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MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN

GENDER-BASED VIOLENCE AND VIOLENCE AGAINST CHILDREN

FACILITATOR'S GUIDE

FOR HEALTH CARE PROVIDERS AND SOCIAL WELFARE OFFICERS

JULY 2017

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FOREWORD

Gender-based violence (GBV) has gained international recognition as a grave social and human rights concern. In Tanzania, GBV and violence against children (VAC) have become major problems due to negative cultural beliefs and practices, existing gender norms, and economic, social, and gender inequalities. Victims of GBV and VAC can be any age and sex, including women, men, girls, and boys. GBV and VAC are related to socially defined norms of gender and sexual identity and can be carried out by intimate partners, family members, community members, people of authority, and others. These acts can take place at home, in public, or in institutions.

The World Health Organization's 2005 Multi-Country Study (WHO 2005) and the 2010 Tanzania Demographic and Health Survey (TDHS) (NBS 2011a) provided evidence for the need to engage the health sector in GBV prevention and response services. The TDHS found that over 20 percent of Tanzanian women aged 15–49 years reported having experienced sexual violence in their lifetime; nearly 40 percent reported having experienced physical violence. The survey also indicates that 44 percent of ever-married women had experienced physical or sexual violence from an intimate partner in their lifetime. A nationally representative survey of violence against children (UNICEF 2011) also found that 75 percent of girls and boys had experienced physical violence (from a relative, authority figure, or intimate partner) by the age of 18 years and nearly 3 in 10 girls had experienced sexual violence before reaching adulthood (NBS 2011b).

The Tanzania Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) revised this Facilitator's Guide to provide updated guidance to trainers of health care providers and social welfare officers on the provision of effective and comprehensive services to GBV and VAC survivors. The revision was based on the GBV and VAC Competency-Based Education and Training, which was also revised in 2016. The rationale for the revision was to align the Training Package with newly documented evidence (WHO/ILO 2009; WHO 2014) and several advancements made on provision of quality GBV and VAC services since 2011, when the original Tanzania GBV and VAC Training Package was produced. The entire GBV and VAC training package has been updated in line with the newly documented evidence, which includes the HIV post-exposure prophylaxis (PEP) regimen (WHO 2014), World Health Organization Clinical and Policy Guidelines (WHO 2013), and guidance on responding to intimate partner violence and sexual violence against women (Ibid.), as well as the National New HIV PEP Guidelines (NACP 2015).

Much progress has been made in Tanzania in GBV and VAC prevention and response. Advances include, among others, development and implementation of national policy, management, and clinical guidelines; increased number of health facilities that provide post GBV and VAC services to survivors; increased number of survivors who are accessing health, social welfare, and legal services; and reduced incidences of GBV and VAC in some areas of the country. These guidelines have provided the framework and guidance for integrating GBV services into health services,

linking health facilities and local communities, developing social and legal protection systems, improving medical management, referral for psychosocial care, development of monitoring and evaluation (M&E) indicators and tools, as well as guidelines for multisectoral coordination (health, social welfare, police, legal, and community) of GBV and VAC prevention and response efforts.

Despite these achievements, challenges remain, including limited access to health, psychosocial, and legal services; shortage of trained medical professionals; shortage of shelters for survivors; limited clinical mentorship; limited onsite sensitization on integrating GBV and VAC in health service provision; and limited number of health care providers and social welfare officers knowledgeable about comprehensive GBV and VAC services. The MOHCDGEC is taking the necessary measures to address these challenges because effective and comprehensive medical and psychosocial care for survivors require health care providers and social welfare officers to have appropriate competencies and skills in preventing acts of violence and providing the needed care to GBV and VAC survivors.

It is my hope that the use of this Facilitator's Guide will provide guidance, effective facilitation and learning modalities, knowledge, and skills required for GBV and VAC service trainers. The ultimate goal of this guide is to facilitate the creation of a pool of qualified health care providers and social welfare officers with competencies in providing quality comprehensive services to GBV and VAC survivors.

Prof. Muhammad Bakari Kambi
Chief Medical Officer

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ACRONYMS

AIDS	acquired immune deficiency syndrome
BCC	behavior change communication
CHMT	council health monitoring team
DHIS	district health information system
ECP	emergency contraceptive pill
FGM/C	female genital mutilation/cutting
FSW	female sex worker
GBV	gender-based violence
HIV	human immunodeficiency virus
HMIS	health management information system
KP	key population
LCA	Law of the Child Act
M&E	monitoring and evaluation
MSM	men who have sex with men
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
PEP	post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPP	purchasing-power-parity
PWID	people who inject drugs
RHMT	Regional Health Monitoring Team
RMNCAH	reproductive, maternal, neonatal, child and adolescent health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SOSPA	Sexual Offenses (Special Provisions) Act
TDHS	Tanzania Demographic Health Survey
TT	tetanus toxoid
UNICEF	United Nations Children's Fund
VAC	violence against children
WHO	World Health Organization

INTRODUCTION TO THE FACILITATOR'S GUIDE

Overview

Many studies conducted in Tanzania indicate unacceptably high levels of gender-based violence (GBV) and violence against children (VAC) (NBS 2011b). The World Health Organization (WHO 2005) multicountry study and the Tanzania Demographic and Health Survey (TDHS) (NBS 2011a) demonstrate the need for the health sector to engage in prevention and response services. The TDHS 2015/16 shows that 17 percent of Tanzanian women aged 15–49 have experienced sexual violence in their lifetime, and 40 percent reported having experienced physical violence. It also shows that 50 percent of ever-married women had experienced physical, sexual or emotional violence from a spouse. A nationally representative survey of violence against children (UNICEF 2011) also found that nearly 75 percent of girls and boys had experienced physical violence (either by an adult or intimate partner) by age 18, and that nearly 3 in 10 girls had experienced sexual violence before reaching adulthood.

Violence against children in particular has a profound impact on emotional, behavioral, and physical health and social development throughout life. Children who experience violence in childhood are less likely to do well in school and are more likely to engage in risky behavior, such as transactional sex and non-use of condoms, which can leave them exposed to sexually transmitted infections (STIs), including HIV, as well as teenage pregnancy. Exposure to violence, especially at home, is a leading cause of children leaving home to live on the streets. Violence against children increases the likelihood that they will live in poverty and inflict similar violence on their children or partners later in life, as well as the likelihood that they will engage in other antisocial behavior that can undermine social and economic development (UNICEF 2011).

VAC is also manifested in early or child marriages and teenage childbearing. Teenage pregnancy is a major health concern because of its association with higher morbidity and mortality for both the mother and child. The TDHS 2015/16 results show that in Tanzania, 27 percent of women age 15–19 have begun childbearing: 21 percent have given birth, and an additional 6 percent are pregnant with their first child. According to the Child Dignity Forum (CDF 2013), the prevalence of early/child marriage is very high in Tanzania, especially in the coastal regions and among the pastoralists. CDF reports that one in every six girls and young women are married before 18 years of age, which makes Tanzania a country with one of the highest rates of adolescent pregnancy and birth rates. The study also reveals that about 37 percent of women aged 20–24 were married/in union before age 18. Early or child marriage is perpetuated and reinforced by cultural and religious beliefs, as well as income poverty,

which positions girls to be seen as family capital by getting married early, bringing the family wealth and reducing its burden of support of children.

The negative effects of GBV and VAC go beyond the health consequences to negatively affect family stability, structure, and livelihoods, which ultimately impacts negatively on overall national development by impeding the government's poverty reduction efforts to improve livelihoods. GBV and VAC in Tanzania are being perpetuated by, among others, negative cultural beliefs and practices and existing gender norms and social gender inequalities. Victims of GBV and VAC are mostly women and children, but also many key population groups (NACP 2010; NACP 2013; MOHSW 2013).

The MOHCDGEC in collaboration with other government and nongovernment stakeholders is making efforts to address these challenges by developing policy and management guidelines for GBV and VAC prevention and response. In 2011 the ministry developed the National Policy Guidelines for Health Sector Prevention and Response and the Medical and Management Guidelines for Prevention and Response to GBV and VAC with a corresponding training package (MOHSW 2011). It also developed Guidelines for Multisectoral Coordination Working Committees/Groups to facilitate a multisectoral approach (health, social welfare, police, legal, and community) to GBV and VAC prevention and response. The guidelines (URT 2013a) have been valuable in providing the national framework for integrating GBV and VAC services into health services and providing linkages between health facilities and local communities, as well as social and legal protection systems, medical management, referral for psychosocial care, and monitoring and evaluation (M&E) systems and tools.

Implementation of the guidelines has led to positive results, including an increase of health facilities that provide GBV and VAC services, as well as an increase in the number of GBV and VAC survivors accessing GBV services. The result has been a reduction of GBV and VAC in some parts of the country as more survivors are accessing GBV/VAC services and referrals to psychosocial and legal services. The guidelines have facilitated the development of GBV and VAC management tools such as medical examination and consent forms; GBV data collection sheets, registers, and a national recording system; harmonization of GBV indicators into the national health management information system (HMIS) and district health information system (DHIS 2); development of locally assembled sexual assault kits; and inclusion of GBV and VAC competencies in the pre-service curricula of clinical assistants, clinical officers, and nurses to ensure GBV is mainstreamed at all levels of the health sector.

Other notable MOHCDGEC achievements include the production of a forensic training manual for health care providers, law enforcement agencies, and social workers, thereby creating an efficient national chain of custody system for forensic samples that allows collected samples from a health facility to proceed to a forensic laboratory for analysis and then to police for legal action. This has not only helped to link GBV survivors to the legal system but also has sped the analysis of forensic samples to help in obtaining justice for GBV and VAC survivors.

The MOHCDGEC is collaborating with other ministries' activities to combat GBV and VAC; for example, with the Ministry of Home Affairs in developing the police standard operating procedures on the prevention of and response to GBV and VAC; establishment of police gender and children's desks, the Police Gender Coordination Group, and "One Stop Centers" for survivors of GBV; and inclusion of GBV modules in pre-service curriculum for the police academy. The MOHCDGEC has also worked with the Ministry of Constitutional and Legal Affairs in the development of regulations to implement the Law of the Child Act, a five-year progressive child justice reform strategy to address children's access to justice, and three-year Multi Sector National Plan of Action to Prevent and Respond to Violence against Children (2013–16) (URT 2013a).

All these developments have facilitated effective and comprehensive provision of medical and psychosocial care to GBV and VAC survivors by health care providers and social welfare officers trained in appropriate competencies and skills in preventing acts of violence and providing the needed care to survivors of violence and abuse.

Given the magnitude and consequences of GBV and VAC, the National Policy Guidelines and Management for Health Sector Prevention of and Response to GBV (MOHSW 2011), were developed to provide guidance on violence prevention and provision of comprehensive, high-quality services for GBV and VAC survivors at all levels of society. One of the objectives of the guidelines is to build the capacity of and train health care providers and social welfare officers to deliver effective GBV-related prevention and response services.

Purpose of this Guide

This *Facilitator's Guide* aims to assist trainers to facilitate GBV and VAC training for health care workers and social welfare officers on effective GBV and VAC prevention and response.

Users of this Guide

The users of this *Facilitator's Guide* will be GBV and VAC trainers from diverse backgrounds, including but not limited to instructors from medical, social welfare, and public health departments; researchers; as well as GBV and VAC experts in M&E, HIV, and human rights programs.

Selection Criteria for GBV and VAC Trainers

Trainers will be selected from among health care workers and social welfare officers who have attended and completed a training-of-trainers and having been certified by the MOHCDGEC as having done so. Trainers will be selected by the Ministry in collaboration with the Regional authorities where the training will take place.

Course Organization

The duration of this course is six days. Facilitators will train participants to understand and apply concepts and principles of responding to acts of GBV and VAC in different settings.

The course is divided into four modules, subdivided into different teaching and learning sessions as shown the Summary of Modules table.

Training Philosophy

This training includes both theory and practice elements and will be up to date and contextually relevant to local settings. The training must be facilitated by qualified instructors who are competent in providing required health and social welfare services to survivors of GBV and VAC. As much learning as possible must be conveyed through clinical practice in health and social welfare settings in conjunction with classroom-based theory. This program offers standardized training regardless of participants' previous learning levels, their cadres in medical and social welfare professions, and the availability of financial and other resources for learning and teaching.

SUMMARY OF MODULES AND SESSIONS

Module	Session	Title	Time
MODULE 01: Introduction to GBV and VAC	1.1	Concepts of Gender, Gender-Based Violence, and Violence Against Children	360 min.
	1.2	Reproductive Health Rights and GBV under National Laws and Policies	180 min.
Total time for Module 1			540 min.
MODULE 02: Management of GBV and VAC Survivors	2.1	Interpersonal Communication, Values, and Attitudes of Health Care Providers	200 min.
	2.2	Principles and Procedures for Management of GBV and VAC Survivors	120 min.
	2.3	Physical Examination and Treatment of Survivors	120 min.
	2.4	Forensic Sample/Evidence Management	120 min.
	2.5	Psychosocial Care and Support	120 min.
Total time for Module 2			680 min.
MODULE 03: Prevention of GBV and VAC	3.1	Prevention and Behavior Change Communication (BCC) for GBV and VAC	120 min.
	3.2	Life Skills in the Prevention of GBV and VAC	90 min.
	3.3	Multisectoral Approach to Prevention of GBV and VAC	120 min.
Total time for Module 3			330 min.
MODULE 04: Management of Data for GBV and VAC Services	4.1	Data Collection and Reporting	60 min.
	4.2	Explanation of Procedures for GBV and VAC Data Reporting	60 min.
	4.3	Supportive Supervision	40 min.
	4.4	Using Data for Decision-Making	120 min.
Total time for Module 4			280 min.
Total time for Modules 1 through 4			30.5 hrs. (appx. 4 days)
PRACTICUMS			8 hours (1 day)
Objective Structured Practical Examination (OSPE)			8 hours (1 day)
Total: class hours, including OSPE and Practicums			6 days

COMPETENCIES OF SERVICE PROVIDERS

Health care providers and social welfare officers are expected to gain a number of competencies as described in Table 0.1.

Table 0.1. Competencies and Qualities of Health and Social Welfare Officers Providing GBV and VAC Services

Module 01: Introduction to Gender-Based Violence and Violence against Children
<ul style="list-style-type: none">• Describe concepts of gender, GBV, and VAC.• Describe causes, magnitude, and consequences of GBV and VAC.• Discuss public health and human rights concerns in relation to GBV and VAC.• Describe concepts of poverty, gender sexual reproductive health and rights (SRHR), and HIV in GBV- and VAC-related services.
Module 02: Management of GBV and VAC Survivors
<ul style="list-style-type: none">• Use principles of interpersonal communication skills in managing GBV and VAC survivors.• Provide preventive and curative therapies to GBV and VAC survivors according to national guidelines.• Provide appropriate referral to survivors of GBV and VAC.• Manage forensic samples/evidence from survivors of GBV and VAC.• Facilitate chain of custody and documentation of samples/evidence related to GBV and VAC.• Interpret findings from GBV and VAC survivors before the court of law.• Use principles of psychosocial care and support to provide social support for GBV and VAC survivors.
Module 03: Prevention of GBV and VAC
<ul style="list-style-type: none">• Explain levels of GBV and VAC prevention.• Describe principles and practices in behavioral change communication (BCC) for GBV and VAC prevention.• Describe life skills in prevention of GBV and VAC.
Module 04: Management of Data for GBV and VAC Services
<ul style="list-style-type: none">• Explain procedures for GBV and VAC data collection.• Explain procedures for GBV and VAC data reporting.• Apply techniques for data verification.• Interpret routine data for service improvement.• Use data for GBV and VAC services for appropriate decision making.• Provide feedback of improvement for survivor's consumption.• Use information collection techniques for client services satisfaction with GBV and VAC services.• Analyze client services satisfaction information for improving GBV and VAC services.• Provide feedback of client services satisfaction for improving GBV and VAC services.

Training Preparations

The organizers should ensure that preparation for the training starts early and they should observe important issues and factors. Table 0.2 presents a step-by-step approach and important milestones to be aware of when organizing this training.

Table 0.2. Training Preparation for Organizers

Time	Activities
4 weeks prior to training	<ul style="list-style-type: none"> • Send out invitations. • Get cost estimates on venue and accommodations. • Contact caterers and get cost estimates.
2 weeks prior to training	<ul style="list-style-type: none"> • Confirm participation of the facilitators and assign sessions. • Print out facilitator guides and send to each facilitator. • Prepare the course agenda and send to the facilitators. • If official opening is needed, identify and contact the guest of honor. • Request finances for participant per diem and transport.
1 week prior to training	<ul style="list-style-type: none"> • Confirm participant attendance and prepare the nametags. • Confirm venue, catering, and accommodations. • Purchase stationery and supplies: notebooks, marker pens, flipcharts, pens, nametags. • Print out participant manuals. • Reserve equipment needed. • Confirm the guest of honor and send speaking notes, if any. • Once again, confirm facilitator attendance.
1 day before the training	<ul style="list-style-type: none"> • Pack all materials and take them to the training venue. • Check all equipment to ensure it is working properly. • Check with the catering service and share the refreshment timeslots. • Hold facilitators meeting (led by the course coordinator): <ul style="list-style-type: none"> ○ Confirm/finalize the course agenda. ○ Go over any questions on content and methods. ○ Discuss expectations and the importance of teamwork. ○ At the end of the meeting, work as a team to prepare the room for the following day. • At the venue, ensure the presence of, unpack, and arrange the following materials: <ul style="list-style-type: none"> ○ Copies of training timetable and pre-training knowledge assessment for all participants ○ Venue set-up ○ Prepared flipchart, pens, and tape ○ Laptop computer and slide projector ○ Facilitator's and participant's manuals

Time	Activities
	<ul style="list-style-type: none"> • Teaching aids • Set up room in a U-shape • Set up a facilitator's table and a table for handouts and supplies. • Place the following in front of each participant's chair: <ul style="list-style-type: none"> ○ Participant's guide ○ Participant registration form ○ Course schedule ○ Folder ○ Pen ○ Notebook
First day of training	<ul style="list-style-type: none"> • Ask participants to fill in the sign-in sheet and give them a name tag. • Ask participants to fill out the registration form. • Collect the registration forms. Count the forms to match the number of forms to the number of participants. Track down all missing forms. • Make sure that all information is complete on the registration form. If not, get clarity from the participants before the course is over.

MODULE 01: INTRODUCTION TO GBV AND VAC

Module 01 introduces the concepts, causes, magnitude, and consequences of gender-based violence and violence against children. It prepares participants to understand essential elements of GBV and VAC and their linkages with public health, human rights, poverty, SRHR, and HIV.

This module comprises two sessions:

- Session 1.1: Concepts of Gender, Gender-Based Violence, and Violence Against Children
- Session 1.2: Reproductive Health Rights and GBV under National Laws and Policies

Session 1.1: Concepts of Gender, Gender-Based Violence, and Violence Against Children

Total session time: 360 minutes

Learning Tasks

By the end of the session, participants are expected to be able to:

- Define main terminology in relation to GBV and VAC.
- Explain types of GBV and VAC.
- Distinguish magnitude of GBV and VAC.
- Describe ecological model of GBV and VAC.
- Explain causes of and contributing factors to GBV and VAC.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers, LCD television monitors and screens, textbooks, and laptop/computer.

SESSION OVERVIEW

Step	Time (min.)	Activity/Method	Content
1	5	Presentation	Introduction of the session learning tasks
2	45	Buzzing Presentation	Definition of key terminology in relation to GBV and VAC
3	60	Presentation	Types of GBV
4	45	Buzzing/presentation	Types of VAC
5	45	Presentation	Magnitude of GBV and VAC
6	60	Brainstorming and presentation	Explain causes of and contributing factors to GBV and VAC
7	45	Presentation	Consequences of GBV and VAC
8	35	Presentation	Describe ecological model of GBV and VAC
9	5	Presentation	Key points
10	5	Presentation	Evaluation
Total	360 min (6 hours)		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ the learning tasks to participants.

ASK participants if they have any questions before continuing.

STEP 2: Definition of key terminology in relation to gender, GBV, and VAC (45 min.)

ACTIVITY: Buzzing (5 min.)

ASK participants to buzz in pairs for minutes on the meaning of the concepts:

- Gender
- Sex
- Violence
- Gender-based violence
- Power
- Child
- Victim
- Consent
- Survivor
- Perpetrator
- Key population
- Adolescent
- Vulnerable groups
- Sexual and reproductive health

ASK one or two pairs to respond to their definitions.

WRITE participants' responses on the board or flipchart.

SUMMARIZE responses and present the definitions as indicated below.

PRESENTATION

Key Terminology in Relation to Gender, GBV, and VAC

Gender

- Gender is a socially constructed concept associated with being female or male.
- It refers to the sociocultural factors (e.g., age, religion, ethnicity, class or caste, education) that influence access, decision-making, and power.
- In any given society, gender refers to the socialization of individuals that determines roles, responsibilities, opportunities, privileges, limitations, and expectations.
- Gender definitions can change with time and among and within different cultures.

Sex

- Refers to biological differences (anatomy, physiology, and genetics) between males and females.
- Does not change (without surgical intervention).
- Examples of attributes of sex are:
 - Anatomy: penis, vagina, breasts, testes
 - Physiology: menstrual cycle, spermatogenesis
 - Genetic makeup: XX and XY chromosomes.

Child

A male or female person under the age of 18 years according to the Child Act 2009, UN Convention on the Rights of the Child, and the Tanzania Penal Code which incorporated sexual offenses special provisions.

Violence

- WHO defines violence as an “intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation” (WHO 2002).
- The words “intentional use” are an important element that distinguishes violence from unintended injuries and harm.

Power

- Refers to using any kind of pressure to obtain favors from a weaker person in exchange for benefits or promises.
- In GBV, unequal power relations are exploited or abused. Power inequality between persons can be exploited by using physical force or making threats. Basically, gender-based violence is an abuse of power. Forms of power can be real or perceived. Forms of power can be having a position of authority, ability to make decisions, or possession of money or weapons.

Consent

- Consent means making an informed choice freely and voluntarily to do something. There is no consent when agreement is obtained through use of threat, force, or other forms of coercion, abduction, fraud, deception, or misrepresentation.
- Acts of gender-based violence occur without informed consent. Even if someone says “yes” during one of these acts, it is not consent because it was said under duress—the perpetrator uses some kind of force to get the victim to say yes.
- Children (under age 18) are deemed unable to give informed consent for acts such as female genital cutting, marriage, and sexual relations.

Gender-based violence

- Gender-based violence is violence that is directed against a person on the basis of gender or sex.
- It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty.
- While women, men, boys, and girls can all be at risk of GBV, women, adolescents, and children are the more vulnerable groups.

Survivor

A survivor is someone (a child or an adult male or female) who has been physically, sexually, and/or psychologically violated because of his/her sex or gender.

Perpetrator

- A perpetrator is a person, group, or institution that directly inflicts, supports, or condones violence or other forms of abuse against a person or group of people.
- A perpetrator could be a partner, ex-partner, boyfriend, father, mother, another family member, another person in the home, teacher/educator, a superior at the work place, colleague at work or school, another acquaintance, or a stranger.
- Perpetrators take advantage of being in a position of real or perceived power, decision making, or authority, and thus exert control over others.

Violence against children (VAC)

- VAC is a broad term that is used to include deliberate behavior by people against children that is likely to cause physical or psychological harm.
- According to Article 19 of the UN Convention on the Rights of the Child, “violence” is understood to mean “all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, exploitation or maltreatment, including sexual abuse.”

Child protection

- This refers to all measures (legislative, administrative, social, and educational) taken to prevent and respond to violence, exploitation, neglect, and abuse against children (including commercial sexual exploitation, trafficking, child labor, and harmful traditional practices, such as female genital mutilation/cutting [FGM/C] and child marriage).

- In order to prevent and respond to VAC (and other forms of abuse) in Tanzania, the Law of the Child Act (LCA) of 2009 sets out the framework for a child protection system.
- The LCA enshrines a key role for the MOHCDGEC to develop and implement this system.

Social welfare officers

These officers are primarily responsible for implementing the child protection system (receiving referrals, investigating cases, ensuring children are removed to a place of safety when necessary, and facilitating alternative care options).

Medical practitioner

Is a person who is registered as a medical practitioner under the Medical Practitioners and Dentists Ordinance as a person who professes to practice medicine, surgery, or midwifery, including a medical doctor, medical officer, assistant medical officer, clinical officer, and assistant clinical officer. A medical practitioner should hold a recognized qualification from a learning institution recognized by the Medical Council of Tanganyika.

Key population

- Key population includes groups of individuals at higher risk of acquiring and transmitting HIV. They are important in establishing, accelerating, sustaining or curbing (reducing) the HIV epidemic. According to the National Guidelines for Comprehensive Package of HIV Interventions for Key Population (URT 2014), this group includes:
 - People who inject drugs (PWID)
 - Sex workers (male and female)
 - Men who have sex with men (MSM)
 - Transgender persons
 - Prisoners
 - Vulnerable groups such as orphans and street children.

Mandatory reporting

It is the duty of any member of the community to report to the local government authority/social welfare office if s/he has evidence or information that a child's protection rights are being infringed or that a parent, guardian, or relative who has custody of the child is neglecting the child and putting him/her at risk of harm (Law of the Child Act section 95(1)).

STEP 3: Types of GBV (60 min.)

PRESENTATION

Gender-based violence can be categorized as follows:

- Physical violence
- Sexual violence
- Psychological or emotional violence
- Economic violence.

Physical violence

- Refers to intentional use of physical force with the potential to cause death, disability, injury, or other harm.
- Acts of physical violence include scratching, pushing, shoving, throwing, grabbing, biting, choking, shaking, slapping, punching, burning, and use of a weapon, restraints, or one's body size or strength against another person.

Sexual violence

- Refers to the use of physical force to compel a person to engage in a sexual act against her/his will, or be subject to attempted or completed sex acts or abusive sexual contact without her/his permission or understanding.
- Acts of sexual violence include sexual harassment, rape, including forceful anal penetration, attempted rape, marital rape, exploitation, child sexual abuse/incest, sexual abuse (non-penetrating), forced prostitution, child prostitution, and sexual trafficking.

Psychological or emotional violence

- Involves trauma to the individual caused by acts, threats of acts, or coercive tactics.
- Psychological/emotional abuse can include, but is not limited to, humiliation, control, withholding information, deliberately making someone feel diminished or embarrassed, isolation from contacts, and denying access to money or other basic resources.

Economic violence

- Acts of economic violence include denial of right to own property and denial of access to money or other basic resources.
- Economic violence is related to economic exploitation and the denial of opportunity for economic empowerment. Lack of ownership and inheritance rights, or limited access to and control over productive/economic resources such as land or bank loans/credit because they do not have property to put down as collateral increase risk of economic abuse.

Harmful traditional practices

- Harmful traditional practices refer to types of violence committed in certain societies as part of accepted cultural practice. Some of these practices include female genital mutilation or cutting (FGM/C), early or forced marriage, and widow inheritance or widow cleansing.

Female genital mutilation/cutting

- FGM/C is removal of part or all of the external female genital organs for cultural beliefs or religious reasons. In Tanzania the following forms of FGM/C exist:
 - **Clitoridectomy:** removal of part or whole of the clitoris.
 - **Excision:** removal of the clitoris and part or total of the labia minora. This is the most common, covering about 80 percent of those who are subjected to FGM/C.
 - **Modified infibulations:** removal of the clitoris and stitching of the anterior two-thirds of the labia minora.

- **Total infibulations:** removal of the clitoris and labia minora, plus incision and stitching the raw surface of the labia minora.
- The consequences of FGM/C for the health of women can be severe, including obstetric problems (antenatal, labor, delivery, postpartum, pregnancy outcome, maternal mortality, and neonatal mortality); gynecological problems, such as menstrual problems; infertility and urinary problems; psychosexual problems; and psychological morbidity (WHO 2000).

Early marriage

- Refers to marriage before the age of 18 when a girl or boy child is considered mature physically and mentally to marry. In some societies in Tanzania girls commonly get married before they are 18 years old.
- Child, early, and forced marriage is regarded as a human rights and sociological violation that has adverse consequences for those violated.
- Most of these marriages are arranged without the prior knowledge or consent of the bride. Child marriage is often accompanied by the following:
 - **Domestic violence:** Abuse is a daily reality for many married girls who are more likely to be beaten or threatened and to believe that a husband might be justified in beating his wife.
 - **Forced sexual relations:** Since there is a wide age gap between child brides and their spouses, it makes child brides less able to negotiate sexual relations or control over their bodies.
 - **Sexual and reproductive health risks, maternal and infant health risks, and teenage pregnancy:** Girls who marry early have their first children at a younger age. Early childbearing contributes to pregnancy-related deaths and birth complications, which are a leading cause of mortality of girls in Tanzania.
 - **Greater exposure to HIV:** Many young brides cannot negotiate safe sex even when they have knowledge about how to protect themselves and are under pressure to demonstrate their fertility.
 - **Illiteracy and lack of education:** Girls tend to drop out of school during the preparatory period before marriage or at the point of union and transfer to the marital home, which affects their ability to access the benefits of education. Education is associated with the prevalence of child marriage in Tanzania: 61 percent of women aged 20–24 with no education and 39 percent with primary education were married or in a union at age 18, compared to only 5 percent of women with secondary education or higher (CDF 2013).
 - **Isolation and psychological trauma:** Child brides are unable to cope with married life; because at their young age they are not well prepared to handle family matters. Poverty and psychological underdevelopment can cause adolescent mothers to under-stimulate their infants (UNFPA 2012).

Other names used to describe gender-based violence

- Violence against women, terminology of the World Health Organization:
 - A common form of violence that refers to types of harmful behaviors directed at women and girls.
 - According to the UN (1994), violence against women is defined as “any act of gender-based violence that results in, or is likely to result in, sexual or mental harm or suffering of women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private.”
 - Intimate partner violence is defined as an actual or threatened physical, sexual, or psychological/emotional abuse directed toward a current or former partner or spouse, boyfriend, or girlfriend.

STEP 4: Types of VAC (45 min.)

ACTIVITY: Brainstorming (10 min.)

ASK participants to brainstorm on types of violence against children.

ASK a few of them to write their responses on flipcharts/whiteboard as they talk.

ASK a few of them to present their responses in class.

CLARIFY participants’ responses with the information below.

PRESENTATION

There are four main types of violence against children:

- Physical abuse
- Sexual abuse
- Psychological or emotional abuse
- Neglect.

Child physical abuse

- Child physical abuse is defined as non-accidental physical injury caused by punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child, which is inflicted by a parent, guardian, caregiver, stranger, or any other person.
- According to Child Protection Regulations of the Law of the Child Act 2009 of Tanzania, acts of physical abuse of children include hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, including causing illness in a child or otherwise deliberately causing physical harm to a child.

Differences between physical abuse and discipline

In physical abuse, unlike physical forms of discipline, the following elements are present:

- Unpredictability

- The child never knows what is going to set the parent/caregiver off.
- There are no clear boundaries or rules.
- The child constantly lives in fear and is never sure what behavior will trigger a physical assault.
- Physically abusive parents/caregiver act out of anger and the desire to assert control, not the motivation to lovingly teach the child.
- The angrier the parent/caregiver, the more intense the abuse.
- Using fear to control behavior
 - Parents/caregivers who are physically abusive may believe that their children need to fear them in order to behave, so they use physical abuse to “keep their child in line.” However, what children are really learning is how to avoid being hit, not how to behave or grow as individuals.

Child emotional abuse

- Emotional abuse means the persistent emotional ill-treatment of a child so as to cause severe and persistent adverse effects on the child’s emotional development.
- It can include seeing or hearing the ill-treatment of another.
- It can involve:
 - Conveying to children that they are worthless, unloved, inadequate, or valued only insofar as they meet the needs of another person
 - Age or developmentally inappropriate expectations
 - Causing children frequently to feel frightened or in danger
 - Exploitation or corruption of children.
- These elements are clearly stipulated in the Child Protection Regulations and the Law of the Child Act of 2009.

Child sexual abuse

- Forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. This may include physical contact or involving children in looking at or in the production of sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (Child Protection Regulations and Law of the Child Act).
- It is one of the forms of maltreatment that must be reported by designated professionals such as social welfare officers who are mandated by the Law of the Child Act to deal with child protection issues.
- The dynamics of child sexual abuse differ from those of adult sexual abuse. In particular, children rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behavior.

- Definitive signs of genital trauma are seldom seen in cases of child sexual abuse. The accurate interpretation of genital findings in children requires specialist training and, wherever possible, experts in this field should be consulted.

Child neglect

- Child neglect refers to failure by the parent/caregiver to provide needed age-appropriate care although financially able to do so or offered financial or other means to do so.
- Neglect is the failure of a parent or other person legally responsible for the child's welfare to provide for a child's basic needs, including providing adequate food, clothing, hygiene, and supervision.
- Child neglect can occur in the following parental/caregiver conditions/situations:
 - Physical inability to care for a child such as an adult with a serious injury
 - Mental inability to care for a child such as an adult with untreated depression or anxiety
 - Alcohol or drug abuse that results in the adult's serious impairment of judgment and the ability to keep a child safe
 - Lack of knowledge of basic care needs of children at different developmental ages
 - Poverty/insufficient funds
 - Lack of knowledge that emotional nurture is an essential need of children.
- Neglect may be physical, for example:
 - Failure to provide necessary food or shelter
 - Lack of appropriate supervision
 - Abandonment (i.e., children who were left by their parents/guardians without information and were not claimed).
- Neglect may be medical, for example:
 - Failure to provide necessary medical or mental health treatment
 - Refusal of health care for a child
 - Delay in seeking/providing health care for a child
 - Prenatal exposure to neglect.
- Neglect may be educational, for example:
 - Failure to educate a child or attend to special education needs.
- Neglect may be emotional, for example:
 - Inattention to a child's emotional needs
 - Failure to provide psychological care
 - Permitting the child to use alcohol or other drugs.

STEP 5: Magnitude of GBV and VAC (45 min.)

PRESENTATION

Magnitude of GBV

- GBV is a worldwide public health and human rights concern that occurs in all countries and societies, and within all social, economic, religious, and cultural groups. However, in a few societies GBV prevalence is very low. The determinants of GBV occur at the individual, relational, community, and societal levels.
- Worldwide GBV ranges from 10 to 69 percent of women reporting having experienced some type of physical violence by an intimate partner in their lifetime.
- The WHO “Multi-Country Study on Women’s Health and Domestic Violence against Women” (WHO 2005) reports a prevalence of sexual violence ranging from 6 to 59 percent. Between 30 and 50 percent of women who had experienced violence reported both physical and sexual violence.
- The 2015/16 Tanzania Demographic and Health Survey found that 40 percent of women age 15–49 have ever experienced physical violence, and 17 percent have ever experienced sexual violence. Fifty percent of all ever-married women reported to have ever experienced physical, sexual, or emotional violence.
- Experience of spousal violence (physical, sexual or emotional) varies from 78 percent in both Mara and Shinyanga regions to 8 percent in Kaskazini Pemba and 9 percent in Kusini Pemba and is lower in urban areas (45%) than in rural areas (52%).
- Perpetrators of either physical or sexual violence are reported to be a spouse or intimate partner. Sixty-three percent of ever-married women who had ever experienced physical violence reported their current/most recent husbands/partners as the perpetrator, and 37 percent reported former husbands/partners as the perpetrator. Forty-eight percent of ever-married women who experienced sexual violence reported their current/most recent husbands/partners as the perpetrators, while 40 percent reported their former husbands/partners as perpetrators.
- The link between intimate partner violence and higher risks of HIV infection is well documented in the literature and is seen throughout Tanzania’s HIV and GBV crisis (WHO/UNAIDS 2013). To date no population-based studies have established an accurate rate of intimate partner violence in Tanzania.
- Population-based studies conducted among adolescents in developing countries indicate that 13.4 percent of males in Tanzania have experienced a sexual assault (CDF 2013).
- Risks for boys and men can include sexually transmitted infections (STIs) and HIV, general and psychological health concerns, substance abuse, reduced productivity, and reassertion of their masculinity by repeating their own victimization but in the role of perpetrator.
- The TDHS 2015/16 reports that 10 percent of women age 15–49 have experienced genital cutting. The practice is prevalent in rural areas than in urban areas. The highest percentages of women who experienced FGM/C are in Manyara and Dodoma regions (58% and 47%, respectively).

- FGM/C is a grave violation of girls' and women's human rights and is prohibited by law in Tanzania; that is, the Sexual Offenses Special Provisions Act (1998) prohibits FGM/C of girls under the age of 18 years.
- In order to ensure that victims of such crimes are brought to justice and to ensure that justice is done, the government of Tanzania has enacted evidentiary and procedural laws that would instill confidence in the victims of such crimes to come forward and testify in private.

Magnitude of VAC (worldwide)

- Violence against children is a major problem across all countries.
- In 2002 almost 53,000 children under 18 years old died as a result of homicide worldwide (WHO 2005).
- On average, 3 in 4 children ages 2–14 are reported to be subjected to some kind of violent discipline, more often psychological than physical.
- Three-quarters of children experienced psychological aggression, and about half experienced physical punishment (UNICEF 2011).
- WHO has estimated that 150 million girls and 73 million boys under the age of 18 have experienced sexual violence involving physical contact (WHO 2006).
- The 2005 WHO “Multi-Country Study on Women’s Health and Domestic Violence against Women” found that from 1 to 21 percent of women surveyed experienced sexual abuse before the age of 15.
- Between 3 and 29 percent of men experienced some form of sexual abuse during childhood.

Magnitude of violence against children (Tanzania)

- The 2009 National Survey on VAC in Tanzania (NBS 2011b) estimates that more than a quarter of girls (28%) and 13 percent of boys have experienced sexual violence, mainly in their homes.
- In Tanzania, about 73 percent of girls and 72 percent of boys experienced physical violence—mostly in the form of being punched, whipped, or kicked—and the majority (60%) by a relative.
- One-quarter of Tanzanian children, both boys and girls, experienced emotional violence in different forms (e.g., feeling unwanted, threatened, or abandoned).

Magnitude of GBV against key populations

- Sexual and physical abuse including rape is estimated to be 51.7 percent among female sex workers (URT 2013b).
- GBV is also high (41%) among MSM in the form of sexual and physical abuse, including rape (URT 2013b).
- Apart from the HIV risk this poses to FSWs and MSM themselves, FSWs have multiple partners, hence they act as a bridge for HIV transmission between FSWs, their partners, other high-risk groups, and the general population.
- Power relations between FSWs and their clients play a big part in not using a condom during the encounter, even their own/female condom because they get paid more if they

do not use condoms during sex (URT 2013b). Studies show that only 18.3 percent of FSWs in Dar es Salaam reported ever using condoms (URT 2013b).

- Violence between sex workers and their clients is sometimes triggered by the issue of condom use. Not using condoms could be due to violence or lack of information, poverty, lack of negotiation power, or refusal by their clients (who usually will pay more for unprotected sex).
- Currently there has been no population-based study conducted in Tanzania to establish the magnitude of GBV among men, as well as members of key populations. However, a recent study conducted in Dar es Salaam and Dodoma has shown that about 1 out of 10 (11.2%) MSM was raped. Those who had their first anal sexual experience before the age of 15 years were significantly more likely to report rape (23.6%) as a major reason that experience occurred compared to those who debuted at later ages (Magesa, Mtui, Abdul et al. 2014).
- Anecdotal evidence also shows that members of KPs acknowledged having experienced physical and sexual violence from their clients/partners. However, KPs face difficulties in reporting violent events to relevant authorities because of limited awareness of their rights and of available sources of assistance. It appears that most cases of violence directed toward KPs do not receive adequate attention from authorities because most incidents are not reported to the police or hospitals.

STEP 6: Causes of, contributing factors to, and consequences of GBV and VAC (60 min.)

ACTIVITY: Brainstorming (10 min.)

ASK participants to brainstorm on causes and contributing factors to GBV and VAC.

ASK a few of them to write their responses on flipcharts/whiteboard as they talk.

ASK a few of them to present their responses in class.

CLARIFY participants' responses with the information below.

PRESENTATION

Root causes of GBV and VAC

The root causes of all forms of GBV and VAC lie in society's attitudes and practices of gender discrimination. The roles, responsibilities, limitations, privileges, and opportunities available for people depends on their gender. The causes can be summarized as follows:

- Male and/or societal attitudes of disrespect or disregard for women and children
- Disregard of belief in equality of human rights for all
- Cultural/social norms that perpetuate gender inequality
- Lack of value of women and women's work
- Political motives
- Collapse of traditional society and family support structures

- Cultural practices and religious beliefs that support GBV
- Men's desire for power over and control of women.

Contributing factors to GBV and VAC

Common factors perpetuate increased risk of GBV and VAC in different settings, including:

- Gender inequalities among men and women in society
- Power imbalances between men and women, and between adults and children
- Male attitudes toward women
- Alcohol and drug abuse
- Lack of respect for the human rights of women and children
- Failure to enforce the law and punish perpetrators of GBV and VAC
- Unquestioned assumptions about appropriate male and female behavior
- Loss of male power/role in family and community and seeking to regain and/or assert that lost power
- Gender discriminative laws such as the 1971 Law of Marriage Act
- Weak community sanctions against perpetrators
- High levels of crime and conflict in society generally
- Financial insecurity
- Poverty, which leads to poor women and girls being victimized by forced prostitution or sexual exploitation.

Contributing factors to GBV among key populations

- Culture and gender norms which condone and perpetuate violence against FSWs. Traditionally sex work is perceived as an inappropriate practice.
- Criminalization of transactional sex and sex between men as well as stigmatization and discrimination because these acts are not culturally acceptable in the society.
- According to the Tanzania Penal Code of 1945, sex acts between men are illegal. The law designates these acts as "carnal knowledge of any person against the order of nature" and sets the penalty as "imprisonment for life and in any case to imprisonment for a term of not less than thirty years." Due to strict laws against sex work, FSWs and MSM are forced to go underground and hence do not seek HIV, STI, and GBV services, thereby increasing the likelihood of spreading HIV and STIs.

STEP 7: Consequences of GBV and VAC (45 min.)

ACTIVITY: Brainstorming (5 min.)

ASK participants to brainstorm on health and non-health consequences of GBV and VAC.

ASK a few of them to write their responses on flipcharts/whiteboard as they mention them and discuss their responses.

CLARIFY their responses with the information below.

PRESENTATION

Consequences of GBV

The effects of GBV and VAC can be devastating and long-lasting for survivors' physical, mental, and reproductive health as well as their socioeconomic status. These effects harm survivors psychologically, cognitively, and interpersonally.



REFER participants to the following handout:

Handout 1.1.1: Health, Socioeconomic, and Psychological Consequences of GBV

Psychological/emotional impact on the survivor

- Trauma caused by physical acts, threats of acts, or coercive tactics
- Humiliation, control, withholding of information, deliberately making someone feel diminished or embarrassed, isolation from contacts, and denial of access to money or other basic resources.

Economic and social impacts

- Economic burden on families due to low or lost productivity resulting from injury or sickness of the survivor
- Rejection, ostracism, and social stigma at the community level
- Reduced ability to participate in social and economic activities
- Fear of future violence, which extends beyond the individual survivors to other members of the community
- Damage to women's confidence resulting in fear of venturing into public spaces; this can curtail women's education, which in turn can limit their economic activity and income
- Increased vulnerability due to other types of gender-based violence
- Job loss due to absenteeism as a result of violence
- Negative impact on women's income-generating power
- Denial of right to own property such as land and denial of access to money/income, loans, or credit
- Lack of inheritance rights, and denial of opportunity for economic empowerment.

Impact on survivor's family and dependents

- Divorce or broken families
- Increase of tension at home and dysfunctional families
- Breakdown of trust in social relationships
- Increased likelihood of VAC in households where there is domestic GBV
- Collateral effects on children who witness violence at home that include emotional and behavioral disturbances such as: withdrawal; low self-esteem; nightmares; self-blame; aggression against peers, family members, and property; increased risk of growing up to be either a perpetrator or a victim of violence; and running away from home.

Indirect effects

- Compromised ability of survivor to care for her children (e.g., child malnutrition and neglect due to constraining effect of violence on women's livelihood strategies and their bargaining power in marriage)
- Ambivalent or negative attitudes of a rape survivor toward the resulting child.

Impact of violence on society

- Hindrance to survivor's participation in the nation's development processes and decreasing of their contribution to social and economic development
- Burden on government health, judicial, and police systems
- Hindrance to economic stability and growth due to survivor's lost productivity
- Constrained ability of survivors to participate in social, political, or economic development.

Handout 1.1.1 Health, Socioeconomic, and Psychological Consequences of GBV

PHYSICAL	REPRODUCTIVE	SOCIOECONOMIC	PSYCHOLOGICAL/EMOTIONAL
Fatal <ul style="list-style-type: none"> • Homicide • Suicide • Maternal mortality • Infant mortality • AIDS-related mortality Acute <ul style="list-style-type: none"> • Injury • Shock • Infection • Chronic • Disability/scars • Somatic complaints • Chronic infections • Chronic pain • Gastrointestinal problems • Eating disorders • Sleep disorders • Alcohol/drug abuse 	<ul style="list-style-type: none"> • Miscarriage • Unwanted/unplanned pregnancy • Management and treatment of complications resulting from abortion (i.e., post-abortion care) and linkage to voluntary family planning services • STIs, including HIV • Menstrual disorders • Pregnancy complications • Infertility • Gynecological disorders • Sexual disorders • Increased "risk" behaviors such as sex with many partners, unprotected sex • Younger age at first intercourse 	<ul style="list-style-type: none"> • High medical and non-medical (e.g., legal, social welfare) costs • Social rejection, isolation • Loss of ability to function in the community (e.g., earn income, low productivity) 	<ul style="list-style-type: none"> • Post-traumatic stress • Depression • Anxiety and fear • Anger • Shame, insecurity, self-hate, self-blame • Mental illness • Suicidal thoughts, behavior, suicide attempts • Difficulty concentrating

Source: Heise and Moreno 2002.

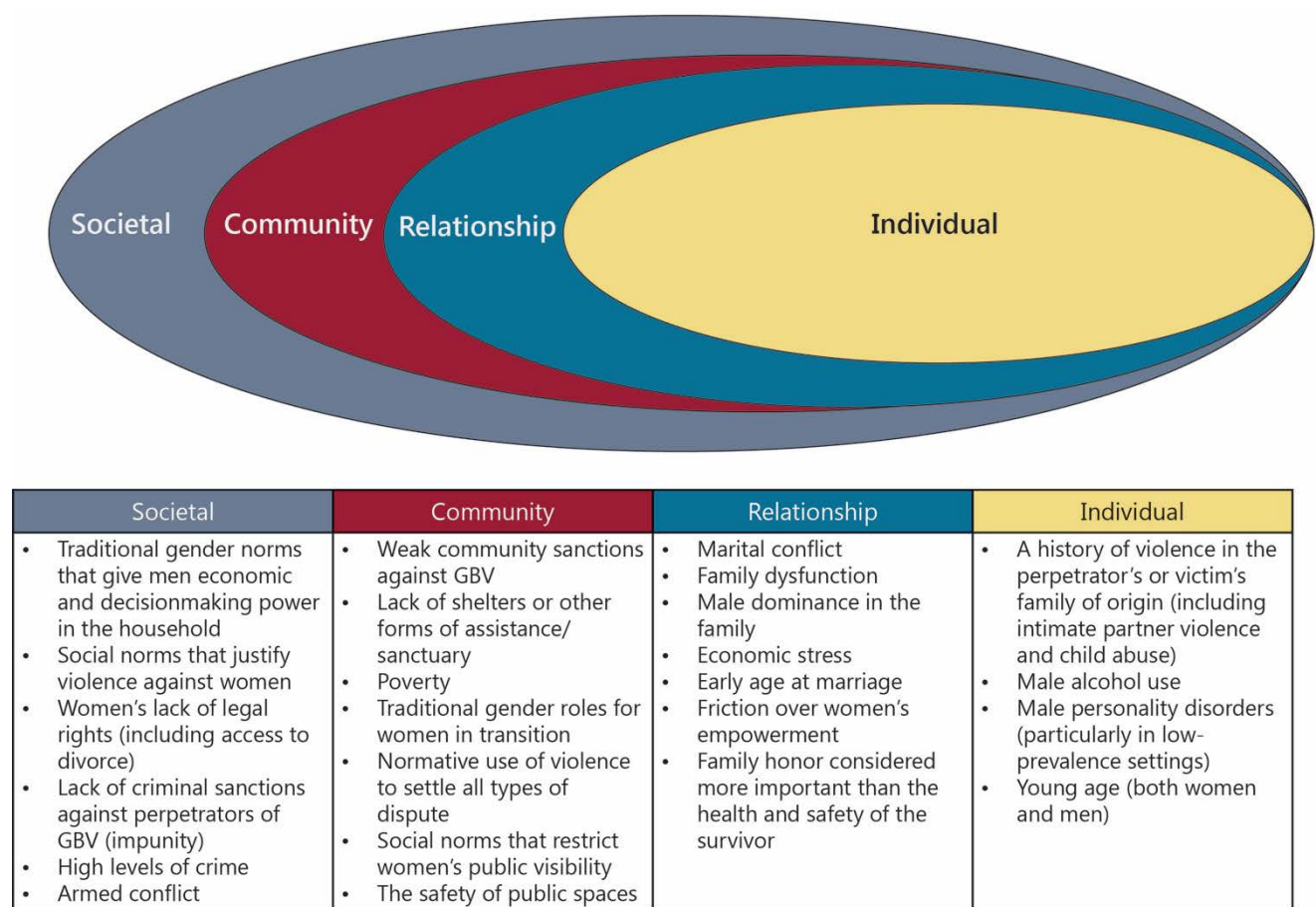
STEP 8: Ecological Model (30 min.)

The ecological model for GBV and VAC emphasizes the fact that the causes of GBV and VAC may be explained at different levels within a society. The model uses environmental and ecological factors in the targeted population, emphasizing that human behaviors are developed as the result of individual factors, interpersonal factors, institutional factors, community factors, and public policies.

The ecological model supports a comprehensive public health approach that not only addresses an individual's risk factors, but also the norms, beliefs, and social and economic systems that create the conditions for the occurrence of a particular behavior (CDC 2004).

Figure 1.1 presents an ecological model summarizing the causes of and contributing factors to GBV and VAC.

Figure 1.1: Ecological Model for GBV and VAC



Individual level: biological and personal history factors among both survivors and perpetrators

Relationship level: proximal social relationships, most importantly those between intimate partners and within families

Community level: the community context in which social relationships are embedded, including peer groups, schools, workplaces, and neighborhoods

Societal level: larger societal factors that create an acceptable climate for violence and reduce inhibitions against violence

STEP 9: Key Points (5 min.)

- Gender-based violence is a general term describing power imbalances that result in acts of abuse or violence.
- Violence against children is deliberate behaviors against children that are likely to cause physical or psychological harm.
- There are different types of GBV and VAC, which include physical, sexual, emotional, and economic violence.

STEP 10: Evaluation (5 min.)

- What is the difference between sex and gender?
- What is child sexual abuse?
- How is power important when describing GBV and VAC?

Session 1.2: Reproductive Health Rights and GBV under National Laws and Policies

Total session time: 180 min.

Learning Tasks

By the end of this session, participants are expected to be able to:

- Identify national laws and policies related to GBV and VAC.
- Explain sexual reproductive health rights as applied to GBV and VAC.
- Explain human rights issues facing key populations.
- Explain the influence of poverty, SRHR, and HIV in GBV- and VAC-related services.
- Explain the relationship between poverty and SRHR in GBV and VAC services.
- Explain roles and recommendations for preventing and responding to violence against key population groups.

Resources Needed

- Flipcharts, marker pens, V cards, masking tape, chalk/whiteboard, chalk/whiteboard markers, LCD, and computer
- Worksheet 1.4.1 Scenario 1.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Session title and learning tasks
2	45 min.	Group assignment and presentation	National laws and policies related to GBV and VAC
3	30 min.	Presentation	Sexual reproductive health rights as applied to GBV and VAC

Step	Time	Activity/Method	Content
4	30 min.	Presentation	Roles and recommendations for preventing and responding to violence against key population groups
5	30 min.	Presentation	Relationship between poverty and GBV and VAC services
6	30 min.	Presentation and discussion	Relationship between HIV and GBV/VAC
7	5 min.	Presentation	Key points
8	5 min.	Presentation	Evaluation
Total	180 min.		

STEP 1: Presentation of session title and learning tasks (5 min.)

READ the learning tasks to participants.

ASK participants if they have any questions before continuing.

STEP 2: National laws and policies related to GBV and VAC (45 min.)

ACTIVITY: Brainstorming (5 min.)

ASK participants to brainstorm for 5 minutes about different national laws and policies related to GBV and VAC.

ALLOW time for participants to respond.

WRITE participants' responses on the board or flipchart.

SUMMARIZE participants' responses and present the points below.

PRESENTATION

National GBV Laws

The Constitution

The Constitution of the United Republic of Tanzania (1977) contains a bill of rights which, among other things, decrees against discrimination on the basis of sex and acknowledges every citizen's right to own property.

The Sexual Offenses Act 1998 (SOSPA)

- In 1998, the Parliament passed the Sexual Offenses Special Provisions Act to safeguard "the dignity and integrity of women and children" and introduced new offenses such as sexual harassment, sexual abuse, and trafficking in persons (1998). It has since been incorporated into the Tanzania Penal Code.
- SOSPA is the main national legal instrument that provides sanctions to combat GBV; it provides for stiff punishment and the right of compensation to survivors of violence.

- SOSPA criminalizes rape and provides severe punishment for the perpetrators of GBV, especially rape, but enforcement has not been easy.
- SOSPA prohibits early marriage below 15 years in order to ensure girls are not withdrawn from schools to be married.
- SOSPA makes reference to the protection of children of up to 18 years from female genital mutilation (FGM).
- SOSPA does not provide protection for older women.

The Penal Code Cap 15, Revised Edition, provides for the following:

Rape

Section 130, cap 15, states that it is an offense for a male person to rape a girl or a woman. A male person commits the offense of rape if he has sexual intercourse with a girl or woman under circumstances falling under any the following descriptions:

- Not being his wife, or being his wife who is separated from him
- Without her consenting to it at the time of the sexual intercourse
- With her consent when the consent has been obtained by the use of force, threats, or intimidation, or by putting her in fear of death or injury.

Attempted rape

Any person who attempts to rape commits the offense of attempted rape and, except for the cases specified in Subsection 3, is liable upon conviction to imprisonment for life, and in any case shall be liable to imprisonment for not less than 30 years with or without corporal punishment.

Sexual assault on persons and indecent assault on women

Any person who, with intent to cause sexual annoyance to any person, utters any word or sound, makes any gesture, or exhibits any word or object intending that such a word or sound shall be heard or the gesture or object shall be seen by another person commits an offense of sexual assault. Upon conviction, this is punishable by imprisonment for a term not exceeding five years, a fine not exceeding 300,000 shillings, or both the fine and imprisonment.

Grave sexual abuse

Any person who, for sexual gratification, does any act, by the use of his genitals or any other part of the human body or any instrument on any orifice or part of the body of any other person, being an act which does not amount to rape under Section 130, commits the offense of grave sexual abuse.

Land Act and Village Land Act of 1999

Tanzania has created an enabling and potential environment to combat GBV through legislation such as the Land Act (1999) and the Village Land Act (1999), which give women access to economic resources including land, the lack of which has resulted in many women's rights being violated.

DNA Act 2009

Samples of human DNA shall be collected and analyzed by the human DNA laboratory of the government chemist laboratory agency or other designated laboratory for human DNA. The analysis of the sample for human DNA shall be initiated by a written application by the requesting authority to the human DNA laboratory of the government chemistry agency or designated laboratory for human DNA.

Law of Marriage Act, 1971

- Sections 10(2), 13(1) and 15 of Tanzania's Law of Marriage Act of 1971 allow men to contract polygamous marriages and permit the marriage of 15-year-old girls, while the minimum age of marriage for boys is 18.
- On 8 July 2016, the High Court of Tanzania took steps to end child marriage for Tanzanian girls. In its decision, [the court ruled that Sections 13 and 17 of the Law of Marriage Act](#) were unconstitutional and directed the government to change the law within one year so that the minimum age of marriage for girls is 18 years—the same as for Tanzanian boys.
- The Law of Marriage Act also provides for women to have equal property rights, but customary law and cultural practice, which are embraced by the courts, tend to undermine women's ability to acquire, inherit, maintain, and dispose of property.
- Section 66 of the Law of Marriage Act states categorically that "it is hereby declared that, notwithstanding any custom to the contrary, no person has any right to inflict corporal punishment on his or her spouse." Despite this clause condemning spousal abuse, at implementation level this clause and others governing spousal relations, including marriage, reconciliation, and divorce, have not managed to address domestic violence at the household level.

The Law of the Child Act (LCA), 2009

The LCA provides for rights and welfare of the child as follows:

- Construction of a child: A person below the age of 18 years shall be known as a child.
- A child shall have a right to live free from any discrimination.
- A child shall have a right to a name and nationality, and to know his/her biological parents and extended family.
- It shall be the duty of a parent, guardian, or any other person having custody of a child to maintain/provide for that child. In particular, the child has the right to:
 - Food
 - Shelter
 - Clothing
 - Medical care, including immunization
 - Education and guidance
 - Liberty
 - Right to play and leisure.

Parental duties and responsibilities

- Parents are responsible for the care of their children all the time according to the LCA.
- Child rights: A child shall have the right to life, dignity, respect, leisure, liberty, health, education, and shelter to be provided by his/her parents.
- Every parent shall have duties and responsibilities, whether imposed by law or otherwise, towards his child which include: the duty to protect the child from neglect, discrimination, violence, abuse, exposure to physical and moral hazards and oppression; to provide guidance, care, assistance, and maintenance for the child and assurance of the child's survival and development; to ensure that in the temporary absence of a parent, the child shall be cared for by a competent person, except where the parent has surrendered his rights and responsibilities in accordance with a written law or any traditional or customary arrangement.
- Where biological parents of a child are deceased, parental responsibility may be passed on to a relative of either parent or a custodian by way of court order or any traditional arrangement. A person shall not deprive a child of reasonable enjoyment out of the estate of a parent.
- Right to own opinion.
- Protection from harmful employment: A person shall not employ or engage a child in any activity that may be harmful to his/her health, education, or mental, physical, or moral development.
- Protection from torture and degrading treatment.

The LCA provides the following when a child is in conflict with the law:

- Right to appear in juvenile court
- Special treatment when a child stands as a witness.

Immature age

- A person under age 10 is not criminally responsible for any act or omission.
- A person under age 12 is not criminally responsible for an act or omission, unless it is proved that at the time of doing the act or making the omission s/he had the capacity to know that s/he ought not to do the act or make the omission.
- A male person under the age 12 is presumed to be incapable of having sexual intercourse.

National policies and plans on GBV

Recognizing the burden related to violence, the Tanzanian government has launched a five-year National Plan of Action (NPA) to end violence against women and children (2017/18–2021/22). This new plan is based on the lessons learnt and successes from the first series of national plans of action on violence against women and children. The main lessons learnt were: the need for a stronger prevention component; the necessity to improve and reinforce coordination between the different levels of service delivery; and the importance of consolidating protection efforts across vulnerable groups.

The new plan is putting more emphasis on violence prevention, including: strengthening the capacity of boys and girls to contribute to their own protection; engaging with parents on positive parenting skills that eliminate use of violence in child rearing; addressing harmful social norms; and creating a movement to end violence against children. In addition, it includes greater emphasis on the role of boys and men in preventing violence against children.

STEP 3: Sexual and Reproductive Health and Rights as Applied to GBV and VAC (30 min.)

ACTIVITY: Small group discussion (10 min.)

DIVIDE participants into manageable groups.

TELL the groups to discuss the meaning of SRHR and how these apply to GBV and VAC.

ASK each group to present their responses in plenary.

SUMMARIZE participants' responses and present the points below.

DISCUSS with participants the points presented in plenary.

CLARIFY participants' responses with the information below.

PRESENTATION

Reproductive Health Rights

The Cairo Program (UNFPA 1994) defined reproductive health as: "A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."

Implicit in this last condition are the sexual and reproductive health rights (SRHR) of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility that are not against the law. Women must also have the right of access to appropriate health care services that will enable them to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (Para. 72 from the Cairo International Conference on Population and Development [UNFP 1994]) and the 1995 Fourth World Conference on Women (UN 1995) (<http://www.srhrguide.org/what-is-srhr>).

A full sexual and reproductive health package includes:

- Family planning/birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Management and treatment of complications resulting from abortion (i.e., post-abortion care) and linkage to voluntary family planning services

- Prevention and treatment of reproductive tract infections and sexually transmitted infections, including HIV
- Early diagnosis and treatment of breast and cervical cancers
- Promotion, education, and support for exclusive breastfeeding
- Prevention and appropriate treatment of subfertility and infertility
- Active discouragement of harmful practices such as female genital cutting
- Adolescent sexual and reproductive health services
- Prevention and management of GBV.

STEP 4: Human rights issues concerning key populations (30 min.)

According to the “National Guideline for a Comprehensive Package of HIV Interventions for Key Populations” (URT 2014), there is a need to focus on addressing KPs, who are discriminated against and stigmatized, which makes them vulnerable to GBV, HIV, and STIs. Key populations include FSWs, PWID, MSM (includes prisoners, miners, and long distance drivers, among others).

Despite the fact that some categories of KPs have not been decriminalized, the Government of Tanzania developed the “National Guideline for Key Populations for HIV Prevention” in 2014 (URT 2014), which also covers issues of GBV prevention and response.

The guideline document is based on the best international evidence and good practice for what is effective in order to guide service providers in all key sectors to deliver equal and comprehensive package of quality health services to all KPs. The goal is to significantly minimize the transmission of HIV and to reduce HIV-related mortality, morbidity, stigma, and discrimination leading to the attainment of the three Zeroes: Zero new HIV infections, Zero discrimination, and Zero AIDS-related deaths. The objectives are (1) to standardize health services for PLHIV, PWID, sex workers, MSM, transgender people, and prisoners and (2) to promote a public health response to address the vulnerability, risk behaviors, and associated adverse health consequences found among key populations, most of whom are afraid to seek HIV and GBV services for fear of stigmatization and discrimination.

STEP 5: Relationship between poverty and GBV- and VAC-related services (30 min.)

ACTIVITY: Small group activity (20 min.)

DIVIDE participants into groups of 5 each.

ASK the groups to work together to respond to Scenario 1 in Worksheet 1.4.1.

ALLOW groups 10 minutes for this exercise.

ASK participants to respond to the scenario questions for 10 minutes in the worksheet.



REFER participants to Worksheet 1.4.1 Scenario 1.0 for 5 minutes.

SUMMARIZE the responses from their worksheets and present the points below.

PRESENTATION

Concept of poverty

Poverty is defined as a pronounced deprivation of wellbeing, comprising many dimensions:

- It includes low income and the inability to acquire the basic goods and services necessary for survival with dignity.
- Poverty also encompasses low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one's life.
- The World Bank defines extreme poverty as living on less than US\$1.25 purchasing-power-parity (PPP) per day, and moderate poverty as less than \$2 or \$5 PPP per day.

Poverty, GBV, and VAC

- GBV and VAC impact productivity, health, and wellbeing, and can result in increased poverty which in turn undermines development.
- Improved economic status is assumed to reduce their risk of partner violence.
- Women's earning power, economic role outside of the household, literacy, and property rights increase their self-esteem.
- Women with stable economic status enhance their wellbeing within the household, including their interpersonal relationships, as well as seek health care services.
- Women who are employed or wage-earners become less dependent and thus enhance their position within the household by their visible financial contribution.
- Women also gain access to support networks from their greater exposure to the community, thus further strengthening the effectiveness with which they are able to act as agents.
- Poverty reduction interventions that do not consider and address underlying gender dynamics within communities can increase the risk of GBV and VAC, negating their positive economic and social impacts.
- GBV and VAC obstruct participation in development activities and hinders progress towards poverty alleviation.

GBV and the economy

- GBV takes an economic toll on countries. The effects of violence on savings, investment, and growth are surprisingly large.
- GBV is not only a serious public health problem and a violation of human rights, but also has large economic costs. It affects productivity and earnings, and it taxes the health care and judicial systems.
- Research has demonstrated that GBV severely limits women's contributions to social and economic development.
- GBV is also a major cause of ill health, an impediment to the accumulation of human capital, and a major factor in the intergenerational transmission of violence from parents to children.

STEP 6: Relationship between HIV and GBV/VAC (30 min.)

ACTIVITY: Small group discussion (10 min.)

USE similar groups from the small group activities above.

ASK the groups to work together to discuss the links between HIV and GBV/VAC for 5 minutes.

ASK the group to write their responses on cards and stick them on the wall, grouping similar sets of responses together.

SUMMARIZE their responses in the presentation using the points below.

PRESENTATION

HIV and GBV/VAC

- Unequal gender relations are a key factor underpinning women's ability to protect themselves from STIs, including HIV.
- Economic violence may increase the risk of acquiring HIV by deepening gender inequalities and increasing vulnerability.
- GBV and VAC, or the threat of violence, may prevent women from being able to practice safer sex.
- Experiencing GBV and VAC may be associated with engaging in HIV risk behaviors, such as unprotected sex, transactional sex, and concurrent sexual partnerships.
- Child sexual abuse is an important facet of GBV and VAC with implications for HIV risk and vulnerability.
- Sexual abuse is associated with risky behavior. The Tanzania National Violence against Children Survey (NBS 2011) showed lower condom use among females and males with a history of childhood sexual violence than among those without such a history.
- Tanzanian females and males with a history of childhood sexual violence are almost twice more likely to have multiple sex partners than those not abused in childhood.
- Trading sex for money or goods was more prevalent among young girls who had experienced childhood sexual violence than among those without a history of childhood sexual violence.
- Combined with higher levels of poor condom use, abused children are at considerably higher HIV risk than their counterparts who were not abused.
- Male perpetrators of violence may engage in HIV risk behaviors, such as not using condoms with multiple casual sexual partners.
- HIV has both immediate impacts and long-term consequences, which together fuel the dynamic between GBV and VAC, poverty, and development.
- VAC is associated with increased chance of survivors perpetrating and experiencing GBV during adulthood.
- Studies have demonstrated a link between GBV, VAC, and HIV infection with violence as a risk factor for HIV, as well as a consequence of being identified as having HIV (WHO 2005).

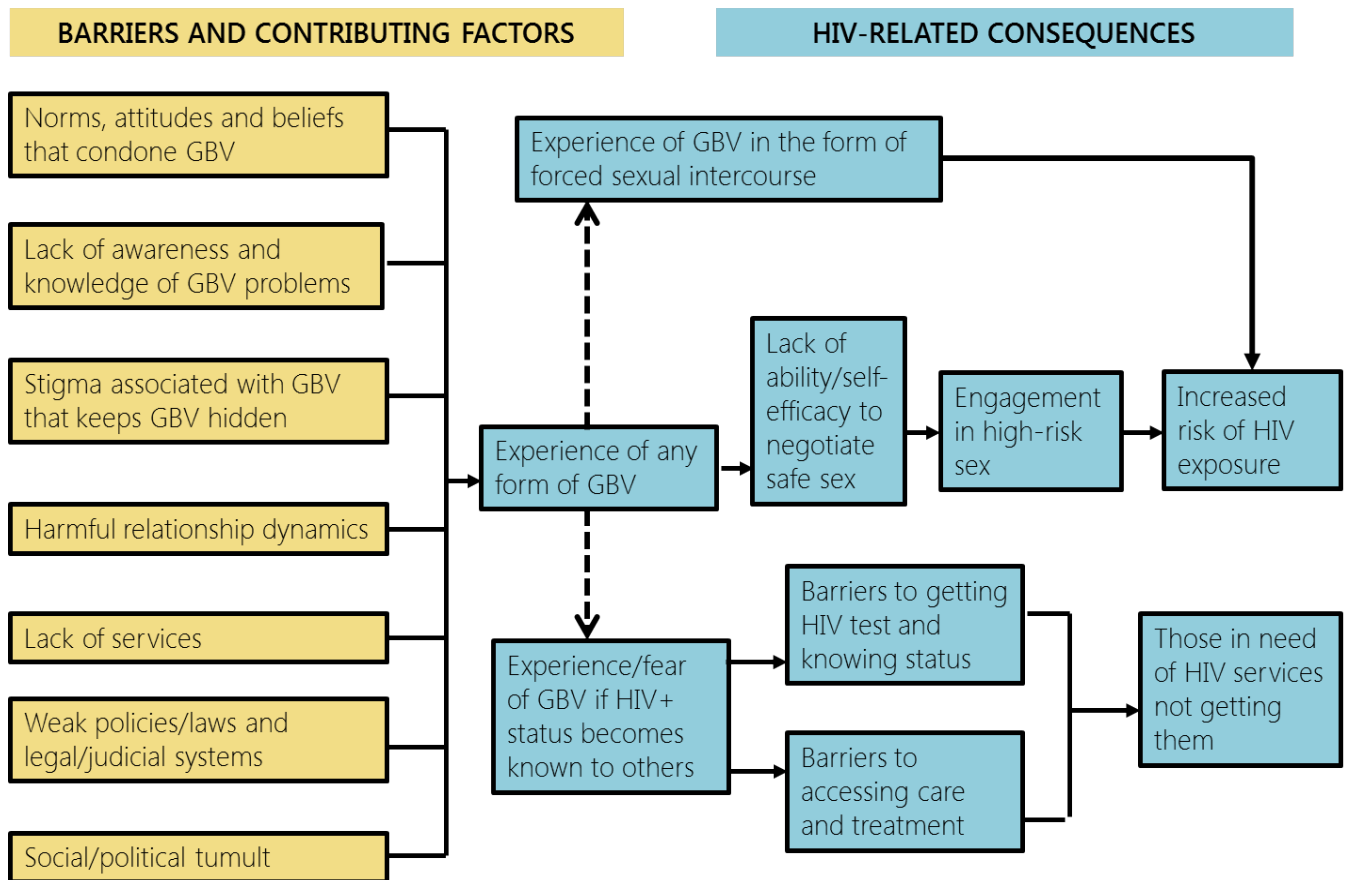
- When women reveal that they are HIV positive, they face the risk of abandonment by their partners, families, and friends, as well as the risk of violence due to their HIV-positive status.
- The sexual exploitation of girls and women is one of the most extreme forms of GBV and an ongoing factor in the spread of HIV.
- Gender-based violence may increase a woman's risk for HIV infection through forced or coercive sex in several ways:
 - The physiology of the female genital tract makes women (especially young women) inherently more susceptible to HIV infection than men. Women are twice as likely to acquire HIV from men during sexual intercourse than men are from women.
 - Forced or violent intercourse can cause abrasions and cuts, which facilitate entry of HIV through vaginal mucosa.
 - Women and girls who are raped or sexually coerced do not have the ability to negotiate condom use, and men who are the perpetrators of such violence do not generally offer to use condoms.
- GBV and VAC are a cause and a consequence of HIV infection, and as such are a driving force behind the HIV epidemic.

GBV and VAC precipitated by HIV and AIDS

- Fear of violence is an undermining factor to seeking treatment.
- Women may hesitate to be tested for HIV or fail to return for the results because they are afraid that disclosing their HIV-positive status may result in physical violence, expulsion from their home, or social ostracism.
- Violence at home increases vulnerability, making it less likely for women to engage in reproductive and child health services.

Figure 1.2: Relationship between GBV and HIV

GBV and HIV

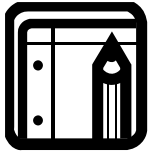


STEP 7: Key Points (5 min.)

- Tanzania is signatory to a number of international GBV and VAC documents.
- The Law of the Child Act provides a framework for child protection in Tanzania.
- GBV- and VAC-related social burdens are enormous, though thus far difficult to quantify.

STEP 8: Evaluation (5 min.)

- Mention important human rights laws for GBV and VAC.
- Why are GBV and VAC a public health concern?



Worksheet 1.4.1: Scenario 1

You are working on a MAJI Project to deliver clean water to a community that is attempting to rebuild after a devastating conflict. The community is very poor and made up primarily of displaced people. The schools are only just starting to function. Most families have little money for clothes for their children. One day you notice a group of very young girls leaving the site in the back seat of a Land Cruiser V8 with two male engineers.

Questions:

- What questions do you have?
- Where can you find the answers?
- What do you do?

Notes for facilitators:

This scenario raises questions of how reasonable/feasible it is for project workers to report suspicious behavior and of power dynamics between project workers (with money and vehicles) and very poor young girls.

Questions could include:

- Why might the girls be riding with the engineers?
- What might the perspective of the girls be?
- What is happening in the project that might contribute to this situation?

MODULE 02: MANAGEMENT OF GBV AND VAC SURVIVORS

The main objective of Module 02 is to provide learning competencies to participants on interpersonal communication skills, medical, medicolegal, and psychosocial care and support to the survivors of GBV and VAC.

The module covers key concepts and principles in GBV and VAC and practices of GBV and VAC care and support in the following sessions:

- 2.1: Interpersonal Communication, Values, and Attitudes of Health Care Providers
- 2.2: Principles and Procedures for Management of GBV and VAC Survivors
- 2.3: Physical Examination and Treatment of Survivors
- 2.4: Forensic Sample/Evidence Management
- 2.5: Approaches in the Provision of Psychosocial Care and Support

Session 2.1: Interpersonal Communication Values and Attitudes of Health Care Providers

Total session time: 200 minutes

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Use principles of interpersonal communication skills in managing GBV and VAC survivors.
- Communicate effectively with children and adolescents who have experienced abuse and violence.
- Identify personal strengths, weaknesses, and values in provision of care and support to child and adolescent survivors of GBV and VAC.
- Identify positive attitudes in service provision for GBV and VAC survivors.
- Explain strategies for improving attitudes towards GBV and VAC survivors.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard and chalk/whiteboard markers, computer, and LCD.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	50 min.	Presentation	Principles of interpersonal communication skills for provision of services to GBV and VAC survivors
3	35 min.	Presentation	Self-awareness
4	100 min.	Presentation	Values and attitudes for provision of services to GBV and VAC survivors
5	5 min.	Presentation	Key Points
6	5 min.	Presentation	Evaluation
Total	200 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ or **ASK** participants to read the learning tasks and clarify.

ASK participants if they have any questions before continuing.

STEP 2: Principles of interpersonal communication skills for provision of services to GBV and VAC survivors (40 min.)

ACTIVITY: Role-play (20 min.)

ASK two participants to volunteer to take part in an effective communication role-play and explain to them the following scenario:

One volunteer will play the role of a health care provider at Y Health Center and will attend a client who has been raped.

The second volunteer will play the role of the young woman who was raped who complains that: "They grabbed me suddenly while I was coming home from work...they hit me and tore my clothes...then all three of them raped me...I felt paralyzed...my voice couldn't come out...I should have run away...If I had succeeded, none of this would have happened...I should have defended myself somehow, even at the risk of being killed."

LET the role-play take 5 minutes.

REQUEST other participants to observe the role-play and note whether the following effective communication skills emerge.

- Building rapport
- Active listening skills
- Questioning skills
- Answering skills
- Summarization
- Paraphrasing

END the role-play.

ASK some of the observers to provide feedback.

GIVE 5 minutes to discuss the issues that are raised and relate them to skills for effective communication.

CULMINATE the exercise by explaining the skills for effective communication and the need to build the skills using the points below.

PRESENTATION

Interpersonal communication is the process by which people exchange information, feelings, and meaning through verbal and nonverbal messages.

Interpersonal communication is not just about *what* is actually said (the language used), but also *how* it is said and the *nonverbal messages* sent through tone of voice, facial expressions, gestures, and body language.

Types of interpersonal communication

- Verbal communication employs words, which can be said, written, or read.
- Nonverbal communication uses gestures, body expressions, tone of voice, and posture.
- Correct mixture of verbal and nonverbal communication makes sharing information and feelings complete.

Influences on interpersonal communication

- Attitudes
- Feelings
- Values
- Social norms
- Environment

Components of interpersonal communication skills

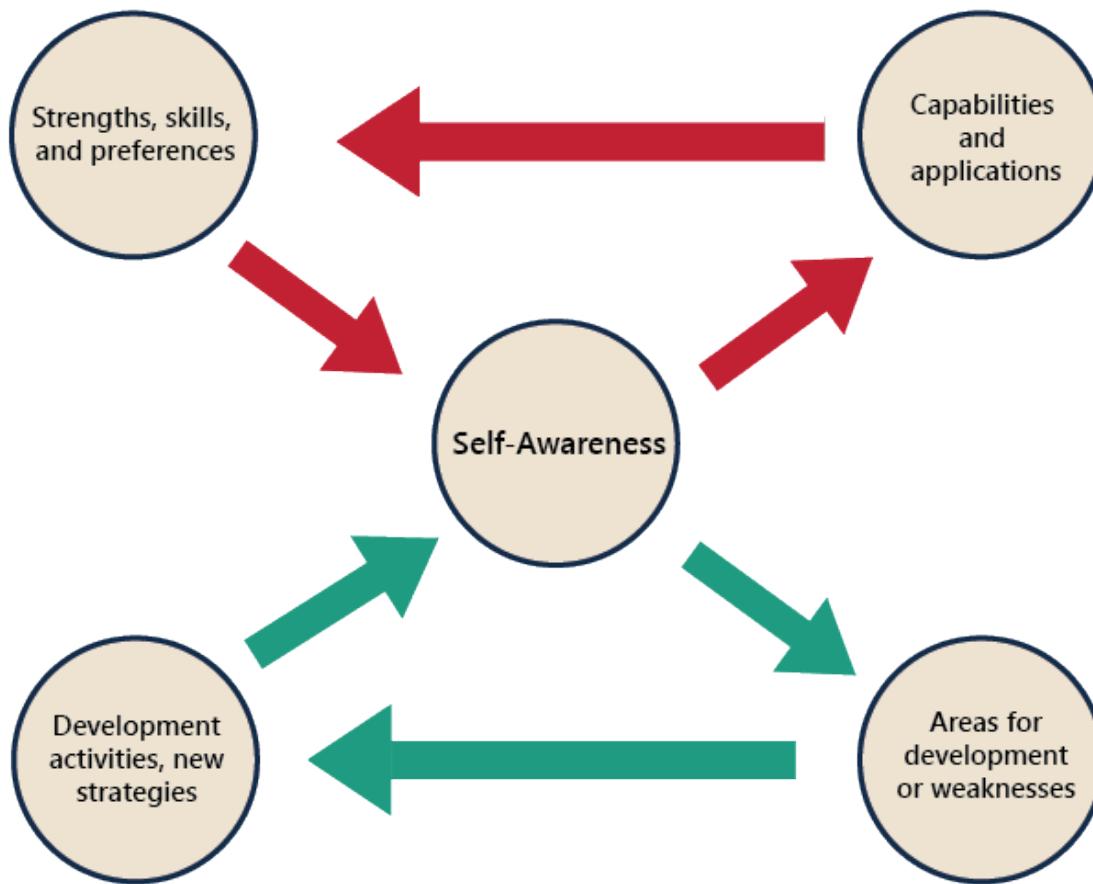
- Build rapport:
 - Establish a harmonious relationship
 - Implies building trust
 - Having each other's best interests in mind
 - Mutual respect.
- Definition of listening:
 - Listening is the absorption of the meanings of words and sentences by the brain.
 - Listening is the ability to accurately receive messages in the communication process.
- Active listening skills:
 - Maintain eye contact
 - Exhibit affirmative nods and appropriate facial expressions
 - Avoid distracting actions or gestures
 - Ask questions
 - Paraphrase
 - Do not interrupt the speaker
 - Do not talk too much!

- Steps of listening:
 - Listen to specific content (who, what, where, when, why).
 - Suspend your personal judgment.
 - Resist distractions, thoughts, and imaginings that take your attention away from the client.
 - Use neutral verbal expressions such as: "Um-hum," "Yes," "Go on," "I see."
 - Maintain eye contact.
 - Use a well-modulated voice, which is reassuring and comforting.
 - Match your body language with your verbal language.
- Questioning skills:
 - Know what you are looking for before asking the question.
 - Minimize use of closed-ended questions as in medical history, for example, "How many injections have you been given?"
 - Use open-ended questions to learn about a client's feelings, beliefs, and knowledge, for example, "What have you heard about gender-based violence?" or "Can you tell me more about why you think positive living is important?"
 - Probe to follow up in response to statement by client.
 - For example, if a client acts and sounds confused, the provider can reflect back the observation and what they have heard: "You seem unhappy today."
 - Paraphrasing: using your own words and the main words of the client to check accurate understanding, for example, "What I hear you saying is..."
- Answering skills:
 - Understand the question and give the correct answer.
 - Use both verbal and nonverbal language.

STEP 3: Self-awareness (35 min.)

Self-awareness is having a clear perception of your personality, including strengths, weaknesses, thoughts, beliefs, motivations, and emotions. It is important to do a self-examination to gain a better understanding of one's strengths, weaknesses, and values and how these issues can impact our interactions with GBV and VAC survivors, as well as other people who care for them. Figure 2.1 shows a conceptual framework for assessing your own self-awareness.

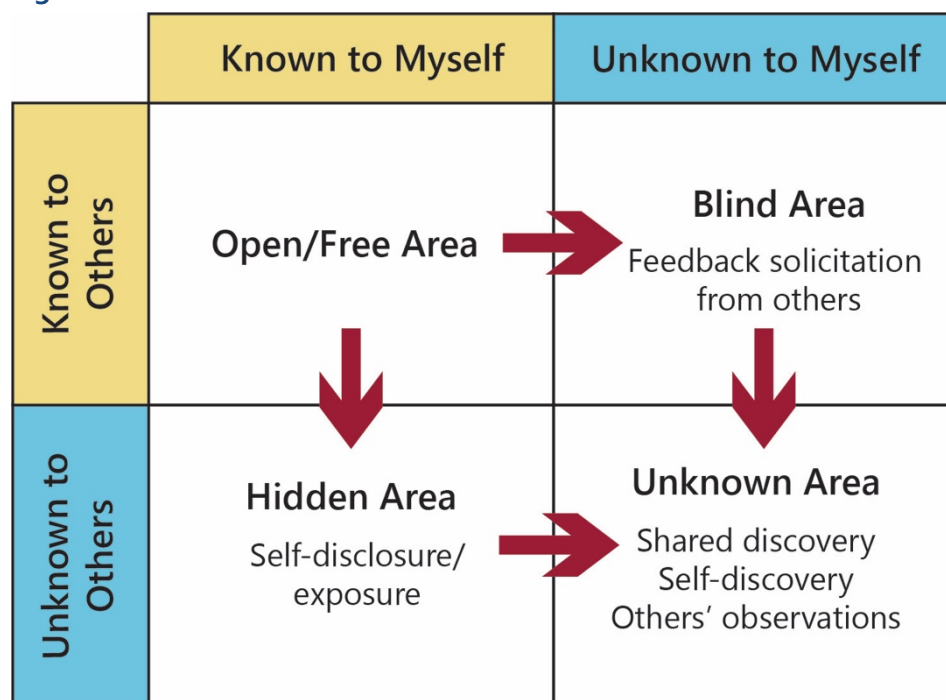
Figure 2.1: Conceptual Model for Assessing Self-Awareness



There are several techniques of assessment for self-awareness. One such technique is the use of the Johari window model. This behavior model is based on a four-square grid representing four different areas of interaction among people (Figure 2.2).

The Johari Window is a model for self-awareness, personal development, and group development and for understanding relationships. Developed by American psychologists Joseph Luft and Harry Ingham in the 1950s, the Johari Window is a simple and useful tool for understanding and training self-awareness, personal development, improving communications, interpersonal relationships, group dynamics, team development, and inter-group relationships.

Figure 2.2: Johari Window Model



Adapted from www.businessballs.com, © Copyright Alan Chapman, 2003.

- **Open/Free Area:** This is the information about the person—behavior, attitudes, feelings, emotions, knowledge, experience, skills, views, etc.—that are known by the person (“the self”) and known by others.
- **Blind Area:** This is the information that is known about a person by others but is unknown by the person himself.
- **Hidden Area:** This is the information that is known to the person but kept hidden from others and therefore unknown to others.
- **Unknown Area:** This area contains information, feelings, latent abilities, aptitudes, experiences, etc., that are unknown to the person herself and unknown to others.

Application of the Johari Window model

- When one works in an open area with others, one becomes more aware of himself and is at his most effective and productive condition.
- Reduce the blind area by soliciting feedback from others, which will expand the open area.
- Move relevant hidden information and feelings into the open area through the process of disclosure, thereby increasing the open area.
- Reducing hidden areas also reduces the potential for confusion, misunderstanding, and poor communication.
- Develop the open area through the process of disclosure, which reduces the hidden area.
- Reduce the unknown area by observation, self-discovery, mutual enlightenment, and discussion.
- Why should the provider be concerned with self-awareness?

- Self-reflection and self-awareness are integral to service provision and professional relationships.
- If we want to be effective in what we do, we need to know how we function emotionally.
- If we do not know our strengths and weaknesses, we cannot help others effectively.
- By developing self-awareness the provider can accomplish the following:
- Gain a realistic view of both your strengths and weaknesses in order to know your true self.
- Capitalize on your strengths and overcome or manage your weaknesses.
- Learn not to exaggerate your weakness and look down on yourself or let other people look down on you.
- Understand that you are an individual person separate from other people.
- Differentiate between what belongs to the client and what belongs to you as the provider, which will reduce burnout and give you a better understanding of the survivor's needs.
- Be more objective towards GBV and VAC survivors and provide them with better services.
- Be genuine in providing services: the more self-aware you are, the more genuine you can be.

Self-awareness helps the service provider to:

- Avoid establishing a dependent relationship with a survivor
- Communicate better
- Encourage survivors to take responsibility for themselves.

You develop self-awareness using the following strategies:

- Self-disclosure
- Being introspective
- Accepting feedback

STEP 4: Values and attitudes for provision of services to GBV and VAC survivors (100 min.)

The discussion of values and their application will start with a value clarification exercise. Participants will be expected to make decisions according to what they believe is right.

ACTIVITY: Values clarification exercise (30 min.)

PLACE three labels "AGREE," "DISAGREE," and "DON'T KNOW" at different points of the room.

INFORM participants that you will read some statements aloud.

ASK every participant to move to the label that stands for his/her decision about that statement read.

ASK them to give reasons for their decision.

TELL them that they are allowed to change their positions as discussions are ongoing.

START to read the following statements and **OBSERVE** their choices: Be sure to sample only a few statements for this exercise.

SUMMARIZE the exercise relating the emerging discussions and decisions to values; for example, statements such as:

- There are times when a woman deserves to be beaten.
- A man should have the final word in decisions in his home.
- Men are strong.
- Education for girls is a waste of time.
- If a woman has been raped or beaten, she should report it to the proper authorities.
- If a man or a boy has been raped or beaten, he should report it to the proper authorities.
- Men are stronger than women.
- Women are strong.
- A woman can say "no" if she doesn't want to have sex.
- The law in Tanzania adequately protects women and girls from GBV.
- It is difficult for men in Tanzania to change their beliefs about women.
- Women can be good leaders.
- Women's empowerment is contrary to our culture.
- Psychological abuse is just as harmful as physical abuse.
- A man can be satisfied with only one wife.
- Men are better than women at making important decisions.
- Men are more reliable and trustworthy than women.
- Men beat women as a way of showing love.
- All human beings are equal in value.
- Women have a right to an equal share in the family's wealth.
- Boys and men should also do housework like cooking, washing, or cleaning.
- Bride price (dowry) makes women seem like men's property.
- Girls can be just as clever as boys.
- Families are stronger when men discipline their wives.
- A woman should tolerate violence in order to keep her family together.
- Gender-based violence is a community concern.
- Everyone has a right to live free from violence.
- Is it never acceptable to hit a child.
- Smacking is acceptable as a form of discipline.
- Child sexual abuse is a problem in my community.
- When adults say they were abused as children, it is usually an excuse for bad behavior.

PRESENTATION

Values

Meaning of “value”

- Value is a measure one’s inner worth or one’s judgment of what is important in one’s life.

Development of values

- Developed while growing up
- Influenced by:
 - Family
 - Environment
 - Culture
 - Religion
 - Schools.
- Values will differ for people who come from different families, societies, and countries.

Importance of values

- Values guide the beliefs and opinions that a person stands for.
- Values determine who the person is, what s/he decides, and how s/he behaves.
- Proper application of values results in respect, love, good health, cooperation, development, comfort, unwavering decisions, and good habits.
- Values govern one’s decisions (for example, those who value other people will offer proper service regardless of their difference in values).
- Decisions that are guided by values give one peace of mind.

How values govern decision-making in provision of GBV and VAC services

- Service providers deal with all types of people, tribes, races, and ages.
- From the social environment where people grow up, they develop certain stereotypes and prejudices about other people and other groups that have a major impact on their social and interpersonal interactions with others.
- Providers need to have some understanding of how stereotypes, prejudices, beliefs, and culture impact service provision.
- Service providers should be aware of how the following elements often have a great impact on the process of service provision:
 - **Ethnicity:** What is seen as appropriate behavior in one ethnic group or tribe may not be seen as appropriate in another group.
 - **Culture:** Similarly, different cultures have different ideas of what is appropriate; for example, in some cultures a child cannot address an adult by his/her first name as this is viewed as rudeness.
 - **Stereotyping:** A set of generalizations about a group (e.g., gender, race, or national origin) that allows others to categorize them. These generalizations do not allow for diversity within groups and may result in stigma and discrimination against groups if

the stereotypes linked to them are largely negative. Stereotyping other people can jeopardize service provision.

Challenges for talking about GBV and VAC

- Belief that GBV and VAC are private matters and should not be discussed in public
- Rationalization of GBV and VAC as something that is acceptable under certain conditions
- Silencing of survivors by perpetrators/family/community
- Placing the blame on the survivor.

Child-friendly values and beliefs

Health care and psychosocial service providers must have the ability and commitment to put child-friendly values and beliefs into practice and to ensure child-friendly attitudes are communicated during the provision of care. The overarching values essential for service providers working with children include the recognition that:

- Children are resilient individuals.
- Children have rights, including the right to healthy development.
- Children have the right to care, love, and support.
- Children have the right to be heard and to be involved in decisions that affect them.
- Children have the right to live a life free from violence.
- Information should be shared with children in a way they understand.
- In addition, there are specific beliefs that are absolutely vital for service providers to have when working with child sexual abuse survivors. They should believe that:
 - Children tell the truth about sexual abuse.
 - Children are not at fault for being sexually abused.
 - Children can recover and heal from sexual abuse.
 - Children should not be stigmatized, shamed, or ridiculed for having been sexually abused.
 - Adults, including caregivers and service providers, have the responsibility for helping a child heal by believing them and not blaming them for sexual abuse.
- The more violence in childhood, the greater the likelihood of developmental delays and later health problems, including heart disease, diabetes, substance abuse, and depression.
- Research (UNICEF 2014) indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response.
- Toxic stress and exposure to violence and abuse during early childhood have a lifelong impact. Toxic stress is operationalized when an infant or young child experiences violence, abuse, chronic neglect, and multiple adversities that disrupt the process of brain development, damaging health and behavior and impeding learning.

Things to consider when interviewing a child survivor of violence

Health workers responsible for interviewing children who experienced violence or abuse may find it useful to bear in mind the following:

- Approach all children with sensitivity and recognize their vulnerability.
- Try to establish a neutral environment and rapport with the child before beginning the interview.
- Try to determine the child's developmental level in order to understand any limitations as well as appropriate interactions.
- It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently than adults, making interpretation of questions and answers a sensitive matter.
- Always identify yourself as a helping person.
- Ask the child if s/he knows why s/he has come to see you.
- Establish ground rules for the interview, including permission for the child to say s/he doesn't know, permission to correct the interviewer, and the difference between truth and lies.
- Ask the child to describe what happened, or is happening, to him/her in his own words.
- Always begin with open-ended questions. Avoid using leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity.
- When planning investigative strategies, consider other children (boys as well as girls) who may have had contact with the alleged perpetrator.
 - For example, there may be an indication to examine the child's siblings.
 - Also consider interviewing the caretaker of the child without the child present.

Guiding principles for interviewing a child victim of violence

Any service provider talking with children affected by abuse should adhere to the following guiding principles, regardless of the purpose of the communication, in order to ensure that children are not further traumatized during communications with service providers.

Be nurturing, comforting, and supportive:

- Children who have been sexually abused most likely will come to your attention through a caregiver or another adult; abused children rarely seek help on their own.
- Children may not understand what is happening to them or may experience fear, embarrassment, or shame about the abuse, which affects their willingness and ability to talk to service providers.
- Your initial reaction will impact a child's sense of safety and willingness to talk, as well as his/her psychological wellbeing.
- Talk with the child about his/her life, school, family and other general topics before asking direct questions about his/her experience of abuse. This helps the service provider to gauge the child's capacity to be verbal and helps a child feel at ease with the service provider.

- A positive, supportive response will help an abused child feel better, while a negative response (such as not believing the child or getting angry with the child) could cause him/her further harm.

Reassure the child:

- Children need to be reassured that they are not at fault for what has happened to them and that they are believed.
- Children rarely lie about being sexually abused and service providers should make every effort to encourage them to share their experiences.
- Healing statements, such as "I believe you" and "It's not your fault," are essential to communicate at the outset of disclosure and throughout care and treatment.
- Direct service providers communicating with child survivors need to find opportunities to tell them that they are brave for talking about the abuse and that they are not to blame for what they have experienced.
- Service providers are required to tell children that they are not responsible for the abuse and to emphasize that the provider is there to help the child begin the healing process.

Do no harm—Be careful not to traumatize the child further:

- As a service provider you should monitor any interactions that might upset or further traumatize the child.
- Do not become angry with a child, force a child to answer a question that he or she is not ready to answer, force a child to speak about the sexual abuse before s/he is ready, or have the child repeat her/his story of abuse multiple times to different people.
- Try to limit activities and communication that cause the child distress.

Speak so the child understands:

- Make every effort to communicate appropriately with the child; information must be presented in ways and language that s/he understands based on age and developmental stage.
- Use as many open-ended questions as possible.
 - Avoid multiple-choice or yes/no questions, which can be confusing and lead the child to give inaccurate responses.
- Avoid using the words "why" or "how come."
 - This will result in answers frustrating for you and the child: "I don't know," for example, or a shrug of the shoulders, or silence.
 - Instead, ask for the child's opinion as to why something is so: "What do you think the reason is...?"
 - In addition, "why" questions can come across as blaming, such as "Why didn't you..."

Help the child feel safe:

- Find a safe space, one that is private, quiet, and away from any potential danger.
- Offer the child the choice to have a trusted adult present while you talk with him/her.
- Do not force a child to speak to, or in front of, someone s/he appears not to trust.
- Do not include the person suspected of abusing the child in the interview.
- Tell the child the truth—even when it is emotionally difficult. If you don't know the answer to a question, tell the child, "I don't know."
- Honesty and openness develop trust and help a child feel safe.

Tell the child why you are talking with him or her:

- Every time you sit down to communicate with a child survivor, take the time to explain the purpose of the meeting.
- It is important to explain to the child why the service provider wants to speak with him/her, and what questions will be asked of the child and his/her caregiver.
- At every step of the process, explain to the child what is happening to help secure his or her physical and emotional wellbeing.
- Use words that encourage the child to continue talking:
 - "Tell me more about that..."
 - "What do you mean by..."
 - "Give me an example of..." or "Describe for me..."
 - "Go on..."
 - "And then what happened...?"

Use appropriate people:

- In principle, only female service providers and interpreters should speak with girls about sexual abuse.
- Male child survivors should be offered the choice (if possible) to talk with a female or male provider, as some boys will feel more comfortable with a female service provider.
- The best practice is to ask the child if he or she would prefer to have male or female trained staff on hand.

Use nonverbal communication and pay attention to body language:

- Nonverbal methods of communication offer many benefits, for example:
 - Children may feel less threatened using nonverbal methods than sitting in a room talking.
 - Children may find it easier to express emotions through drawings or stories, especially younger children and children not used to expressing emotions or answering questions.
- Children express emotions, thoughts, ideas, and experiences both during and after a nonverbal communication activity

- It is important to pay attention to both the child's and your own nonverbal communication during any interaction. A child may demonstrate that s/he is distressed by crying, shaking, or hiding his/her face, or changing body posture.
- If the child curls into a ball, for example, this is an indication to take a break or stop the interview altogether.
- Conversely, adults communicate nonverbally as well.
- If your body becomes tense or if you appear to be uninterested in the child's story, he or she may interpret your nonverbal behavior in negative ways, thus affecting his or her trust and willingness to talk.

Respect the child's opinions, beliefs, and thoughts:

- The child has a right to express her opinions, beliefs, and thoughts about what has happened to her as well as any decisions made on her behalf.
- Service providers are responsible for communicating to the child that he has the right to share (or not share) his thoughts and opinions.
- Empower the child so he/she is in control of what happens during communication exchanges.
- The child should be free to answer "I don't know" or to stop speaking with a service provider if he/she is in distress.
- The child's right to participation includes the right to choose not to participate.

Empower the child:

- After the child describes events or occurrences in his/her life and talks about his/her reactions, s/he must be reassured that s/he "did the right thing" by telling another person about these events.
- It may be helpful to allow his/her the opportunity to explore his/her ideas and solutions, for example:
 - "What would you tell other kids to do if they were in the same situation?"
 - If they are unable to reply, you can offer them paper and crayons and see if they want to draw their ideas.

Step 5: Key Points

- Principles of interpersonal communication for effective provision of services to GBV and VAC survivors.
- Importance of self-awareness and values in provision of services.

Step 6: Evaluation

What key skills does a health worker need in order to effectively communicate with children and adolescents?

Session 2.2: Principles and Procedures for Management of GBV and VAC Survivors

Total session time: 120 min.

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Screen for GBV and VAC survivors.
- Obtain consent from the client.
- Conduct comprehensive history from GBV/VAC survivors.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers, computer, LCD

SESSION OVERVIEW

mm	Time	Activity/Method	Content
1	5 min.	Presentation	Presentation of session title and learning tasks
2	15 min.	Presentation	Basic principles for providing care to GBV and VAC survivors
3	20 min.	Presentation	Screening for GBV and VAC clients
4	20 min.	Presentation	Obtain consent from the client
5	30 min.	Presentation	Conduct comprehensive history for GBV/VAC survivors
6	20 min.	Presentation	Safety planning for survivors of GBV and VAC
7	5 min.	Presentation	Key points
8	5 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ or ASK participants to read the learning tasks and clarify.

ASK participants if they have any questions before continuing.

STEP 2: Basic principles for providing care to GBV and VAC survivors (15 min.)

The care of survivors is guided by the following principles in the provision of services by health professionals:

Ensure safety of the survivor

- Survivors are exposed to different risks after violence. Ensure you conduct conversations and assessments in a safe setting.
- Ensure you assess the safety of the survivor (e.g., the place where the survivor will go after the assessment. Will the survivor be confronted with the perpetrator?).
- Assess if referral is needed and take action to ensure safety of the survivor.



Refer participants to Handout 2.2.1: Guiding Questions for Assessing a Survivor's Safety

Ensure confidentiality

- Information should only be shared with authorized professionals when providing care with clear understanding and consent of the survivor.
- Failure to keep survivors' information confidential is one of the reasons why survivors do not opt to report GBV incidences in the health facility.
- Respect the wishes, rights, and dignity of the survivor.
- Every action taken should be guided by the wishes, needs, and capacities of the survivor.
- Respect the survivor's strength and capacity to cope with what happened to her/him.
- Ensure attention is paid to all of the survivor's needs: medical, psychosocial, material needs, as well as the need for justice.
- Provide the survivor with information about available services to enable him/her to make a choice about the care and support s/he needs.
- The survivor has the right to make his/her own choices.
- For children, the best interest of the child should be a primary consideration, and children should be able to participate in decisions related to their lives.
- Adults must take into account the child's age and capacity when determining the weight that should be given to their wishes.
- Treat the survivor with dignity. Show that you believe the survivor and do not question the story or blame the survivor.
- Provide emotional support to the survivor. Retain a caring attitude regardless of the intervention you make.

Ensure nondiscrimination

- Treat every survivor in a dignified way, independent of her/his sex, background, race, ethnicity, or the circumstances of the incidents.
- Treat all survivors equally. Do not make assumptions about the survivor's history or background.
- Be aware of your own prejudices and opinions, and do not let them influence the way you treat a survivor.

STEP 3: Screening for GBV and VAC clients (20 min)

- Screening is defined as presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures which can be applied rapidly (WHO).
- In GBV and VAC screening involves asking a client about experiences of violence/abuse, whether or not s/he has any signs or symptoms.



Refer participants to Handout 2.2.2: Abuse Assessment Screening Tool

Importance of screening for GBV and VAC

- Survivors of violence tend to average more visits to the physician and pharmacy, a greater number of surgeries, more hospital stays, and increased mental health consultations.
- Often providers fail to correctly detect the real cause of the health problems presented by survivors of violence.
- Screening improves the quality of care survivors receive by diagnosing the root of the problem instead of focusing exclusively on the symptoms presented.
- Early identification of survivors allows the provider to help the survivor before the violence escalates.
- Early recognition of the problem has been shown to significantly reduce the morbidity and mortality that results from violence.
- Screening enables the provider to accurately diagnose and assess the health consequences associated with GBV and how best to counsel survivors on other aspects of family planning, STI/HIV prevention, and mental health.
- Detection gives the provider a chance to make a link between the survivor with other services available such as counseling services and legal aid.
- Screening enables service providers to document the survivor's history of abuse, which will allow him/her to receive appropriate medical care in the short and long term.
- Documentation can also become essential to supporting the survivor should s/he decide to pursue legal courses of action.
- MOHCDGEC recommends selective screening for GBV and VAC survivors which means asking an individual about violence when a health care provider has some reason to suspect violence/abuse based on certain signs and symptoms. Asking all individuals in a given health care setting about experiences of violence/abuse, whether or not they have signs or symptoms (universal screening) is not recommended.

Steps for screening for GBV and VAC

Attend to the client's current needs

- Clients who visit the health facility will have reasons of their own for their visit.
- The health care provider should consider attending to these needs first before screening them for gender-based violence.

- This helps prevent the client from seeing the screening as annoying process or time wasting.

Note: Sometimes screening can be conducted before the other needed types of services are offered, e.g., when a client is waiting in queue to see a doctor. In other situations screening can be done during other services provision, e.g., during history taking for other complaints that are not GBV-related. If a service provider finds an indication that GBV is likely to be happening to a client, she or he should introduce the screening and continue with other service provision afterwards.

Engage the client in the screening process

- Start the screening by giving an introduction of what you are going to do and why.
- Give a broad neutral statement that will not make the client feel victimized. For example you can say: "Understanding that gender-based violence results in various health problems, the MOHCDGEC has introduced screening and other services for all clients. For this reason we ask our clients a few questions and I would like to ask you to allow me to ask the same questions to you."
- Be sensitive, nonjudgmental, and encouraging towards the client's comments and answers.
- Ask for verbal consent and continue with screening only when the client consents.
- If the client does not consent, then thank the client and continue addressing other needs that made the client come today.

Screen the clients

- Screen the client only when the environment ensures privacy and confidentiality. Facilitator should introduce Handout 2.2.2: Abuse Assessment Screening Tool here and the modified children screening questions.
- The tool has five questions asking about emotional, physical, and sexual violence and one question that assesses the safety of the survivor.
- The questions in the abuse assessment tool are broad and cover different types of violence.
- Although the questions are ordered based on the assumption of starting with less severe and moving toward more severe forms of violence, these questions can be asked in different orders depending on the situation.
- For example, if a health care provider is taking a gynecological and sexual history from a client and suspects a history of sexual violence, then s/he can decide to ask the specific question (question no. 3) before asking about emotional or physical violence.

Address safety and referral measures

- For the clients who turn out to be GBV or VAC survivors, different needs will arise from their narratives/stories.
- Health care providers should ask additional questions to understand their needs and address them.
- Screening for GBV or VAC and then not addressing the needs is unethical and may put the survivor in more danger.

STEP 4: Obtain consent from the client (20 min)

PRESENTATION

In the context of GBV and VAC, informed consent should involve giving adequate information to the survivor covering the following areas:

- What the history-taking process will involve.
- Types of questions that will be asked and the reason for them.
- What the physical and pelvic examination will involve.
- Examination will be conducted in privacy and in a dignified manner.
- S/he will lie on an examination couch/bed during the examination.
- S/he will be touched during the physical and pelvic examinations.
- Genital and anal examinations will require her/him to lie in a position where genitals can be adequately seen with the correct lighting.
- Specimen collection (where needed) involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine, and saliva.
- Clothing may be collected.
- Not all of the results of the forensic analysis may be made available to the survivor and the reasons for this.
- S/he can refuse any aspect of the examination that s/he does not wish to undergo.
- S/he will be asked to sign a form that documents that s/he was informed of and agreed to the procedures to be done.
- Inform the survivor that the information told to the health or social welfare worker during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice with her/his consent—*only* if s/he decides to pursue legal action.



Refer participants to Handout 2.2.3: Consent Form; and Handout 2.2.4: Modified Screening Questions for Children.

According to the Law of the Child Act, Tanzania's child protection regulations will pertain in the following cases:

- When there is reasonable cause to believe that a child is suffering or is at risk of suffering significant harm.
- When the Social Welfare Department has decided that a medical examination of the child or any other child in the household should be undertaken.
- If the parents, guardian, or caregiver refuse to consent to such an examination, the social welfare officer shall seek alternative consent for the examination and any necessary treatment of the child.
- Consent may be provided by the child, where he or she is of sufficient maturity to understand why a medical examination and any necessary treatment should be undertaken.

- The determination of whether the child is of sufficient maturity shall lie with the doctor undertaking the examination. In any case where emergency treatment is required to prevent loss of the child's life or to prevent permanent damage to the child, the doctor may proceed without the consent of either a parent or the child.
- In all other cases, where consent is not forthcoming, the social welfare officer may seek an order from the juvenile court under LCA section 95(3)(a) permitting the medical examination to take place. Any such application shall be heard on the day that the application is made.
- Children 16 years and older are generally sufficiently mature to make decisions.
- Children between ages 14 and 16 are presumed to be mature enough to make a major contribution. Children between ages 9 and 14 can meaningfully participate in the decision-making procedure, but maturity must be assessed on an individual basis.
- Children younger than age 9 have the right to give their informed opinion and be heard. Views of the child should be weighed and decisions taken on a case-by-case basis, depending on his/her age, level of maturity, developmental stage, and cultural, traditional, and environmental factors.
- Involve the children's department, social welfare worker, and police so investigations can start while the child is in a safe place.
- Consent for a child survivor is signed by the child's parent or legal guardian, unless the child's parent/guardian is the suspected perpetrator.
- If the parent/guardian is the suspected perpetrator, a consent form may be signed by a social welfare officer, head of facility, or three health facility staff members, keeping in line with the LCA.
- The most crucial thing to remember about consent, however, is that while legally children cannot give consent to examination and services, they shall *not* be compelled or forced to undergo an examination or treatment, unless it is necessary to save the life of the child.

STEP 5: Conduct comprehensive history from GBV/VAC survivors (45 min.)

ACTIVITY: Brainstorming (5 min)

ASK participants to brainstorm on the type of information they will collect when taking history from a GBV or VAC survivor.

REFER to previous sections on special considerations and communication techniques for working with child and adolescent survivors as needed.

PRESENTATION

Collecting comprehensive history from GBV/VAC survivors

Guidelines for taking history from clients

- Introduce yourself to the survivor and explain your role.
- Explain what you are going to do at every step.
- Ask if the survivor wants to have a specific support person of his/her choice present.
- Cover the medical instruments until they are needed if the interview is conducted in the treatment room.
- Avoid any distractions or interruptions while you are taking the history.
- Limit the number of people allowed in the room during the examination. If others are present, explain their role and ask permission from the survivor.
- Reassure the survivor that any information given or found during examination will be kept confidential.
- Provide relevant information on the GBV incident and the need for medicolegal documentation.
- Review any documents or paperwork brought by the survivor to the health center before taking the history. This may include referral notes.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Let the survivor tell her/his story the way s/he wants to.
- Explain to the survivor that s/he is in control of the pace and timing during the conversation.
- Avoid questions that suggest blame or judgment, such as: "What were you doing there alone?"
- Take sufficient time to collect all needed information without rushing.
- Do not ask questions that have already been asked and documented by other people involved in the case.
- Have the survivor sign the consent form if the situation dictates, otherwise the survivor may wish to sign later during the course of treatment.
- In case of medicolegal issues, you must obtain history after the survivor consents. Note that the survivor may wish to get medical services only and opt not to pursue legal redress—respect that!
- When interviewing children, the age and cognitive development of the child will influence the way in which the interview is conducted.
- Every effort should be made to minimize the number of times the child is interviewed.
- Refer to the session on communication with children.

Steps to ensure comprehensiveness of history taking

The provider may not necessarily follow the order provided here. However, it is necessary to make sure all the elements in the history-taking are well covered and documented in the GBV and VAC form.

General information

- Ask and document name, address, sex, and date of birth (or age in years) of the survivor.
- Document the date and time of the examination.
- Document names and function of any staff or support person (someone the survivor may request) present during the interview and examination.

Description of the incident

- Ask the survivor to describe what happened. Allow the survivor to speak at his/her own pace.
- Do not interrupt to ask for details; follow up with clarification questions after s/he finishes telling her/his story.
- Find information on the location where the assault took place, use of violence or weapons, use of condoms, and penetration with fingers or objects.
- Find out the nature of the assault (e.g., sexual assault: oral, vaginal, or anal intercourse; physical assault: kicked, punched, slapped, or shoved).
- Obtain information about the perpetrator(s) including:
 - Survivor's relationship to perpetrator(s), if any
 - Number of perpetrators.
- Explain that s/he does not have to tell you anything s/he does not feel comfortable talking about.
- Explain to the survivor the importance of understanding exactly what happened in order to check for possible injuries and to assess the risk of HIV, STIs, and pregnancy, so that the survivor may be as open as possible despite the trauma s/he may be feeling in talking about the encounter.
- Reassure her/him of confidentiality if s/he is reluctant to give detailed information.
- Determine whether the survivor has bathed, urinated, defecated, vomited, eaten or drunk something, brushed teeth, used a vaginal douche, or changed his/her clothes or underpants. These may affect what forensic evidence can be collected.

Sexual history (males and females)

- Obtain history of prior sexual encounters, as well as whether or not they were consensual.
- Find out if the survivor has a sexual partner (or partners). Determine the last time the survivor had sexual intercourse with the partner prior to the incident.
- Determine if the survivor has had STIs before and if s/he was treated.
- Determine if the survivor has ever been tested for HIV before and his/her HIV status.

Gynecological history (females)

- Inquire if the survivor has attained menarche.
- Obtain the date of the first day of her last menstrual period.
- Determine if the survivor has been pregnant before. If so, when and what was the outcome.

- Determine if the survivor uses contraception; if so, the type, how long used, and her compliance, when relevant.
- Evaluate for possible pregnancy. Ask for details on contraceptive use.

Mental health history (males and females)

- Obtain a mental health history. Salient points include previous and current psychiatric diagnoses, prior hospitalization, previous and current medication, drug use, and family history of mental illness.
- Ask for symptoms that may suggest presence of some common mental health consequence of GBV and VAC.
 - **Depression and other mood disorders:** In depression the person is often sad, irritable, or angry; has feelings of hopelessness; stops pleasurable activities; loses or gains weight; has trouble sleeping or oversleeps; does not feel like eating; experiences fatigue, energy loss, poor concentration, and low self-esteem; makes statements such as “nobody likes me” or “I’m stupid”; is very self-critical; and/or becomes socially withdrawn. In other mood disorders the survivor can have great difficulty regulating his/her mood and emotional states, is unable to soothe him/herself (most of the time), has drastic mood swings, engages in high-risk behaviors, exhibits alternating mood extremes (“highs” and “lows”) frequently, or may often be physically aggressive.
 - **Anxiety:** The person feels restless, has trouble sleeping, loses sleep, is nervous, has specific fears like fear of dying, experiences heart racing or trouble breathing, is irritable, will not leave caregiver’s side, has nausea, or will not go to school or leave home.
 - **Suicidal ideation/behavior:** The survivor expresses hopelessness or a wish to be dead or attempts to harm him/herself. If the survivor has these symptoms, gather a detailed history of suicidal behavior (How many times was suicide attempted? Methods of attempts? Current plan for suicide?), and make an immediate referral to a psychiatrist.
 - **Substance abuse:** Ask for use of substance, types, when started, and frequency of use.

Past medical and surgical history (males and females)

- Ask about possible medical conditions, allergies, vaccinations, HIV status, and previous surgery.
- These questions should help you to determine the best treatment and to provide counseling and follow-up health care.

Step 6: Safety planning for survivors of GBV and VAC (20 min.)

- A survivor safety plan is a plan developed collaboratively by a health care provider/social welfare officer and a survivor that contains specific activities and measures to be taken to keep the survivor safe from an offender.

- It is an essential step to be completed with all adult and child survivors of violence.
- It allows individualized planning for situations the survivor and children or family may encounter while planning their next steps.
- Age-appropriate safety planning is also important for child survivors/witnesses of domestic violence.

Things to consider when developing a safety plan

- Keep a record of phone numbers of important people, that is, those who can help if violence occurs.
- Plan an escape route out of your home. Teach your children the route too.
- Put away some money—even if it is just enough for public transport.
- Keep copies of your ID, student ID, maternal and child health clinic card, and birth certificate in a safe place.
- Put together a bag/basket/pouch of essential clothing and medicines. Leave it with a trusted friend.
- Have the numbers of the shelters handy, but hidden.
- In a violent situation, avoid rooms with access to weapons (e.g., kitchen).
- Teach children not to intervene in a violent situation. The most important thing is for the children to be protected and to protect themselves.
- Teach your children a code and use it to signal to them when you need them to go get help.
- Change your routine, schedule, or the route you take your children to school when you decide to leave or have already left the abusive relationship.
- Alert school authorities of the situation and consider changing children's school.
- Talk to your neighbors and request that they call the police if they feel you may be in danger.
- Safety plan should not be documented anywhere for your own safety.

Address safety and referral measures

- For the clients who turn out to be GBV or VAC survivors, different needs will arise from their narratives/stories.
- Health care providers should ask additional questions to understand and address survivors' needs.
- Screening for GBV or VAC and then not addressing the needs is unethical and may put the survivor in more danger.

Safety planning measures

When you talk about safety with the survivor, start with the following questions:

- How can I help you?
- What do you need to be safe?
- What have you tried in the past to protect yourself (and your children)?
- What worked? What did not work?

If the survivor is separated from the perpetrator and living alone, discuss the following options:

- Changing the locks; installing a better security system (window bars, safety locks, better lighting, etc.)
- Talking to schools and kindergartens about the danger to child victims and giving them clear directions about who has permission to pick up the children and who does not.
- Teaching the children how to call the police or other persons who can help (family members, friends, etc.)
- Finding a survivor support service like a women's center/shelter that can help them and inform them of their rights and the available legal protection.
- Finding a competent lawyer.
- Applying for a protection order at the court.
- Asking somebody to move into the house so that they are not alone.

If the victim is planning to leave the perpetrator:

- How and when can the victim (and the children) leave most safely?
- Do they have a car or other transportation? Money?
- Do they have a safe place to go to?
- What can the victim and others do to make sure they will not be located by the perpetrator?
- What does she need to take with her?

Step 7: Key Points (5 min.)

- Screening should be conducted for individuals presenting with symptoms.
- Consent needs to be explained to and obtained from the client.
- Obtaining a comprehensive GBV/VAC history is important for medical and legal reasons.

Step 8: Evaluation (5 min.)

- Explain the steps for obtaining consent from an adult survivor and from a child survivor.
- Explain the screening process.
- Identify considerations that need to be made when safety planning with survivors.



Handout 2.2.1: Guiding Questions for Assessing a Survivor's Safety

QUESTION	YES	NO
1. Are there certain signs in your partner's behavior that alert you to the possibility of violence?		
2. Can you get out of the house before the violence starts?		
3. Can you send a message to someone for help?		
4. Are there neighbors whom you could talk to about the violence who could help you in emergency situations?		
5. Is there a way you can communicate to alert neighbors that you need help?		
6. If violence begins, can you move into a room where you could escape or where others could hear you? Or that might be safer?		
7. Are there weapons in the house? Where? Can you remove or hide them? Are there places where you could go in an emergency (relative, neighbor, local leader)?		
8. Can you keep a bag hidden (either at home or at a friend's/family member's home) for emergencies filled with clothes, some money, keys, and copies of telephone numbers or important documents in case you need to leave quickly?		



Handout 2.2.2: Abuse Assessment Screening Tool

Questions	Responses	
	Yes	No
1. Have you ever been emotionally or physically hurt by anyone in your lifetime?		
2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?		
3. If yes, by whom? (Relationship, not a name).....		
4. Total number of times		
5. Within the last year has anyone forced you to have sexual activities?		
6. If yes, by whom? (Relationship not a name)		
7. Total number of times.....		
8. Are you afraid of anyone of the people you mentioned above?		
9. Please tell me any complementary information regarding the violence you have been subjected to. Is there something that you would like to tell me?		
10.		
11.		



Handout 2.2.3: Consent Form

Name of Facility:

I.....authorize the above named health facility to perform the following:

Item	Yes	No
Conduct a medical examination, including pelvic examination.		
Collect evidence, such as body fluid samples, samples of clothing, hair combings, scrapings or cuttings of finger nails, blood samples, and photographs.		
Provide evidence and medical information to the police and law courts concerning my case. This information will be limited to the results of this examination and any relevant follow-up care provided.		

Signature: _____ **Witness:** _____

Date: _____



Handout 2.2.4: Modified Child Abuse Screening Questions

For children ages 11–18 years

Children in many parts of the world have been exposed to violence or bad treatment at school, in their communities, at their family home, or in institutions. We want to find out about experiences that happen to children so that people can know what things they have to pay attention to keep children safe. We would like to ask you about your experiences with violence directed against you.

We want to find out about the things that adults sometimes do to children and adolescents that may hurt or make them feel uncomfortable, upset, or scared in their school. These questions may seem strange or hard to answer, but try and answer them as best you can, thinking back over the past year. This is not a test. There is no right or wrong answer, if at any point you feel too uncomfortable to continue, you can stop.

If you want to get help about any of the things we ask about, talk to the person who gave this questionnaire to you. Unless you tell us you want to talk, no one will ever know that the answers that you give are about you.

Has anyone ever:

Questions	Yes	No
1. Slapped you with a hand on your face or head as punishment?	<input type="checkbox"/>	<input type="checkbox"/>
2. Twisted your ear as punishment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Pulled your hair as punishment?	<input type="checkbox"/>	<input type="checkbox"/>
4. Hit you by throwing an object at you?	<input type="checkbox"/>	<input type="checkbox"/>
5. Hit you with a closed fist?	<input type="checkbox"/>	<input type="checkbox"/>
6. Kicked you?	<input type="checkbox"/>	<input type="checkbox"/>
7. Crushed your fingers or hands as punishment?	<input type="checkbox"/>	<input type="checkbox"/>
8. Made you stay outside in the cold or heat to punish you?	<input type="checkbox"/>	<input type="checkbox"/>
9. Made you stand or kneel in a way that hurts to punish you?	<input type="checkbox"/>	<input type="checkbox"/>
10. Burnt you as punishment?	<input type="checkbox"/>	<input type="checkbox"/>
11. Put you into hot or cold water as punishment?	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|--|--------------------------|--------------------------|
| 12. Took your food away from you as punishment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Choked you? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Tried to cut you with a sharp object? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Tied you up with a rope or belt? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Touched your body in a sexual way or in a way that made you uncomfortable? By "sexual way" we mean touching you on your genitals or breasts. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Showed you pictures, magazines, or movies of people or children doing sexual things? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Made you take your clothes off when it was not for a medical reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Opened or took their own clothes off in front of you when they should not have done so? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Did anyone make you have sex with them? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Did anyone make you touch their private parts when you didn't want to? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Did anyone touch your private parts or breasts when you didn't want them to? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Did anyone give you money/things to do sexual things? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Did anyone involve you in making sexual pictures or videos? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Did anyone kiss you when you didn't want to be kissed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you feel safe at home? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you scared to go home? | <input type="checkbox"/> | <input type="checkbox"/> |

Session 2.3: Physical Examination and Treatment of Survivors

Total session time: 120 minutes

Prerequisites: None

Learning Tasks (5 min.)

By the end of this session, participants are expected to be able to:

- Perform physical examination of GBV/VAC survivors for medical and medicolegal purposes.
- Conduct investigations and take evidence for medical and medicolegal purposes while maintaining sample integrity (see forensic sample collection, session 2.4).
- Provide post-trauma medical treatments (pain, wound care, surgeries, antibiotics, etc.)
- Provide preventive therapy including HIV post-exposure prophylaxis (PEP), emergency contraceptive pill (ECP), tetanus toxoid (TT), and STI-physical therapy (STI-PT)
- Provide appropriate referral.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers, computer, LCD
- Handout 2.3.1: GBV and VAC Medical Forms

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction Learning tasks
2	40 min.	Presentation	Perform physical examination of GBV/VAC survivors for medical and medicolegal purposes
3	20 min.	Presentation	Perform physical examination of children and adolescent survivors
4	30 min	Presentation	Provide post-trauma medical treatment
5	15 min.	Presentation	Provide preventive therapies (ECP, TT, STI-PT), documentation, and referral
6	05 min.	Presentation	Key points
7	05 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ or ASK participants to read the learning tasks and clarify.

ASK participants if they have any questions before continuing.

STEP 2: Perform physical examination of GBV/VAC survivors for medical and medicolegal purposes (40 min.)

ACTIVITY: Demonstration

TELL participants that they are going to observe and conduct feedback demonstrations on comprehensive physical examination in class.

TELL participants to observe the steps for comprehensive physical examination for adult GBV to be conducted by the facilitator.

START to conduct the demonstration as follows.

PREPARE an adult mannequin and an examination bed.

PREPARE required basic instruments for physical examination (e.g., a tray with a torch/movable light, patella hammer, stethoscope, swabs, disposable gloves of various sizes, etc.).

EXAMINE systematically while participants observe:

- Head-to-toe examination
- Mental status assessment
- Genital-anal examination.

ENCOURAGE participants to ask questions at any time.

GIVE participants examples that specifically describe the survivor's mood, such as "depressed," "anxious," "good," or "tired" (e.g., in mental status assessment).

ALLOW participants to give a repeat demonstration.

LEAD participants to identify the steps missed.

DISCUSS necessary precautions to be taken for child survivors.

Procedures for comprehensive physical examination for GBV adult survivors

- Inform the survivor that at any point during the physical examination s/he can ask the provider to stop.
- Tell the survivor what to expect at every step of the physical examination and what will happen next.
- Collect specimens as the physical examination is being conducted.
- Examine the GBV survivor systematically.
- Collect clothes for forensic examination and put them in a paper sheet/bag when sexual and physical violence has occurred.
 - Undress the survivor over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs that would support her/his information about the assault or violence.
- Record all findings appropriately in a GBV Medical Form. If this form is not available, record findings on a sheet of paper, following the GBV form format.
- Conduct the examination under natural light, if possible. To see injuries better use special lamps, such as a Wood's lamp or UV light, if available.

Steps of physical examination for GBV adult survivors

Head-to-toe examination

- Conduct a head-to-toe examination, paying special attention to the face, upper limbs, neck, breasts, thighs, and perineum when sexual violence is involved.
- Note the general appearance of the survivor:
 - Level of consciousness
 - Signs of alcohol or drug intoxication
 - Extent of body injury
 - Signs of acute crisis reaction
- Take vital signs: blood pressure, pulse rate, temperature.
- Measure height and weight.
- Examine the head and neck for wounds, bruises, abrasions, swelling, hair clumps/bald spots, pain on motion or touching, and other injuries.
- Examine the eyes and ears (the outer ears, ear drums, and conjunctiva) for hemorrhage.
- Examine the mouth and throat for wounds, dental damage, mucosal damage or hemorrhage, swelling, and other injuries.
- Examine the upper and lower limbs for swelling, abrasions, and any sign of other injuries.
- Do abdominal, chest, and back examinations to look for wounds, bruises, bites, lacerations, or other injuries.
- Collect any forensic specimens as you examine the survivor as described above.

Mental Status Assessment

Appearance and Behavior

- Recall how the survivor first appeared upon entering the office for the interview, whether relaxed or nervous, and note whether these have changed with time. Note also any changes in posture and motor activity.
- Record the survivor's facial expressions and attitude toward the examiner: whether the survivor has maintained eye contact throughout the interview or if s/he has avoided eye contact as much as possible, scanning the room or staring at the floor or the ceiling.
- Note whether the survivor appeared interested during the interview or bored. Assess whether the survivor is hostile and defensive or friendly and cooperative.
- Record notes on grooming and hygiene.

Mood

- Ask questions such as "How do you feel now and most of the days for the past two weeks?" to trigger a response.
- Helpful answers include those that specifically describe the survivor's mood, such as "depressed," "anxious," "happy," or "irritable."
- Elicited responses that are less helpful in determining a survivor's mood adequately include "OK," "rough," and "don't know." These responses require further questioning for clarification.

Affect

- This is determined by the observations made by the interviewer during the interview.
- A survivor's affect may be defined as expansive (happy and contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), or flat (no variation).
- A survivor whose mood could be defined as expansive may be so cheerful and full of laughter that it is difficult to refrain from smiling while conducting the interview.

Speech

- Document information on all aspects of the survivor's speech. If the survivor is depressed or anxious, the speech could be of low tone and slow.
- Sometimes speech can be word salad (nonsensical responses, i.e., jabberwocky) or neologism (creating new words).

Perception

- Determine if the survivor is experiencing hallucinations. Ask if she has experience of hearing abnormal voices when no one else is around, seeing abnormal things/images/people that no one else can see, or other unexplained sensations such as unusual smells, sounds, or feelings.

Thought processes

- Record how the survivor processes information; whether it is relevant to the topic, racing or rapid thoughts, vague (beating around the bush), or limited in content.
- Thought content.

- Note if a survivor is having delusions (fixed false beliefs about something) or if other people have told her/him that his thoughts are strange.
- Sometimes a survivor may report having special powers or abilities or receiving special messages through television or radio. All these indicate delusions.
- Signs of ritualistic type behaviors should be explored further to determine the severity of the obsession or compulsion.
- Determine if survivor has any fears that cause him/her to avoid certain situations.
- Assess for suicidal ideation or intent: start by inquiring if the survivor feels like s/he is losing hope, thinking that s/he would be better off dead, or having thoughts of wanting to harm or kill him/herself. If the reply is positive for these thoughts, inquire about specific plans, suicide notes, family history (e.g., anniversary reaction), and impulse control.
- Assess for any risk of homicidal ideation or intent: inquire from the survivor if they have any thoughts about wanting to hurt anyone or wishing that someone were dead. If the reply to one of these questions is positive, ask the survivor if s/he has any specific plans to injure someone and how s/he plans to control these feelings if they occur again.

Cognition and sensorium

- **Consciousness:** Levels of consciousness are determined by the interviewer and are rated as: (1) coma, characterized by unresponsiveness; (2) stupors, characterized by nonresponse to pain; (3) lethargic, characterized by drowsiness; and (4) alert, characterized by full awareness.
- **Orientation:** Ask the survivor if s/he knows people surrounding him/her (not necessarily names but can be their role at that moment), ask if s/he knows where s/he or she is and why/s/he is there, and lastly, ask for the time in terms of the month, date, year, day of the week, and time.
- **Impulsivity:** Ask the survivor about doing things without thinking or planning in order to estimate the degree of his/her impulse control.
- **Reliability:** Comment on the survivor's reliability by determining if the survivor seems reliable, unreliable, or if it is difficult to determine. Sometimes determination requires collateral information of an accurate assessment, diagnosis, and treatment.

Genital and anal examination for women

- Explain the procedure to the survivor, providing details of each step.
- Examine the outer genitalia.
- Examine the pubic hair, labia majora and minora, urethral meatus, introitus, and perineum.
- Look for swelling, mucosal injuries, bruises, lacerations, bleeding, or other injuries.
- Recover pubic hair and any other pieces of physical evidence that may be seen in the genitalia.
- Examine the inner genitalia.
- Examine the hymen, vagina, posterior fornix, portio, and cervix.
- Look for swelling, mucosal injuries, bruises, lacerations, bleeding, or other injuries.

NOTE: Lubricate with water ONLY.

- Bimanual palpation of the cervix, uterus, ovaries/oviducts:
 - Look for tenderness when palpating and other abnormal findings during palpation.
 - Do speculum and digital examinations (under no circumstance should this be done prior to taking the external and internal vaginal swabs).
 - High vaginal swab should be taken during speculum examination.
- Examine the anus for redness, swelling, bleeding, mucosal lacerations or fissures, scarring, sphincter injury, or pain to palpation.
- Look for secretions or foreign materials.
- Conduct proctoscopy if indicated (lubricate with water ONLY).
- Look for redness, swelling, bleeding, or lacerations.
- Document any wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration).
- Control bleeding, if any.
- Take all the swabs, in the following order: external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swab.
- The other swabs are oral swabs for secretory factors in cases where oral sex is implicated and skin swabs when a suspicious seminal stain is present on the skin.

Genital and anal examination for men

- Explain the procedure to the survivor, providing details of each step.
- Examine the outer genitalia (pubic hair, penis shaft, frenulum, glans, urethral meatus, and scrotum).
- Look for swelling, mucosal injuries, bruises, lacerations, bleeding, or other injuries.
- Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.
- Examine the anus for redness, swelling, bleeding, mucosal lacerations or fissures, scarring, sphincter injury, or pain to palpation.
- Look for secretions or foreign materials.
- Document any wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration).
- Collect swabs from areas of contact and other specimens as you conduct physical examination.
- Conduct proctoscopy if indicated (lubricate with water ONLY).
- Look for redness, swelling, bleeding, and lacerations.
- Control bleeding, if any.

Step 3: Physical examination of children and adolescent survivors (20 min.)

Steps for performing physical examination of children and adolescents are sometimes different than steps for performing physical examination of adult survivors, although the process may appear similar. The specifics for children are as follows.

Examination steps for GBV child survivors

- Make sure to record the height and weight of the child because neglect may coexist with sexual and other physical abuse.
- Note any bruises, burns, scars, or rashes on the skin. Carefully describe the size, location, pattern, and color of any such injuries.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Check for any signs that force and/or restraints were used, particularly around the neck and the extremities.
- Record the child's sexual development and check the breasts for signs of injury.

Mental status examination in children

- Mental status examination in children is done in few aspects only including:
- Appearance and behavior; the child may appear anxious, extremely fearful, or restless or hyperactive. Some children can be hostile and defensive.
- Mood and affect; it is important to record how the child feels in his/her own words, noting down how s/he expresses his/her feelings as well.

Genital and anal examination for girls

- Explain each step of the examination.
- Examine the external genitalia.
- Examine the labia and other related structures.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outward and downward.
- Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymeneal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do not carry out a digital vaginal examination if the hymen is intact.
- Do speculum and digital examination. Speculum examination for children should be done only if the child has internal bleeding from a penetrating vaginal injury. In this case, speculum examination is done under general anesthesia.
- Use a pediatric or nasal speculum for examining small girls.
- Note that speculum examination on girls who have not reached puberty causes pain and may cause injury and should be avoided unless, as mentioned, there is bleeding from the vagina.
- The child may need to be referred to a higher level health facility for this procedure.
- Girls should have an anal examination as well as a genital examination.
- Examine the anus with the child in the supine or lateral position.

- Avoid the knee-chest position, as assailants often use it.
- Look for bruises, tears, or discharge. Record the position of any anal fissures or tears.
- Do not carry out a digital examination to assess anal sphincter tone.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.

Genital and anal examination for boys

- Check for injuries to the skin that connects the foreskin to the penis.
- In an older child, the foreskin should be gently pulled back to examine the penis.
- Do not force it since doing so can cause trauma, especially in a young child.
- Check for discharge at the urethral meatus (tip of penis).
- Examine the anus, looking for bruises, tears, or discharge, and help the boy to lie on his back or on his side.
- The boy should not be placed on his knees as this may be the position in which he was violated.
- Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.
- Check for injuries to the frenulum of the prepuce and for anal or urethral discharge. Take swabs if indicated.
- Do not carry out a digital examination to assess anal sphincter tone.
- Record the position of any anal fissures or tears. Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.



REFER participants to Handout 2.3.1: GBV and VAC Medical Form.



Handout 2.3.1: GBV and VAC Medical Form

Examination Documentation Form For GBV and VAC Survivors

General Information	Name of Health Facility
Full Name(s)	Survivor Registration No.
Date of birth (MM/DD/YEAR) ____/____/____	Marital status (tick ✓) Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>
Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Residence
Witnesses	Contact(s)
Occupation	
Description of Incident	
Date of assault (MM/DD/YEAR) ____/____/____	Time of assault (Hour:Minute) __:__ AM <input type="checkbox"/> PM <input type="checkbox"/>
Place of assault	Number of assailants
Alleged assailants <input type="checkbox"/> Unknown <input type="checkbox"/> Known (indicate relationship with victim) _____	Type of assault <input type="checkbox"/> Sexual <input type="checkbox"/> Physical <input type="checkbox"/> Psychological
Presenting symptoms/complaints	Circumstances of incident (penetration, how/where, and what was used?)
Did the assailant use a condom? <input type="checkbox"/> No <input type="checkbox"/> Yes	Did the survivor have a bath? <input type="checkbox"/> No <input type="checkbox"/> Yes

<p>Did the survivor vomit after assault?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>Did the survivor go to the toilet?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>
<p>Was the incident reported to police?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (Indicate name of station)</p>	
OB/GYN History (for females)	
<p>Last normal menstrual period</p> <p>____/____/____</p>	<p><input type="checkbox"/> Gravida</p> <p><input type="checkbox"/> Parity</p>
<p>History of sexual intercourse prior this incidence?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>History of pregnancy</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> Don't know</p>
<p>History of contraception</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (indicate the types)</p>	<p>Last consensual sexual intercourse (MM/DD/YEAR)</p> <p>____/____/____</p>
<p>History of current sexual relationship</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>HIV status</p> <p><input type="checkbox"/> Positive</p> <p><input type="checkbox"/> Negative</p> <p><input type="checkbox"/> Unknown</p>

Examination	
Date ____/____/_____ Time (Hour:Minute) ____:____ AM <input type="checkbox"/> PM <input type="checkbox"/>	
Mental health state (comment[s]) <input type="checkbox"/> Normal <input type="checkbox"/> In shock <input type="checkbox"/> Tearful <input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious <input type="checkbox"/> Confused <input type="checkbox"/> Hyper-arousal <input type="checkbox"/> Coma <input type="checkbox"/> Other(s).....
Physical Examination	
Comment on general condition of the survivor	BP_____mmHg Pulse Rate_____beat/min Resp Rate_____cycles/min Temp_____°C
Did the survivor change clothes? <input type="checkbox"/> No <input type="checkbox"/> Yes (where were the worn clothes taken?) _____	State of the clothes <input type="checkbox"/> Stains <input type="checkbox"/> Tears <input type="checkbox"/> Color
Any visible, obvious injuries? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes comment in box on right)	
Genital-Anal Examination	
Describe in detail the physical state of the following structures:	
External genitalia	Cervix
Vaginal/hymen	Digital rectal examination
Other orifices (oral cavity, tongue, palate)	

Type of GBV/VAC Encountered	
<input type="checkbox"/> Physical <input type="checkbox"/> Sexual <input type="checkbox"/> Emotional <input type="checkbox"/> Physical and sexual	
Emergency Treatment Given	
Stitching surgery <input type="checkbox"/> No <input type="checkbox"/> Yes (comments)	Emergency contraception <input type="checkbox"/> No <input type="checkbox"/> Yes (indicate which drugs)
PEP <input type="checkbox"/> No <input type="checkbox"/> Yes	STI preventive treatment <input type="checkbox"/> No <input type="checkbox"/> Yes
Comment on any other medication/treatment/management given to the survivor:	
Laboratory Investigation	Comments
Urine-pregnancy test	
Microscopy	
Other(s)	
Vaginal swab-sperm	
Culture and sensitivity	
Blood	
DNA	
Venereal Disease Research Laboratory test (VDRL) (screening for syphilis)	
Hepatitis B surface antigen	
Full blood picture	
Hemoglobin (HB)	

X-matching	
Blood chemistry	
Serological test for HIV	
Anal Swab	
Other(s):	
Survivor Referred To:	
Police station Voluntary HIV counseling and testing clinic Other (specify) _____	
Remarks:	
Name and signature of examining doctor Name: _____ Signature _____	Date ____/____/____
Name and signature of examining nurse Name: _____ Signature _____	Date ____/____/____
END	

STEP 4: Providing post-trauma medical treatment to GBV and VAC survivors (30 min.)

- Treat all GBV and VAC cases as emergencies and do not allow them to queue in the intake line.
- Attend to life-threatening injuries as a first priority before all other aspects of GBV care.
- Any medical officer, clinical officer, or nurse who is trained in GBV and VAC may manage a survivor and be able to fill in the GBV documentation forms.
- Preventive treatments should be provided concurrently with other medical procedures, including post-exposure prophylaxis (PEP), emergency contraception, and tetanus toxoid. Presumptive treatment for STIs should be given if indicated.
- All GBV survivors require GBV psychosocial assessment, counseling, psychosocial support, and follow-up once they are stable.
- Health care providers should ensure proper documentation and safekeeping of medical records for purposes of security and for future use.
- All health institutions providing GBV services should have a network directory of GBV service providers within their locality for purposes of referral.

Procedures for physical injury management

- Clean abrasion and superficial lacerations with antiseptic solution.
- Stitch under local anesthesia if stitching is required.
- Examine the perineum for genital injuries, conduct speculum examination, and do a high vaginal swab; all require the survivor to be in lithotomy position.
- Consider sedation if the survivor is anxious or general anesthesia if he or she has major injuries such as high vaginal vault, anal and oral tears, or third or fourth degree perineal injury.
- Vaginal injuries with cuts requiring sutures should be managed under sedation or anesthesia.
- In cases of confirmed or suspected perforation, laparotomy should be performed and any intra-abdominal injury repaired.
- Other supportive medication should be given, including analgesics and antibiotics (when required).
- All these procedures must be done in a room with privacy. For life-threatening conditions like severe injuries or shock, procedures should be done in a place with the capacity to conduct them.

STEP 5: Providing preventive therapies (HIV PEP, ECP, TT, and STI) (15 min.)

- Perform counseling and testing at baseline before administering PEP. It is important to establish the survivor's baseline.
- Determine HIV status before administering PEP in order to prevent the potential for developing drug resistance, should the individual be HIV-positive.
- If a rape survivor is **HIV-negative**:

- Administer the first dose of PEP as early as possible. The efficacy of PEP decreases with the length of time after an assault.
- Offer PEP promptly, preferably within 2 hours but not later than 72 hours after the survivor was raped.
- If the rape survivor is **HIV-positive**:
 - Refer the person to an HIV care and treatment center for enrollment and further management.
 - Do not offer PEP.
- Rape survivors presenting later than 72 hours after being raped should not be offered PEP.
- If the rape survivor is not psychologically ready:
 - The baseline HIV test can be delayed by up to 3 days after commencement of PEP.
 - If the test result is positive, PEP should be stopped and the client should be referred to an HIV care and treatment center.
 - It should also be explained to the rape survivor that the HIV infection is not the consequence of the sexual assault but from previous exposure.
- Provide psychosocial support and ensure adherence to PEP regime. The loss rate is high in this group of clients.
- Monitor for antiretroviral toxicity and manage the conditions (if present) accordingly.

HIV PEP regimens for adult survivors

The recommended HIV PEP regimen is:

- Tenofovir 300 mg PO od + lamivudine 300 mg PO od + efavirenz 600 mg, once a day for 4 weeks
- Alternatively, the following regimens can be given, but they are not recommended for routine PEP:
 - Zidovudine 300 mg bd + lamivudine 150 mg PO bd + efavirenz 600 mg PO od
 - Tenofovir 300 mg PO od + lamivudine 300 mg PO od + ritonavir 100 mg PO od—boosted Lopinavir (400 mg).

Table 2.1: HIV PEP Regimen for Children

	Medicine	Application
First Line	<ul style="list-style-type: none"> Tenofovir/lamivudine/efavirenz (tab/cap) 75/75/150 mg Tenofovir (oral powder/tabs) + lamivudine (syrup) + efavirenz (tab/cap) 	Once a day PO for 28 days (dose depends on body weight)
Second Line	<ul style="list-style-type: none"> Lopinavir/Ritonavir (80/20 mg per ml) Lopinavir 10 mg per kg/RTV 2.5mg per kg up to 400/100 mg (5 ml) 	Twice a day PO for 28 days

Activity: Demonstration (5 min.)

DEMONSTRATE a tin of antiretroviral medications and **DISTRIBUTE** for each participant to examine.

Provision of ECP to GBV and VAC survivors

- According to national guidelines, the options for emergency contraceptives are:
- FIRST CHOICE**
 - Progestin only pills; Postinor 2[®] (Levonogestrel) 1 tab bd stat (or 2 tabs stat) OR
 - Progestin only pills; POP (Levonorgestrel/Norgestrel) 20 every 12 hours (total 40 tabs per day) for 1 day
- SECOND CHOICE**
 - Combined oral contraceptive pills with high dose of estrogen (50 µg); Ovral[®] 2 tabs every 12 hours (total 4 tabs per day) for 1 day OR
 - Combined oral contraceptive pills with high dose of estrogen (30 µg); Nordette[®] 4 tabs every 12 hours (total 8 tabs per day) for 1 day
- Hormonal methods of contraception can be used to prevent pregnancy if taken within 120 hours following an unprotected act of sexual intercourse. ECP method should be taken as soon as possible within 120 hours of unprotected intercourse
- When initiated within 24 hours after unprotected sexual intercourse they prevent pregnancy by 95 percent; if used between 24 and 48 hours they prevent pregnancy by 85 percent. The sooner ECPs (Levonorgestrel 0.75 mg, Postnor 2) are taken after unprotected sexual intercourse, the more likely the pregnancy will be prevented.

Prevention of tetanus for GBV and VAC survivors

- Tetanus (TT) prophylaxis should be given if there are any breaks in skin or mucosa, unless the survivor has been fully vaccinated.

Table 2.2: Tetanus Toxoid (TT) Vaccine Schedule

Dosing Schedule	Administration Schedule	Duration of Immunity Conferred
1 st TT dose	At first contact	Nil (0)
2 nd TT dose	1 month after 1 st TT	1–3 years
3 rd TT dose	6 months after 2 nd TT	5 years
4 th TT dose	1 Year after 3 rd TT	10 years
5 th TT dose	1 Year after 4 th TT	20 years

Treatment of STIs of GBV and VAC survivors

A presumptive treatment for STIs and reproductive tract infections should be provided in accordance with the National Sexually Transmitted Infections/Reproductive Tract Infections guidelines to all rape, sexual assault, GBV, and VAC survivors as follows:

	Option 1	Option 2	Option 3
Coverage	All single dose, highly effective. Choose one from each box (= 3 or 4 drugs) ^a	Effective substitutes –possible resistance in some areas, or require multiple dosage	If patient is pregnant, breastfeeding or under 16 years old Choose one from each box (= 3 or 4 drugs) ^a
Syphilis	Benzathine penicillin 2.4 Mega units by intramuscular injection	Doxycycline^c 100mg orally twice a day for 14 days (in case of penicillin allergy only)	Benzathine penicillin 2.4 MU by single intramuscular injection
Gonorrhoea/Chancroid	Cefixime 400 mg orally as a single dose, or ceftriaxone 125 mg by intramuscular injection	Cefixime 400mg as a single dose, or spectinomycin 2g by intramuscular injection	Cefixime 400 mg orally as a single dose, or ceftriaxone 1 gm stat by intramuscular injection
Chlamydia/Lymphogranuloma Venereum	Azithromycin 1g orally as single dose	Doxycycline^c 100mg orally twice a day for 7 days, or tetracycline 500mg orally 4 times a day for 7 days	Azithromycin 1g orally as single dose, or erythromycin 500 mg orally 4 times a day for 7 days
Trichomoniasis	Metronidazole^b 2g orally as a single dose	Tinidazole^e 2g orally as a single dose	Metronidazole^b 2g orally as a single dose, or 400–500 mg 3 times a day for 7 days

- a. **Benzathine penicillin** can be omitted if treatment includes either azithromycin 1 g or 14 days of doxycycline, tetracycline or erythromycin, all of which are effective against incubating syphilis.

- b. **Metronidazole** should be avoided in the first trimester of pregnancy. Patients taking metronidazole should be cautioned to avoid alcohol.
- c. These drugs are contraindicated for pregnant or breastfeeding women.
- d. The use of quinolones should take into consideration the patterns of *Neisseria gonorrhoeae* resistance.
- e. Patients taking **Tinidazole** should be cautioned to avoid alcohol.

STI presumptive treatment options for children

Coverage	All single-dose antibiotics are highly effective. Choose one from each box (= 3 or 4 drugs)	Older children and adolescents
Syphilis	Benzathine penicillin 50,000 units/kg of body weight by single intramuscular injection, or erythromycin 12.5 mg/kg of body weight orally 4 times a day for 14 days	>45 kg, use adult protocol
Gonorrhoea/ chancroid	Cefixime 8 mg/kg of body weight as a single dose, or ceftriaxone 125 mg by intramuscular injection, or spectinomycin 40 mg/kg of body weight (maximum 2 g) by intramuscular injection	>45 kg, use adults protocol
Chlamydia/ lymphogranuloma Venereum	Erythromycin 12.5 mg/kg of body weight orally 4 times a day for 7 days	12 years or older, use adult protocol
Trichomoniasis	Metronidazole 5 mg/kg of body weight orally 3 times a day for 7 days	12 years or older, use adult protocol

Procedures for conducting laboratory investigations

Laboratory investigations are done to help address medical problems resulting from violent assault in order to give appropriate treatment and provide preventive therapies.

Laboratory tests

- Laboratory tests include: HIV testing, pregnancy test, urinalysis, and screening for STIs, but additional tests can be done according to the clinician's opinion and recommended procedures for the level of health facility.

- GBV survivors may contract an STI as a direct result of the assault. Infections most frequently contracted by the survivors, and for which there are effective treatment options, are as follows:
 - HIV
 - Chlamydia
 - Gonorrhea
 - Syphilis
 - Trichomoniasis
 - Human papilloma virus
 - Herpes simplex virus type 2
 - Hepatitis B and C

Step 6: Key Points (5 min.)

- Treat all GBV and VAC cases as an emergency and do not allow survivors to queue in the line.
- Attend to all life-threatening injuries as a first priority before all other aspects of GBV/VAC care.
- Preventive treatment should be provided concurrently with other medical procedures.

STEP 7: Evaluation (5 min.)

- What preventive therapies can be offered to a GBV and VAC survivor?

Session 2.4: Forensic Sample/Evidence Management

Total session time: 120 min.

Prerequisites: None

Learning Tasks

By the end of this session participants are expected to be able to:

- Define the term “forensic evidence” and give examples.
- Facilitate chain of custody and documentation of sample/evidence related to GBV and VAC survivors.
- Interpret findings from GBV and VAC survivors before the court of law.
- Explain procedures for collecting and handling specimens and other relevant information for medicolegal evidence.
- Explain procedures for storage and transportation of samples of forensic evidence.
- Explain roles of health care providers and social welfare officers as factual or expert witnesses.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers, computer, LCD rape kit, mannequin, high vaginal swab, swabs, gauzes, glass slides, white sheets, apron, investigation bottles, gloves (clean and sterile), envelopes, dust bin, alcohol hand rub, etc.
- Handout 2.4.1: Table of Different Materials and Procedures for Collection of Forensic Evidence

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Presentation of session title and learning tasks
2	20 min.	Presentation	Introduction to forensic evidence
3	40 min.	Presentation	Clinical procedures for collecting and handling specimens as forensic evidence
4	20 min.	Presentation	Chain of custody and documentation of forensic evidence
5	10 min.	Presentation	Steps to maintain the chain of custody of forensics
6	15 min.	Presentation	Roles of health care provider and social welfare officer as factual or expert witness
7	5 min.	Presentation	Key points
8	5 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ or **ASK** participants to read the learning tasks and clarify.

ASK participants if they have any questions before continuing.

STEP 2: Introduction to forensic evidence (20 min.)

Definitions

- **Chain of evidence:** The process of obtaining, processing, and conveying evidence whereby movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigations, and legal action.
- **Evidence:** A piece of information indicating whether a belief is true or valid to establish facts in legal investigation or admissible as testimony in a court of law.
- **Forensic evidence:** (also known as medicolegal evidence) Evidence collected during a medical examination using scientific methods which can be used in court to link the suspect to the crime. This includes biological materials such as blood, hair, urine, sperm and seminal fluid, nails, and DNA, where available.
- **Crime:** an act committed or omission that constitutes a serious offense against an individual or the state and is punishable by law.
- **Physical evidence:** An exhibit in the form of objects, material, or substances (e.g., condoms, ropes, cigarette butts, masks) that support the investigation process in identifying the suspect in the crime.
- **Witness:** A person who sees an event take place or gives sworn testimony to a court of law or the police.

Purpose of forensic evidence: Forensic evidence is used to link the suspect to the crime (or de-link the suspect from the crime), to ascertain that violence occurred, and to help in collection of data on the perpetrator of violence.

Two types of evidence

- Evidence to confirm that assault has occurred, for example:
 - Evidence of penetration (torn hymen)
 - Bruises, tears, and cuts around the genitalia/anus
 - Stained clothes.
- Evidence to link the alleged perpetrators to the assault, for example:
 - Perpetrator's torn clothes
 - Used condoms
 - Grass and blood stains
 - Scratches and bite marks on the perpetrator
 - Eyewitness testimony.

Forensic materials to be collected

- Mouth swab
- Urine of both the victim and the suspect
- Pubic and/or head hair
- Foreign fibers, grass, soil
- Blood
- Semen
- Fingernails, scrapings or clippings.

NOTE: Different materials can be collected from objects, the body, or at crime location. Material collected can be from the suspect, victim, or witness.

STEP 3: Clinical procedures for collecting and handling specimens as forensic evidence (40 min.)

PRESENTATION

- Strictly adhere to the following principles when collecting specimens for forensic analysis:
- **Avoid contamination:** Ensure that specimens are not contaminated by other materials. Store each exhibit separately using clean containers and ensuring protection from weather and other contamination. Wear gloves at all times for your own protection and also to ensure that the exhibit is not contaminated.
- **Collect early:** Try to collect forensic specimens as soon as possible after the assault. The likelihood of collecting evidentiary material decreases with the passing of time. Ideally, specimens should be collected within 24 hours of the assault. After 72 hours, yields are reduced considerably.
- **Handle appropriately:** Ensure that specimens are packed, stored, and transported correctly. As a general rule, some fluids (e.g., urine) should be refrigerated; anything else should be kept dry. In some instances, blood can be dried on gauze and stored as such. Biological evidence material (e.g., body fluids, soiled clothes) should be packaged in paper envelopes or bags after drying. Avoid use of plastic bags.
- **Label accurately:** All specimens must be clearly labeled with the survivor's name and date of birth, the health care worker's name, the type of specimen, and the date and time of collection.
- **Ensure security:** Specimens should be packed to ensure that they are secure and tamperproof. Only authorized people should be entrusted with specimens.
- **Maintain continuity:** Once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded. Maintain an exhibit/evidence register at each facility. Ensure that the survivor does not move any samples taken from one facility to another for any analysis.
- **Document collection:** It is good practice to compile an itemized list in the survivor's medical notes/reports of all specimens collected and details of when, and to whom they were transferred.

General considerations for collection of various forensic materials

- If specimens are collected within 72 hours of the incident, injuries should be documented.
- Samples collected during this period, such as broad hour saliva and sperm, may help to support the survivor's story and identify the perpetrator.
- After 72 hours post-incident, the amount and type of evidence that can be collected will depend on the situation.
- When using swabs for the collection of various materials for forensic analysis:
 - Use only sterile cotton swabs (or swabs recommended by your laboratory).
 - Do not place the swabs in a medium as this will result in bacterial overgrowth and destruction of the material collected by the swab. Swabs placed in medium can only be used for the collection of bacteriological specimens.
 - Moisten swabs with sterile water or saline when collecting material from dry surfaces (e.g., skin, anus).
 - If microscopy is going to be performed (e.g., to check for the presence of spermatozoa), a microscope slide should be prepared. Label slide and after collecting the swab, rotate the tip of the swab on the slide. Both swab and slide should be sent to the laboratory for analysis.
 - All swabs and slides should be dried before sealing them in appropriate transport containers. A hole or cut may be made in the swab sheath to allow drying to continue.

Foreign material attached to a survivor's skin

- There are a number of ways in which foreign material attached to a survivor's skin or clothing can be collected.
 - If there is a possibility that foreign materials have adhered to the survivor's skin or clothing, s/he should be asked to undress over a large sheet of paper. Any loose material will fall onto the paper and can either be collected with a pair of tweezers, or the entire sheet of paper can be folded in on itself and sent to the laboratory.
 - Alternatively, the survivor's clothing can be collected and sent to the laboratory. If the clothing is wet, however, it should be dried before being packaged up, and sent to the laboratory without delay.
- Scalp and pubic hair
 - Collection of scalp hair is rarely required, but may be indicated if hair is found at the scene. About 20 hairs can be plucked or cut. Ask for guidance from the laboratory regarding the preferred sampling techniques for scalp hair.
 - The survivor's pubic hair may be combed if you are looking for the assailant's pubic hair. The combings should be transported in a sterile container.

- Materials from the mouth
 - Firmly wiping a cotton swab on the inner aspect of a cheek (i.e., a buccal swab) will collect enough cellular material for analysis of the survivor's DNA. Alternatively, blood may be taken. Buccal swabs should be dried after collection.
 - Buccal swabs should not be collected if there is any possibility of foreign material being present in the survivor's mouth (e.g., if ejaculation into the survivor's mouth occurred).

Toxicological analysis

- This may be indicated if there is evidence that a survivor may have been sedated for the purpose of a sexual assault. In cases where the survivor presents within 12–14 hours after possible drug administration, blood samples should be taken. Urine samples are appropriate when there are longer delays.
- Seek the advice of the laboratory regarding suitable containers for specimens of this type.

Other materials

- If the survivor scratched the assailant, material collected from under the survivor's nails may be used for DNA analysis.
- Sanitary pads or tampons should be air-dried if possible. They should then be wrapped in tissue and placed in a paper bag.

NOTES:

- All tests and results should be recorded on a laboratory form and/or register that includes name, registration number, date, age, sex, investigations done, specimens collected, results, and a place for anyone who takes possession of the specimens to sign in order to maintain a chain of custody of evidence.
- All GBV and VAC registers, including those that contain laboratory results, should be kept locked up and accessible only by authorized health facility personnel as a measure to preserve confidentiality.
- The above tests can be carried out on the survivor and also on the perpetrator.
- With regard to the perpetrator, the court can order that certain specific samples be collected.



REFER to Handout 2.4.1: Table of Different Materials and Procedures for Collection of Forensic Evidence

Procedures for storage and transportation of samples for forensic evidence

- Forensic evidence must be stored in a manner that ensures its integrity and maintains its availability while criminal investigations and judicial proceedings continue.
- Each item should be properly filed and marked.
- Biological samples should be dried before packaging to minimize sample degradation.

- Packing in paper is preferred, but liquid samples should be packed in glass or plastic containers.
- Dry stains, swabs, hairs, clothes, and nails are stored at room temperature.
- Wet samples and DNA extracts are stored frozen at -20°C .
- During transportation, avoid keeping evidence in a vehicle for a long time. Heat, cold and humidity can damage and destroy evidence.

STEP 4: Chain of custody and documentation of forensic evidence (20 min.)

- Health care providers are required to document evidence that can corroborate the survivor's account in a court of law.
- All the evidence collected should be recorded in the client case note file and on the GBV and VAC Medical Form.



Refer participants to Handout 2.4.1. GBV and VAC Medical Form

- All GBV and VAC registers, including those that contain laboratory results, should be kept locked up and accessible only by authorized health facility personnel to preserve confidentiality.
- Health care providers as expert witness are required to file the Police Medical Form Number 3 (PF3).



Refer participants to Handout 2.4.2: Police Medical Form Number 3

- The PF3 form is a form that police use to request medical examination of a survivor of an alleged offense. The form is also linked to the survivor receiving medical attention.
- The recent review of the PF3 and the procedures for receiving medical treatment when a PF3 is required to be filed resulted in the decision that survivors are required to get medical services immediately after the act, rather than having to go to a police station first to acquire a PF3 before they can receive medical attention. Police are required to provide the PF3 to the medical staff and survivors at the health facilities.
- Other forms to document forensic evidence include:
 - GBV and VAC Health Facility Register
 - GBV and VAC Consent Form for Adult and Child
 - Pictograms: Pictorial documentation is best to describe findings of physical examination, laboratory investigations, and results (Refer participants to National Guidelines for Health Sector Prevention and Response to GBV [MOHSW 20110]).
- Evidence should be released to the authorities only if the survivor decides to proceed with a legal case.
- All tests and results should be recorded on a laboratory form and register that contains the name, registration number, date, age, sex, investigations done, evidence collected, results, and a place for anyone who takes specimen to sign in order to maintain a chain of custody of evidence.

ACTIVITY: Demonstration: collecting and documenting forensic evidence

Note: This demonstration can be done along with that of Session 2.4

DEMONSTRATE collecting and document forensic evidence in a GBV Medical Form and Police Form Number 3.

ALLOW participants to do feedback demonstration.

PROVIDE Feedback to the participants on the missing points.

COMPLETE the demonstration as of session 4.

Step 5: Steps to maintain the chain of custody of forensics (10 min)

- Preserve sample/evidence integrity, the sample should be properly collected, packaged, and stored.
- Avoid tampering with the sample/evidence.
- Properly label and seal the sample to prevent tampering.
- The chain of custody form and the right and assurance form should be completed across all the levels of sample/evidence management.
- Other forms to document forensic evidence include:
 - GBV and VAC Health Facility Register
 - GBV and VAC Consent Form for Adult and Child
 - Pictograms
 - Pictorial documentation is best to describe findings of physical examination, laboratory investigations, and results.
 - Evidence should be released to the authorities only if the survivor decides to proceed with a legal case.

STEP 6: Roles of health care provider and social welfare officer as factual or expert witness (15 min.)

Responsibilities of health care providers and social welfare officers

- Collecting and handling the evidence and documenting all the forensic information that can be used as exhibit.
- Reporting medical findings in a court of law. The health worker who examines the survivor after the incident may be asked to report on the findings in a court of law. Providing such evidence is an extension of their role in caring for the survivor.

NOTE: It is a duty of the prosecutor to link the suspect to the crime, not the health worker or social welfare officer.

How to appear in court as witness

- As a general rule, all witnesses must be examined in open court under oath or affirmation. This means that they must swear or affirm (depending on their religious beliefs) to tell the whole truth and nothing but the truth.
- Use precise medical terminology.
- Answer questions as thoroughly and professionally as possible.
- If you do not know the answer to a question, say so. Do not make up an answer and do not testify about matters that are outside your area of expertise.
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of a question.

Three stages in the examination of a witness

- **Examination-in-chief:** In this stage the party calling the witness examines him/her. This means s/he asks the witness questions, the answers to which will support his/her case. The object of this examination-in-chief, therefore, is to let the witness give all the material facts that s/he knows and on which the case of the party calling him/her wholly or partly depends.
- **Cross-examination:** When the examination-in-chief is completed, the opposing party is given an opportunity to examine the witness. The purpose is to test the accuracy and truthfulness of the witness's statements, to destroy or weaken his/her evidence, to show that the witness is unreliable, or to extract from the witness evidence favorable to the party cross-examining the witness.
- **Re-examination:** After the cross-examination the party calling the witness will examine the witness again, if s/he so desires. The purpose of re-examination is, so to speak, to mend holes in or repair the damage done by cross-examination. It is the last opportunity a witness has to explain vague statements or apparent contradictions revealed in cross-examination.

NOTE: Examination of a witness must follow well-defined rules of evidence and must not be done haphazardly. For instance, during the examination-in-chief, the examiner, generally speaking, may not ask leading questions. The examiner may not cross-examine his/her own

witness unless the witness has turned hostile and the court has given the examiner permission to cross-examine the witness.

Step 7: Key Points (5 min.)

- Forensic evidence (also known as medicolegal evidence) is the evidence collected during a medical examination using scientific methods.
- Forensic evidence includes biological materials such as blood, hair, urine, sperm and seminal fluid, nails, and DNA, where available, which can be used in court to link the suspect to the crime.

Step 8: Evaluation (5 min.)

- List materials and describe procedures for collection of forensic evidence.



Handout 2.4.1: Table of Different Materials and Procedures for Collection of Forensic Evidence

SITE	MATERIAL	EQUIPMENT	SAMPLING INSTRUCTIONS
Anus (rectum)	Semen	Cotton swabs and microscope slides	Use swab and slides to collect and plate materials. NOTE: Lubricate instruments with water only, not lubricant.
	Lubricant	Cotton swab	Dry swab after collection.
Blood	Drugs	Appropriate tube	Collect 10 ml of venous blood.
	DNA (survivor)	Appropriate tube	Collect 10 ml of blood.
Clothing	Foreign adherent (e.g., semen, blood, hair, fibers)	Paper bags	Clothing should be placed in a paper materials bags. Collect paper sheet or drop cloth. Wet items should be bagged separately.
Genitalia	Semen	Cotton swabs and microscope slide	Use separate swabs and slides to collect and plate material collected from the external genitalia, vaginal vault, and cervix. Lubricate speculum with water not lubricant, or collect a blind vaginal swab.
Hair	Comparison to hair found at scene	Sterile container	Cut approximately 20 hairs and place hair in sterile container.
Mouth	Semen	Cotton swabs, sterile container (for oral washings) or dental flossing	Swab multiple sites in mouth with one or more swabs. To obtain a sample of oral washings, rinse mouth with 10 ml water and collect in sterile container.
	DNA (survivor)	Cotton swab	
Nails	Skin, blood, fibers, etc. (from perpetrator)	Sterile toothpick or similar or nail scissors/clippers	Use the toothpick to collect material from under the nails, or the nails can be cut and the clippings collected in a sterile container.
Sanitary pads/tampons	Foreign material (e.g., semen, blood, hair)	Sterile container	Collect if used during or after vaginal or oral penetration.
Skin	Semen	Cotton swab	Swab sites where semen may be present.

SITE	MATERIAL	EQUIPMENT	SAMPLING INSTRUCTIONS
	Saliva (e.g., at sites of kissing, biting or licking), blood	Cotton swab	Dry swab after collection.
	Foreign material (e.g., vegetation, matted hair or foreign hairs)	Swab or tweezers	Place material in sterile container (e.g., envelope or bottle).
	Injuries	Pictogram/photo	Record when there is physical harm or injuries.
Urine	Drugs	Sterile container	Collect 100 ml of urine.



Handout 2.4.2: Police Form Number 3



TANZANIA POLICE FORCE MEDICAL EXAMINATION REPORT

PART I: REQUEST FOR MEDICAL EXAMINATION

(To be completed by Police Officer requesting Medical Examination)

CASE FILE NO.....

POLICE STATION.....

TO: THE MEDICAL PRACTITIONER

.....
.....

Dear Sir/Madam,

I have the honour to request for Medical Examination
of..... (Male/Female)

Age..... who is sent to hospital/health center/dispensary on this day of
.....20..... Please furnish me with brief examination results
and/or findings of the nature and extent of bodily injuries sustained by the person named
herein above.

Date and details of the alleged offence:

.....
.....
.....

Name, Signature of Requesting Officer and Stