state your name] and I am working with [State the name of your organization]. My organization is conducting an assessment in selected health facilities in collaboration with the Ministry of Health.

The purpose of this assessment is to determine the current capacity of health facilities to provide integrated GBV and SRH services and to learn more about existing resources and remaining gaps.

Your facility was selected to participate in this assessment, and we would appreciate your participation. We expect to spend [X] hours in your facility conducting this assessment.

Taking part in this assessment is voluntary and the information you provide will be kept strictly confidential and none of your names will appear in any report. This information will be used only for program planning and implementation purposes with the aim of improving quality of health services and the performance of your facility. Feel free to request clarification of unclear issues during this assessment.

Choosing not to participate in this assessment will not involve any penalty and your participation will not result in a reward, but your information will provide us with an enormous opportunity to support your health facility to provide better health care services. You may also choose to withdraw from the assessment at any time during the interview without penalty to you or your facility. Do you have any questions?

May I begin the interview?"	YES 1 NO 2
Get the consent signed by the Participant	
INTERVIEW START TIME (use the 24 hour-clock system)	……. H……..min

ANNEX 1 HEALTH FACILITY ASSESSMENT

MODULE 1: Facility Identification, Infrastructure and Capacity

(The questions in this module should be directed to the Facility Manager)

SECTION 1: FACILITY IDENTIFICATION

CODES	QUESTIONS	RESPONSES
M1101	Health Facility (HF) Code Number	
M1102	Name of the health facility	
M!103	Address of the HF	
M1104	Region/province	
M1105	District/Health Zone	
M1106	Type/level of HF **List should be adapted at country level prior to implementation*	1.National referral hospital 2.Provincial/Regional hospital 3.District hospital 4.Health center/clinic 5.Health post 6.Other (specify)……
M1107	Managing authority of the HF	1.Public/Government 2.Private for profit 3.Private non-profit 4.Missions/FBO 5.Other (specify) ……
M1108	Type of Services	1.Outpatient only 2.Inpatient 3.Day care only
M1109	Location of the HF	1.Urban 2.Peri urban 3.Rural 4.Slum 5.Refugees Camp 6.IDPs Camp 7.Other (specify)……
M1110	Number of villages / community units served (List of villages/units served with name)	
M1111	Total Population served by the HF	
M1112	Estimated women of reproductive age (WRA): [Apply 22,5% of the total population served.]	
M1113	GPS Coordinates of the HF	1.Altitude: 2.Latitude: 3.Longitude:
M!!14	Name of the HF In-Charge/Manager	
M!!15	Phone number of the HF or the manager	
M1116	Email of the HF or the manager	
M1100	**Summary of important observations**	

SECTION 2: LIST OF HEALTH SERVICES AVAILABLE

CODES	SERVICES	DETAILS OF SERVICES	RESPONSES
M1201	FP/CONTRACEPTION	Family planning: Emergency contraception pills	Yes 1 No 2 NA 0
M1210		Family planning: Emergency contraception Copper IUCD	Yes 1 No 2 NA 0
M1211	Comprehensive Abortion Care (CAC)	CAC: Medical abortion	Yes 1 No 2 NA 0
M1212		CAC: MVA	Yes 1 No 2 NA 0
M1213		CAC: D&E	Yes 1 No 2 NA 0
M1214		CAC: PA/FP	Yes 1 No 2 NA 0
M1215	HIV/STI	Syndromic management of sexually transmitted infections	Yes 1 No 2 NA 0
M1216		HIV testing and counselling	Yes 1 No 2 NA 0
M1217		HIV treatment	Yes 1 No 2 NA 0
M1218		Prevention of mother-to-child transmission of HIV	Yes 1 No 2 NA 0
M1219		HIV care and support	Yes 1 No 2 NA 0
M1220	MNCH	Antenatal care	Yes 1 No 2 NA 0
M1222		Gynecological care	Yes 1 No 2 NA 0
M1226		Blood transfusion	Yes 1 No 2 NA 0
M1227		Obstetric Ultrasound	Yes 1 No 2

			NA 0
M1230	GBV	Immediate psychosocial support	Yes 1 No 2 NA 0
M1231		Referral to other services (legal, ongoing psychosocial, etc.)	Yes 1 No 2 NA 0
M1232		GBV responsive FP/HIV counseling and emergency contraception	Yes 1 No 2 NA 0
		If the above services are offered. Complete questions for "All Facilities" under the GBV Module	
M1233		Clinical Management of Rape	Yes 1 No 2 NA 0
M1234		Clinical Management of Rape for Pre-Pubescent Children	Yes 1 No 2 NA 0
M1235		Treatment for physical trauma (e.g. broken bones)	Yes 1 No 2 NA 0
		If the above services are offered. Complete questions for "All and Comprehensive Facilities" under the GBV Module	
M1236		Medico-legal documentation services *Requires additional quality assessment not included in this tool.*	Yes 1 No 2 NA 0
M1237		Forensic laboratory services *Requires additional quality assessment not included in this tool.*	Yes 1 No 2 NA 0
M1238		Advanced recto-genital surgical repair (e.g. for vaginal or anal fistula) *Requires additional quality assessment not included in this tool.*	Yes 1 No 2 NA 0
		*If the above services are offered. Complete questions for all questions in the GBV Module **AND** refer to WHO Guide to Medical-Legal Services chapter of their Clinical Handbook for Health Providers* for additional assessment criteria.	
M1239	AYSRH	Counseling for AY	Yes 1 No 2 NA 0
M1240		Integrated AY SRHR services	Yes 1 No 2 NA 0
M1200	**Summary of important observations**		

SECTION 3: HUMAN RESSOURCES/STAFFING

CODES	QUESTIONS	Number	Sex ratio (M/F)
M1201	Total number of staff in this HF		
M1302	Admin/managerial staff		
M1303	Specialist medical doctors		
M1304	Non-specialist medical doctors		
M1305	Certified/registered midwives		
M1306	Certified/registered nurses		
M1307	Clinical officers/assistant medical officers		
M1308	Nursing assistants/nursing aides		
M1309	Pharmacists/dispensers		
M1310	Laboratory technicians		
M1311	HMIS personnel/records assistants		
M1312	Certified/registered counselors (HIV, FP, PAC, GBV and MNH)		
M1313	Community health workers		
M1314	Social workers		
M1300	**Summary of important observations**		

SECTION 4: INFRASTRUCTURE AND GENERAL ENVIRONMENT

CODES	QUESTIONS	RESPONSES		COMMENTS
M1401	Was the HF open when you arrived?	Yes No	1 0	
M1402	Was there some type of notice board showing the HF's hours of service?	Yes No	1 0	
M1403	Was there a clearly visible display on what reproductive health services are available?	Yes No	1 0	
M1404	What is your general impression of the state of the building housing the HF? Is it safe? Electric fittings are safe, no loose wires, fire safety equipment is functioning, and all exits are well maintained without any obstruction	Stable and safe building Unsafe building	1 0	
M1405	What is your general impression of the state of cleanliness outside the HF?	Clean Unclean	1 0	
M1406	What is your general impression of the state of cleanliness inside the HF.? What are the areas where cleanliness can be improved?	Clean Unclean	1 0	

M1407	Does the facility have visible data dashboards/wall charts on service-related data?	Yes 1 No 0	
M1408	Was a Patients Charter available and on display?	Yes 1 No 0	
M1409	Were there clear signages to direct patients?	Yes 1 No 0	
M1410	Was there IEC material in waiting areas on all services provided at the HF?	Yes 1 No 0	
M1411	Is informed consent taken (as appropriate) before providing services?	Yes 1 No 0	
M1412	Are there separate toilets for male and female?	Yes 1 No 0	
M1413	Are the toilets functional?	Yes 1 No 0	
M1414	Does the HF have a functioning power source?	Yes 1 No 0	If No, skip to M1417
M1415	If Yes, what is the source of power?	----------	Do not count in the score
M1416	Is the power source available 24 hours a day? If No, does facility have 24x7 power back-up for delivery room, OT, radiant warmer, refrigerator and lighting of premises	Yes 1 No 0	
M1417	What are the hours/time of load-shedding/unavailability of power?	----------	Do not count in the score
M1418	Is there running clean water in this HF?	Yes 1 No 0	
M1419	What is the main source of water? [Select one or more responses]	**1=Mentioned. 0=Not mentioned** a. Piped 1 0 b. Open well 1 0 c. Bore well 1 0 d. Rainwater Harvesting 1 0 e. Water delivery 1 0 g. Other (specify)..... 1 0	If a or b or both is mentioned as a water source type, it will be a 1 to include in the score of this section
M1420	What Communication and technology resources are used or are available at this HF?	**1=Mentioned. 0=Not mentioned** a. Landline telephone 1 0 b. Mobile phones 1 0 c. Short wave radio 1 0 d. Computer 1 0 e. Internet Connection 1 0	If a or b or c or both is mentioned as a communication resource, it will be a 1 to include in the score of this section
M1421	Does the HF have any functional emergency transportation (i.e., in good working order and with fuel)?	Yes 1 No 0	

M1423	Does the HF have a functional referral system? (e.g. referral protocol and list of referral institutions by service) Referral facility contact numbers and address/distances Referral form Referral audit process in place	Yes 1 No 0 Yes 1 No 0 Yes 1 No 0 Yes 1 No 0	
M1424	What is the distance in kilometers between the HF and the nearest referral facility?	Km	Do not count in the score
M1425	Using a vehicle, what is the average trip time between the HF and the nearest referral facility during the rainy season? [Report the hours OR the minutes from records or audit reports of timely transfers]	Hours ☐	Do not count in the score
M1426	Thinking about the last time an emergency patient was transferred to the referral hospital, how long did it take from the time the decision to transfer was made until she reached the hospital? [Report the hours OR the minutes	Hours ☐ Min ☐	Do not count in the score
M1427	[If the time mentioned above is greater than the transfer time under normal circumstances, ask for the causes of the delay]: "What were the causes of the delay this last time?" Enquire if there is a referral audit SOP or referral audit report		Do not count in the score
M1428	Is informed consent taken (as appropriate) before providing services?	Yes 1 No 0	
M1429	SCORE **(/22)**	--------**/22**	
M1400	**Summary of important observations**		

SUMMARY OF SCORES, STRENGTHS AND GAPS

	SCORES	COMMENTS
Only Section 4	**……../22**	The total score for module 1 (/22) considers only section 4.
TOTAL	**……/22**	
Summary of observations from all sections		

ANNEX 1 HEALTH FACILITY ASSESSMENT

MODULE 2: Sexual and Gender-based Violence

SECTION 1: AVAILABILITY AND PROVISION OF GBV SERVICES

CODES	QUESTIONS	RESPONSE	SKIP TO
	Facility consistently offers a standard package of services and referrals (All FACILITIES)		
M4101	Does the facility have a written scope for the tier of GBV response it is eligible to provide?	Yes 1 No 0	
M4102	Are the standards of practice for designated service tier are printed and available in-service rooms?	Yes 1 No 0	If No, SKIP TO QUESTION M4104
M4103	Do written service SoPs state that services should be offered to all people regardless of age, gender, marital status, disability, religion, skin color, etc.?	Yes 1 No 0	
M4104	Do facility staff routinely complete quarterly checks on commodity expiration and storage requirements?	Yes 1 No 0 *Only record a Yes, if signed commodity spot-check register is observed and complete.*	
M4105	Does the facility provide GBV care without requiring the patient to report to police?	Yes 1 No 0	
M4106	Do the FP and PP service rooms have IEC materials pertaining to IPV responsive counseling and universal right to safety?	Yes 1 No 0	
M4107	Do the HIV clinics have IEC materials and job aids for IPV-responsive counseling?	Yes 1 No 0	
M4108	Do emergency departments have a written policy directing stabilization of life-threatening injuries prior to any comprehensive intake and/or referral for further GBV services?	Yes 1 No 0	

M4109	Do providers refrain from requiring patients to talk about experiences of violence beyond stating physical or health concerns?	Observed 2 Reported, not observed 1 No 0	If the facility only provides first line response, SKIP TO QUESTION M4-1.23.
M4110	Does client intake include declaration of client rights to decline any part of exam and treatment at any time, including client right to request pause in exam or treatment at any time?	Observed 2 Reported, not observed 1 No 0	
M4111	Do providers offer referral and accompanied transfer to a facility with anesthesia capability in the event that a pediatric client requires internal physical examination and/or treatment?	Yes 1 No 0	
M4112	Do any GBV providers at the facility utilize a hymenal presence "test"?	Yes 0 No 1	
M4113	Client confidentiality is protected and proactively assured	Yes 1 No 0	
M4114	Do GBV service rooms offer visual and auditory privacy?	Yes 1 No 0	
M4115	Is the signage for GBV service rooms discreet and WITHOUT terms such as GBV, sexual violence, rape crisis center?	Yes 1 No 0	
M4116	Does the facility have a visually private area for GBV clients to wait, as well as for GBV clients to recuperate following care until ready to leave the facility?	Yes 1 No 0	
M4117	Are GBV client records stored in a locked cabinet or file drawer, with only limited staff having access to the keys?	Yes 1 No 0	
M4118	Do SoPs provide guidance for immunizations (e.g. tetanus) and treatment of physical injuries?	Yes 1 No 0	
M4119	Do SoPs indicate that PEP should be offered up to 72 hours following a sexual assault?	Yes 1 No 0	If no, SKIP TO QUESTION M4-1.21
M4120	If yes, do client records indicate PEP being offered between 0-72 hours following assault?	Yes 1 No 0	
M4121	Is EC offered up to 5 days (120 hours) following an unprotected penile-vaginal penetrative assault?	Yes 1 No 0	If no, SKIP TO QUESTION M4-1.23
M4122	If yes, do client records indicate EC being offered within 5 days (120 hours) following assault?	Yes 1 No 0	
	Psycho-social services are available in the facility (ALL FACILITIES):		
M4123	Can providers demonstrate/name at least two techniques for appropriate and empathetic history taking and counseling with GBV patients?	Yes 1 No 0 *Sample techniques include:* - *Using open/uncrossed body language and making eye contact with the client* - *Asking open ended questions*	

		speaking slowly - *Stating that the violence experienced is not the client's fault* - *Stating that the client has a right to feel safe. You are sorry they had to go through what happened to them.*	
24	Do providers utilize staged undressing, drapes, and coverings to maximize privacy during physical examination and treatment?	Yes 1 No 0	
25	Do non-GBV providers offer referral to all patients disclosing GBV or IPV for safety planning?	Yes 1 No 0	
	Psycho-social services are available in the facility (**COMPREHENSIVE GBV RESPONSE FACILITIES**):		If facility only offer first line response, SKIP TO QUESTION M4-1.31
26	Do providers offer follow-up touch point before concluding each appointment?	Yes 1 No 0	If no, SKIP TO QUESTION M4-1.28
27	Are safe contact details documented in the client's chart and phone credit provided if needed to enable follow-up?	Yes 1 No 0	
28	Are job aids present in GBV treatment rooms to enable identification of PTSD and other severe psychological conditions?	Yes 1 No 0	
29	Do providers conduct safety counseling and planning as part of every GBV visit?	Reported and observed 2 Reported, not observed 1 No 0	
30	Do non-GBV providers (e.g. FP or MNH) call in a colleague trained in safety planning after every client disclosure of IPV?	Reported and observed 2 Reported, not observed 1 No 0	
	Referral services and pathways defined and in-use (ALL FACILITIES)		
31	Is there a referral flow chart job aid present in FP, ANC, and HIV clinic rooms?	Yes 1 No 0	
32	Does each ward (emergency, FP, HIV, MNH, immunization) have a directory of proximate advanced clinical GBV services, judicial, and social service locations?	Yes 1 No 0	
33	Is there a confidential method for verifying referral completion (e.g. an alpha numeric code) documented in client records?	Yes 1 No 0	
34	Do providers ask and document if client gives consent to receive follow-up by phone or SMS?	Yes 1 No 0	
35	If yes, do client records document the number and any special instructions to ensure safety of contact?	Yes 1 No 0	
	Referral services and pathways defined and in-use (COMPREHENSIVE GBV CARE FACILITIES)		If facility only provides first line

			response, SKIP TO SECTION 3
M4136	Is there a directory of fistula repair clinics/centers and referral procedures present in GBV service room?	Yes 1 No 0	
M4137	Do providers and/or assigned case managers complete and document phone-based follow-up to clients 2 weeks and at 2 months following assault?	Yes 1 No 0	
M4138	If yes, do follow-up records document non-health services accessed?	Yes 1 No 0	
M4139	**SCORE:** To calculate the score for this section **for first line facilities**, sum all answers that refer to "Yes" or "1" for the following questions: M4101-M4125 and M430-M4135, a total of 30. **For comprehensive facilities**, sum all answers that refer to "Yes" or "1" for all questions listed in this section, a total of 38. Max for first line facilities: ……/30 Max for comprehensive facilities:…./38		
M4140	**Summary of important observations**		

SECTION 2: GBV SERVICE DELIVERY DATA AND TOOLS

[Skip to Section 3 if the facility does not provide comprehensive GBV clinical response]

CODES	QUESTIONS	RESPONSE	SKIP TO
M4201	Are client records/charts coded with an alpha-numeric, or other anonymized system?	Yes 1 No 0	
M4202	Is there a summary register that records GBV service data in aggregate, anonymized view, at monthly cadence?	Yes 1 No 0	IF NO, SKIP TO QUESTION M4-2.09
M4203	Is the summary register up to-date and completed for all data fields?	Yes 1 No 0	
M4204	Are GBV data disaggregated by sex (male and female)?	Yes 1 No 0	
M4205	Are GBV data disaggregated by age?	Complex disaggregation: *0-9, 10-14, 15-19, 20-24, 25-49, 50+* **2** Simple disaggregation*: 0-9; 10-18; 19+* **1** No disaggregation **0**	
M4206	Are GBV data disaggregated by type of violence experienced and whether the perpetrator was an intimate partner or non-partner? ○ sexual violence by a partner or non-partner ○ physical violence by a partner or non-partner ○ emotional violence by a partner or non-partner	Type and perpetrator 2 Type only 1 No 0	

M4207	Do GBV data include the number of people who completed the PEP regimen?	Yes 1 No 0	
M4208	Are anonymized, aggregate data reports for GBV services and beneficiary demographics (with no personal identifying information of patients) shared with facility management, referral partners, and district budget decision makers?	Yes 1 No 0	
M4209	Are improvement plans for service delivery made after GBV data are reviewed, including changes or updates to the services offered, approaches used, and commodities procured?	Yes 1 No 0	
M4210	Are patient level GBV service data/client records linked to HIV and other health services data through common unique identifiers (such as a numeric code)?	Yes 1 No 0	
M4211	**SCORE** **[To calculate the score for this section, sum all answers that refer to " Yes" or "1" ; Total score =10**	……/10	
M4212	**Summary of important observations**		

SECTION 3: HUMAN RESOURCES FOR SGBV SERVICES

Trained staff refers to providers trained or re-trained in the service in the last 2 years.			
CODES	**QUESTIONS**	**RESPONSES**	
	STAFFING		
	FOR ALL HEALTH FACILITIES:	Response - Score	Skip To
M4301	Is there a documented scope and role in providing GBV response for each cadre working in SRH services, case management, or social support functions at the facility?	Yes 1 No 0	If the facility only offers first line response, SKIP TO QUESTION M4-3.06.
	FOR SITES INTENDING TO PROVIDE COMPREHENSIVE GBV RESPONSE:		
M4302	Is at least one trained, competent staff available through call or being on-site 24h 7 days/week? (evidence of availability)	Yes 1 No 0	
M4303	Does the facility have a supervision plan to ensure direct observation of at least one provider-client response per GBV provider a minimum of 3x/year?	Yes 1 No 0	If facility has a single GBV provider omit this response and SKIP TO QUESTION M4305.
M4304	Do facility clinical supervisors hold monthly review of complex, medico-	Yes 1 No 0	

	legal, and cases involving fatalities (and/or near miss) (fatality may be delayed and/or due to secondary impact such as suicide)?					
M4305	Do GBV providers have routine opportunity to conduct case review with GBV providers in other facilities?	Yes 1 No 0				
	TRAINING AND SUPERVISION	**PROVIDER TYPE**				
Review training curricula, training certificates, and direct questioning to providers to record the number of providers trained in each competency, by cadre.						
M4306	Training for providers **at any facility providing SRHR services** should include most of the 9 following elements (Record number of SRHR providers by cadre whose training included each element)[1]:	Medical Doctor	Registered Nurse/ Clinical Officer	Registered Midwife	Other health workers	Total (Male/ Female)
	Maintaining patient privacy and confidentiality Risks of breaching confidentiality, intentionally or unintentionally Values clarification re: gender-based violence and gender norms/roles Addressing stigma and non-discrimination, including re: unmarried, sex workers, and persons with disabilities Providing psychological first aid when responding to disclosures of GBV Forms and impacts of GBV Creating safe space for IPV disclosures when clients come to SRH appointments with their partner Providing referrals for comprehensive GBV response Local laws (if applicable) around mandatory reporting and for which populations/ages					
M4307	**For sites interested in providing comprehensive GBV services:** Clinical staff working in GBV rooms/wards have					

	received competency-based training including most of the 12 following elements (Record number of GBV providers by cadre whose training included each element)[2]:					
	Maintaining patient privacy and confidentiality Risks of breaching confidentiality, intentionally or unintentionally Values clarification re: gender-based violence and gender norms/roles Addressing stigma and non-discrimination, including re: unmarried, sex workers, and persons with disabilities Client intake Documentation of medical history, clinical observations, and reported and observed injuries. Providing first line response including safety planning and referral for on-going support. Forms and impacts of GBV Local laws (if applicable) around mandatory reporting and for which populations/ages Preventing re-traumatization during examination and treatment Assessing and treating genital and non-genital injuries common in sexual and non-sexual assaults Timeline, treatment windows, and referral options for testing, emergency contraception, PEP and other STI prophylaxis, forensic sample collection[3]					

	Review against total number of providers as recorded under Module 1.					
M4308	**SCORE** [To calculate the score for this section, sum all answers that refer to "Yes" or "1 from M4301 to M4305]	……../5				
M4300	**Summary of important observations**					

SUMMARY OF SCORE AND OBSERVATIONS

SECTIONS	DESCRIPTION	SCORES	COMMENTS
Section 1	Availability and provision of SGBV services		
Section 2	SGBV service delivery data and tools		
Section 3	Human resources for SGBV		
Section 4	Infection prevention and control (IPC)		See Annex 1
Section 5	Pharmacy and stock management		See Annex 2
Section 6	Commodities and supplies for SGBV services		See Annex 3
Section 7	Equipment for SGBV services		See Annex 4
SCORE (TOTAL)			
Summary of strengths and gaps			

ANNEX 1 HEALTH FACILITY ASSESSMENT

MODULE 3: Gender-sensitive Health Facility[1,2] Services

(The questions in this module should be directed to the Facility Manager)

The objective of this module is to assess whether health facilities are organized following gender standards and providers, and facility mangers provide gender sensitive[3] service for clients, their partners, and families[4,5].

CODES	QUESTIONS	RESPONSES	SKIP To
Facility policies and protocols exist that define the need for gender equality, non-discrimination, and support equal opportunities and compensation for providers of all genders[6].			
M8101	Does facility have written policies that prohibit gender-based discrimination in hiring and compensation of staff?	Yes/Observed 1 No/Not sure 0	
M8102	Does facility has written zero-tolerance policy or client service charter that expressly prohibits sexual, physical, or other abuse of clients and providers?	Yes/Observed 1 No/Not sure 0	
M8103	Does facility have written policies outlining appropriate conduct with fellow employees and patients?	Yes/Observed 1 No/Not sure 0	
M8104	Does facility have a process for patients reporting complaints, sexual harassment, and mistreatment by providers that is displayed in language and format that is accessible to clients?	Yes/Observed 1 No/Not sure 0	
M8105	Does facility have written policies that mandate providers give female clients information about their health directly (e.g. does not give information to male spouse instead)?	Yes/Observed 1 No/Not sure 0	
Health providers knowledgeable on gender			
	During orientation of a new hire, is the staff member made aware of gender-sensitive policies, specifically:		
M8106	- Written policies that prohibit gender-based discrimination in hiring staff?	Yes 1 No/Not sure 0	
M8107	- Written policies that guarantee gender equity regarding salary and are fixed, based on the cadre?	Yes 1 No/Not sure 0	
M8108	- Written policies outlining appropriate conduct with fellow employees and patients?	Yes 1 No/Not sure 0	

[1] Adapted from Irani, L., K. Hardee, and M. Bishop. 2015. A Tool to Assess the Gender Sensitivity of a Health Facility: Pilot Tested in Afghanistan. Washington, DC: Futures Group, Health Policy Project.

[2] Adapted from JHPIEGO Gender Service Delivery Standards, 2018

[3] 'Gender sensitivity' measures how service providers treat women, girls, men, boys, and individuals with diverse gender identities in service delivery facilities, which and thus affects client willingness to seek services, continue to use services, and carry out the health behaviors advocated by the services.

[4] Adapted from Irani, L., K. Hardee, and M. Bishop. 2015. A Tool to Assess the Gender Sensitivity of a Health Facility: Pilot Tested in Afghanistan. Washington, DC: Futures Group, Health Policy Project.

[5] Adapted from JHPIEGO Gender Service Delivery Standards, 2018

[6] Policies and protocols that define the need for gender equality and non-discrimination within the health workforce are critical to a gender equitable working environment and gender responsive health services.

M8109	Has facility ensured all health providers and clinical managers have received training on gender equality and/or gender related topics within the past year?	Yes 1 No/Not sure 0	If no, skip to question M8111
M8110	If yes, how many providers for each cadre and admin/managers have received training on gender-related topics:		
	Admin/managerial staff Medical doctors Registered midwives Registered nurses Other Health workers	__(M)/__(F) -----% __(M)/__(F) -----% __(M)/__(F) -----% __(M)/__(F) -----% __(M)/__(F) -----%	
Facility services are fairly and equitably accessible to women, men, girls, boys, and individuals of all gender identities and sexual orientations respecting their agency and confidentiality			
M8111	Does the facility provide all clients the full range of information and services they need, regardless of age, marital status, gender identity, sexual orientation, or socioeconomic status[7]?	Yes 1 No/Not sure 0	
M8112	Does facility ensure confidentiality (non-disclosure) of health information to all clients of all gender identities and sexual orientations equally?	Yes 1 No/Not sure 0	
M8113	Are there any types of people who the facility does not provide services to[8]?	Yes 1 No/Not sure 0	If No, skip to M8114
M8114	If yes, can you mention the types of people the facility does not provide services to?	Yes 1 No/Not sure 0	
M815	Except for minors, facility **does not** require spousal and/or family approval/consent for any services, including contraception, that a patient receives[9].	Yes 1 No/Not sure 0	
M8116	Does facility provide care to all individuals according to the facility's triage system or on a first-come, first-serve basis, regardless of gender identity or whether the client is accompanied by a spouse, partner, or family member?	Yes 1 No/Not sure 0	
Facility provides couple counseling, partner counseling and promotion of joint decision-making			
M8117	Do providers in this facility ask clients if they would like to have a companion present AND only invites a companion to be present if the client gives permission?	Yes 1 No/Not sure 0	

[7] Potential probe could be "Can a married adult woman seeking family planning services receive the same information and services as an unmarried adolescent"?

[8] Potential probes could be refugees, or internally displaced persons (IDPs) and unmarried individuals.

[9] Requiring approval from a parent/spouse/ mother-in-law can deter people from seeking services.

	Have providers in this facility have been specially trained to **counsel couples** on: ANC, Family Planning, PMTCT and HCT, couple's communication, joint decision-making on FP and birth planning?		
M8118	- ANC?	Yes 1 No/Not sure 0	
M8119	- Family Planning?	Yes 1 No/Not sure 0	
M8120	- PMTCT?	Yes 1 No/Not sure 0	
M8121	- HCT	Yes 1 No/Not sure 0	
M8122	- Couples Communication?	Yes 1 No/Not sure 0	
M8123	- Joint decision-making on FP?	Yes 1 No/Not sure 0	
M8124	- Joint decision-making on birth planning?	Yes 1 No/Not sure 0	
M8125	**SCORE** [To calculate the score for this section, sum all answer that refer to "Yes"]	……./**23**	
M8100	**Summary of important observations**		

ANNEX 1 HEALTH FACILITY ASSESSMENT

MODULE 4: General Quality Considerations

4-1: Infection Prevention and Control

CODES	QUESTIONS	RESPONSES	SKIP TO
A101	Does this service have clean water for all uses (i.e., for the prevention of infections, use by patients and the caregivers, etc.)?	Yes 1 No 0	
A102	A sharps box is available for appropriate storage of sharps waste in the room	Yes 1 No 0	
A103	Methods for handling medical waste **[Select one or more responses]**	1=Mentioned, 0=Not mentioned a. Incinerator 1 0 b. Waste pit 1 0 c. Pit latrine 1 0 d. Outside dump 1 0 e. Burning 1 0 f. Discharging in a body of water 1 0 g. Other (specify)..... 1 0	Include in the score if the method for handling medical waste is incinerator.
A104	Are sharps separated from other waste?	Yes 1 No 0	
A105	Where/how are sharps disposed of? [Select one or more responses]	1=Mentioned, 0=Not mentioned a. Pit latrine 1 0 b. Waste pit 1 0 c. Burned/incinerator 1 0 d. Other (specify)..... 1 0	
A106	Does the HF have a sterilizer (dry heat sterilizer or autoclave)?	Yes 1 No 0	
A108	Does the HF have a handwashing station with soap?	Yes 1 No 0	
A109	Does the HF have decontamination solution (e.g. chlorine solution, 0.5%)?	Yes 1 No 0	
A110	Does the HF have decontamination containers with lids?	Yes 1 No 0	
A111	**SCORE**	**……./10** (Per the quality standards, the acceptable minimum required is 8/10)	
A112	**Summary of important observations**		

4-2: Pharmacy and Stock Management

CODES	QUESTIONS	RESPONSES
A201	Is there a designated room for the pharmacy?	YES 1 NO 2
A202	Is there a full-time certified pharmacist?	YES 1 NO 2
A203	Is the pharmacist trained on stock management	YES 1 NO 2
A204	If YES, when was the last time the pharmacist was trained in stocks management?	…… (Year)
A205	What is your general impression of the state of the building housing the pharmacy? (moisture, heat, racks/shelving, cobwebs, cleanliness, organization etc.)	
A206	Does the HF have any of the following supply management tools? [Select one or more responses]	1=Mentioned, 0=Not mentioned a. Records of stock for each product 1 0 b. Printed purchase orders 1 0 c. Monthly supply management reports 1 0 d. Records of stock movements 1 0 e. Other (specify)…… 1 0
A207	Were these tools all up to date at the time of your visit?	Yes 1 No 0
A208	Methods for storing medications. [Select one or more responses]	1=Mentioned, 0=Not mentioned a. Racks/shelving 1 0 b. Boxes 1 0 c. Cabinet 1 0 d. Other (specify)…… 1 0
A209	Ventilation of pharmacy	Yes 1 No 0
A210	Methods of temperature control [Select one or more responses]	1=Mentioned, 0=Not mentioned a. Air conditioning 1 0 b. Fan 1 0 c. None 1 0 d. Thermometer d. Other (specify)…… 1 0
A211	**SCORE**	**……/10**
A212	**Summary of Important Observations**	

4-3: Commodities and Supplies

CODES	TYPES OF ITEMS	QUESTIONS	QUANTITY AVAILABLE AND SEEN DURING THE ASSESSMENT VISIT	DATE OF LAST STOCKOUT (MONTH/YEAR)	REASONS FOR STOCKOUT
	Are/Will the following medicines and commodities be available?				
A3201	Emergency contraception and/or oral contraceptives with job aid AND client guide for EC dosing	YES 1 NO 0			
A3202	PEP Kits	YES 1 NO 0			
A3203	Tetanus toxoid vaccine	YES 1 NO 0			
A3204	Hep B vaccine	YES 1 NO 0			
A3205	Abortion/PAC supplies (see Module 2)	YES 1 NO 0			
A3206	Oral analgesic (e.g. paracetamol)	YES 1 NO 0			
A3207	Local anesthetic (e.g. lidocaine) for suturing; upper vaginal fornix, or cervical examination	YES 1 NO 0			
A3208	Rapid pregnancy testing kit	YES 1 NO 0			
A3209	Rapid tests for gonorrhea and chlamydia	YES 1 NO 0			
A3210	Sanitary pads (in case of pelvic bleeding)	YES 1 NO 0			
A3211	Cloth wraps/blankets for the event a client's clothes are torn or soiled	YES 1 NO 0			
A3212	Sterile lubricant	YES 1 NO 0			
A3213	Size 2.0 sutures with round needle	YES 1 NO 0			
A3214	Size 3.0 sutures with round needle	YES 1 NO 0			
A3215	Size 4.0 sutures with round needle	YES 1 NO 0			
A3216	Sterile gauze	YES 1 NO 0			
A3217	Self-adhesive bandages	YES 1 NO 0			
A3219	Sterile gloves	YES 1 NO 0			
A3220	Non-sterile gloves	YES 1			

		NO 0			
A3221	**SCORE**	…….**/20**			
A3200	**Summary of Important Observations**				

4-4: Equipment for services

CODES	TYPES OF ITEMS/MATERIALS OR EQUIPMENT	RESPONSES	QUANTITY	RECORD OF DISINFECTION AND/OR STERILIZATION
A4201	Exam light or another spot lighting source (torch, headlamp)	YES 1 NO 0		
A4202	Tongue depressors	YES 1 NO 0		
A4203	Cheatle forceps or long clamps for removal of foreign objects	YES 1 NO 0		
A4204	Stethoscope	YES 1 NO 0		
A4205	Pedersen speculum	YES 1 NO 0		
A4206	Graves speculum	YES 1 NO 0		
A4207	Autoclave or UV sterilizer	YES 1 NO 0		
A4208	Buckets for disinfection	YES 1 N0 0		
A4209	Toys, drawing supplies, or child-safe found objects (e.g. shells, smooth or brightly colored small rocks) to enable child appropriate history taking	YES 1 NO 0		
	For sites interested in offering medico-legal services only:			
A4210	Paper bags and sealing tape to hold soiled clothing	YES 1 NO 0		

A4211	Blue light filter and/or blue film to cover spotlight can aid in visualization of contusions on dark skin	YES 1 NO 0		
A4212	Envelopes and markers	YES 1 NO 0		
A4213	Forensic examination/documentation form	YES 1 NO 0		
A4214	Clock	YES 1 NO 0		
A4215	Sterile combs for hair combing	YES 1 NO 0		
A4216	Glass slides and sterile water	YES 1 NO 0		
A4217	Sterile urine containers	YES 1 NO 0		
A4218	Magnifying glass	YES 1 NO 0		
A4219	Measuring tape with MM and CM markings	YES 1 NO 0		
A4220	**SCORE** Max score for comprehensive sites: ……/20 Max score for medico-legal facilities:…./20			
A4221	**Summary of important observations**			

ANNEX 2

IPV Responsive Care Mentorship Checklist

General Information

Name of the health facility: _____ **Region/Province:** _____

Name of the mentee: _____ **Gender of the mentee:** Male/Female/Non-Binary

Qualification of the mentee: _____

Name of the mentor: _____ **Qualification of the mentor:** _____

Mentors should use the following checklist to assess each aspect of providing the service. Checklist completion is best done through continuous observation of a single simulation or client interaction. Choose when in your mentorship visit will best allow this to happen.

Checklist directions:

Rate the performance of each step or task using the following rating scale:

2 = Performs the step or task completely and correctly.

1 = Performs the step or task partially, or needs to ask questions to complete the task.

0 = Unable to perform the step or task correctly or mentee skipped the step/task.

N/A (not applicable) = Step was not needed. Note why not under comments.

Each visit column should be marked with the date and each element marked with the appropriate score.
If a given element was not clinically necessary for the observed client, indicate by marking N/A (e.g: in the event of normal delivery of the placenta, "Takes steps to manage retained placenta" would be marked N/A).

Practice checklist: {IPV Responsive Care} steps	Date						
	Rating						Comments
Person-Centered Care							
1. Introduce yourself to the client and inquire whether they would like to proceed with the visit in private (without the presence of whomever accompanied them)							
2. Present the extent and limits of the confidentiality you can offer for information shared.							
3. Request verbal informed consent to proceed.							
4. Engage with and respond to client feedback throughout procedure							
Total points for phase of service (Max = 8)							
Preparation							
1.Confirm which GBV services and providers are currently available within the same facility.							
2. Review the same day available GBV services at accessible points of service beyond the facility.							
Total points for phase of service (Max = 4)							
PROCEDURE STEPS:							
1. Use open ended questions to inquire if the client has any safety concerns about or while at home.							
2. Contraceptive method counseling includes information on visibility and risk of tampering by method.							
IF client discloses IPV or other GBV:							
3. **Listen** to information shared with open body language and without interrupting							
4. **Inquire** about the client's current needs and priority concerns. Does NOT ask about curiosity details (e.g: why did that happen?).							
5. **Validates** client experience and feelings. Assures the client the violence is not their fault.							
6. **Enhance safety** by referring client to a colleague or appropriate department within the clinic for safety planning. If within the provider's skill set, provides safety plan counseling directly (see separate checklist).							
7. Connect the client to **support services** by offering information and referral to appropriate medical, psycho-social, and legal services.							

Total points for phase of service (Max = 14)							
Practice checklist: {IPV Responsive Service} steps	**Date**						
	Rating						**Comments**
POST-SERVICE STEPS:							
1. Inquire whether the client has any concerns about family member opposition to follow up or recommended course of care							
2. Inquire whether the client has any other concerns they would like to discuss today							
Total points for phase of service (Max = 4)							
Documentation							
1. Share information you intend to document and seek client consent to do so.							
2. If physical injuries are present, document in the client's chart.							
3. Seek client consent to complete a IPV incident form if violence was disclosed.							
4. If completed, IPV incident form is safely filed in designated, locked storage system.							
Total points for phase of service (Max = 8) *Probable score = 4. A majority of visits will not include disclosure of violence.*							
Scoring							
A: Total elements marked N/A (*skill/task not indicated during the observed service*)							
B: Total possible points for the case observed (**19**-**A**) x 2 = total possible points							
C: Total points earned							
D: Record score as a percentage = **C/B*100** *Ex: 15/24*100 = 62.5%*							

Final steps:

- Remember to give positive feedback to your mentee before highlighting any priority areas for practice and/or improvement.
- Ask if your mentee has any questions.
- Record the final score in your mentor's summary sheet.
- Proceed to other mentorship activities (e.g., case review, simulation practice of skills needing improvement).

Score	Color coding	Interpretation	Corrective action
≥ 90%	**Green**	Competent	Provider to sustain performance, may be "graduated" from mentorship. Continue routine in-service training and supportive supervision.
65-79%	**Yellow**	Needs improvement	Provider has key areas to improve on. Continue routine mentorship visits to address gaps
<65	**Red**	Needs urgent remediation	Quality of care needs urgent remediation Discuss with clinical supervisor before departing facility and agree on modified duties, supervised provision of care, and/or re-training for the provider. Maintain enrollment in mentorship program.

Summary Comments (corrective actions taken; focus area for next visit):

Visit 1:

Visit 2:

Visit 3:

Visit 4:

Visit 5:

Visit 6:

ANNEX 2

Disclosure Reponse to GBV Mentorship Checklist

General Information

Name of the health facility: _____ **Region/Province:** _____

Name of the mentee: _____ **Gender of the mentee:** Male/Female/Non-Binary

Qualification of the mentee: _____

Name of the mentor: _____ **Qualification of the mentor:** _____

Mentors should use the following checklist to assess each aspect of providing the service. Checklist completion is best done through continuous observation of a single simulation or client interaction. Choose when in your mentorship visit will best allow this to happen.

Checklist directions:

Rate the performance of each step or task using the following rating scale:

2 = Performs the step or task completely and correctly.

1 = Performs the step or task partially, or needs to ask questions to complete the task.

0 = Unable to perform the step or task correctly or mentee skipped the step/task.

N/A (not applicable) = Step was not needed. Note why not under comments.

Each visit column should be marked with the date and each element marked with the appropriate score.

If a given element was not clinically necessary for the observed client, indicate by marking N/A (e.g: in the event of normal delivery of the placenta, "Takes steps to manage retained placenta" would be marked N/A).

Practice checklist: {Disclosure Response to GBV} steps	Date						
	Rating						Comments
Person-Centered Care							
1. Thank the client for trusting you with their experience.							
2. Present the extent and limits of the confidentiality you can offer for information shared.							
Total points for phase of service (Max = 4)							
Preparation							
1. Confirm which GBV services and providers are currently available within the same facility.							
2. Review the same day available GBV services at accessible points of service beyond the facility.							
Total points for phase of service (Max = 4)							

PROCEDURE STEPS:							
1. **Listens** to information shared with open body language and without interrupting							
2. **Inquires** about the client's current needs and priority concerns. Does NOT ask about curiosity details (e.g: why did that happen?).							
3. **Validates** client experience and feelings. Assures the client the violence is not their fault.							
4. **Enhances safety** by referring client to a colleague or appropriate department within the clinic for safety planning. If within the provider's skill set, provides safety plan counseling directly (see separate checklist).							
5. Connects client to **support services** by offering information and referral to appropriate medical, psycho-social, and legal services.							
Total points for phase of service (Max = 10)							

Practice checklist: {Disclosure Response to GBV} steps	Date						
	Rating						Comments
POST-SERVICE STEPS:							
1. Inquires whether the client has any concerns about family member opposition to follow up or recommended course of care							
2. Inquires whether the client has any other concerns they would like to discuss today							
Total points for phase of service (Max = 4)							
Documentation							
1. Share information you intend to document and seek client consent to do so.							
2. If completed, incident form is safely filed in designated, locked storage system.							
Total points for phase of service (Max = 4)							
Scoring							
A: Total elements marked N/A (*skill/task not indicated during the observed service*)							
B: Total possible points for the case observed (**13**-**A**) x 2 = total possible points							
C: Total points earned							
D: Record score as a percentage = **C/B*100** *Ex: 20/26*100 = 77%*							

Score	Color coding	Interpretation	Corrective action
≥ 90%	**Green**	Competent	Provider to sustain performance, may be "graduated" from mentorship. Continue routine in-service training and supportive supervision.
65-79%	**Yellow**	Needs improvement	Provider has key areas to improve on. Continue routine mentorship visits to address gaps
<65%	**Red**	Needs urgent remediation	Quality of care provided needs urgent remediation Discuss with clinical supervisor before departing facility and agree on modified duties, supervised provision of care, and/or re-training for the provider. Maintain enrolment in mentorship program.

Summary Comments (corrective actions taken; focus area for next visit):

Visit 1:

Visit 2:

Visit 3:

Visit 4:

Visit 5:

Visit 6:

ANNEX 2

Clinical Management of Rape Mentorship Checklist

General Information

Name of the health facility: _____ **Region/Province:** _____

Name of the mentee: _____ **Gender of the mentee:** Male/Female/Non-Binary

Qualification of the mentee: _____

Name of the mentor: _____ **Qualification of the mentor:** _____

Mentors should use the following checklist to assess each aspect of providing the service. Checklist completion is best done through continuous observation of a single simulation or client interaction. Choose when in your mentorship visit will best allow this to happen.

Checklist directions:

Rate the performance of each step or task using the following rating scale:

2 = Performs the step or task completely and correctly.

1 = Performs the step or task partially, or needs to ask questions to complete the task.

0 = Unable to perform the step or task correctly or mentee skipped the step/task.

N/A (not applicable) = Step was not needed. Note why not under comments.

Each visit column should be marked with the date and each element marked with the appropriate score.

If a given element was not clinically necessary for the observed client, indicate by marking N/A (e.g: in the event of normal delivery of the placenta, "Takes steps to manage retained placenta" would be marked N/A).

Practice checklist: {Clinical Management of Rape} steps	Date						Comments
	Rating						
Person-Centered Care							
1. Introduce yourself to the client and inquire whether they would like to proceed with the visit in private (without the presence of whomever accompanied them)							
2. Present the extent and limits of the confidentiality you can offer for information shared.							
3. Request verbal informed consent to proceed.							
4. Engage with and respond to client feedback throughout procedure **Do not rate this skill until the end of the service visit. During CMR it is critical that the provider frequently seeks consents and responds to client cues and preferences.**							
Total points for phase of service (Max = 8)							
Preparation							
1. Wears a clean plastic or rubber apron, rubber boots, and eye goggles.							
2. Wash hands thoroughly with soap and water, and dry them with a clean, dry cloth (or air dry).							
3. Use sterile or high-level disinfected (HLD) surgical gloves on both hands.							
4. Has CMR documentation form on accessible writing surface along with a HLD writing instrument.							
5. Has reviewed the same day available GBV services at accessible points of service beyond the facility.							
6. Reviews any existing documentation that arrives with the client (e.g. police reports, client records from referring provider)							
Total points for phase of service (Max = 12)							

Practice checklist: {Clinical Management of Rape} steps	Date / Rating						Comments
PROCEDURE STEPS:							
1. Takes complete medical history. Including any medications taken, any use of contraception, and any underlying medical conditions.							
2. Ascertains time elapsed since assault. Seeks pertinent details of assault while providing explanation of why the information is necessary.							
3. Uses LIVES methods to provide psychological first aid.							
Provide a physical assessment using the following steps (score each step separately):							
5. Use a systematic progression from head, to limbs, to trunk, and lastly the pelvic area. Verbally share all findings with the client as the exam proceeds.							
6. Document any visible signs of injury or assault on the provided exam form as the exam progresses.							
7. Provide first aid as indicated based on findings of physical exam. If severe injuries are revealed, refer for emergency care and/or hospital admission.							
8. Present reasons for conducting a genito-anal exam and seek consent to proceed with this portion of the exam: • Assess signs and/or extent of possible injuries • Assess and repair internal lacerations if known or suspected • Collect forensic evidence (ONLY IF FORENSIC SERVICES ARE AVAILABLE AT LOCATION AND FORENSIC EXAM CONSENT HAS BEEN OBTAINED[2])							
9. Verbally state each step and touch as you proceed through the genito-anal exam. Stop at any point that the client requests to do, or says "Stop." Ensure client is as covered as possible during the exam. NEVER CONDUCT "VIRGINITY-TEST." This has no scientific or clinical validity.							
IF within 72 hours of penetrative assault:							
10. Provide counseling and informed consent for PEP - HIV							
11. Assess for potential tetanus exposure. Provide prophylactic dosage of tetanus toxoid as soon as possible after wounds were incurred[3].							

[2] This checklist is not appropriate for assessment of forensic exam and evidence collection.

[3] Tetanus Immunoglobin (TIG) is indicated for unvaccinated individuals presenting 24-72 hours after possible exposure. However, TIG is rarely available in low-resource settings. If there is a high risk of tetanus exposure (e.g. penetration with a metal object) consider transferring to tertiary level hospital where TIG is present.

IF within 120 hours (5 days) of peni-vaginal assault:							
12. Offer and seek informed consent for emergency contraception: 1.5mg levonorgestrel							
Regardless of time elapsed since assault:							
13. Offer and seek informed consent for prophylactic antibiotics against STIs.							
14. Provide counseling on potential for onward infection until antibiotic courses are complete.							
Total points for phase of service (Max = 28)							
POST-SERVICE STEPS:							
1. Enhances safety by offering to help the client prepare a safety plan.							
2. Provides options for where and how the safety plan will be documented.							
3. Provides counseling for self-care, including techniques for anxiety management; s/sx of infections; and where to seek emergency help for mental health crises.							
4. Connects client to **support services** by offering information and referral to appropriate psycho-social and legal services. Include referral to a case manager if available.							
5. Advises and schedules follow up care; including a plan for safe and confidential contact. 2-week; and 3-month visits.							
Total points for phase of service (Max = 10)							
Documentation							
1. Standard form is completed. Note location, size, and any information of direct cause of injury (e.g. semi-circle of puncture wounds on R bicep. 4cm diameter, punctures ~1cm deep, apparent bite mark). Specific location of all injuries noted on the body diagram regardless of need for treatment (e.g. mild contusions and/or petechiae should also be noted).							
2. All treatments provided are recorded in the CMR record, including wound care, medications given; tests or lab work conducted.							
3. Follow up care indicated (e.g. pregnancy test; HIV testing). Follow up care scheduled.							
4. Referrals made; document both active and passive referrals.							
5. Chart is coded, filed, and locked according to facility protocols.							

6. Anonymized, summary information is entered into the clinic register.							
Total points for phase of service (Max = 12)							
Scoring							
A: Total elements marked N/A (*skill/task not indicated during the observed service*)							
B: Total possible points for the case observed (**35**-**A**) x 2 = total possible points							
C: Total points earned							
D: Record score as a percentage = **C/B*100** *Ex: 59/70*100 = 84%*							

Final steps:

- Remember to give positive feedback to your mentee before highlighting any priority areas for practice and/or improvement.
- Ask if your mentee has any questions.
- Record the final score in your mentor's summary sheet.
- Proceed to other mentorship activities (e.g., case review, simulation practice of skills needing improvement)

Score	Color coding	Interpretation	Corrective action
≥ 90%	**Green**	Competent	Provider to sustain performance, may be "graduated" from mentorship. Continue routine in-service training and supportive supervision.
65-89%	**Yellow**	Needs improvement	Provider has key areas to improve on. Continue routine mentorship visits to address gaps
<65%	**Red**	Needs urgent remediation	Quality of care provided needs urgent remediation Discuss with clinical supervisor before departing facility and agree on modified duties, supervised provision of care, and/or re-training for the provider. Maintain enrollment in mentorship program.

Summary Comments (corrective actions taken; focus area for next visit):

Visit 1:

Visit 2:

Visit 3:

Visit 4:

Visit 5:

Visit 6: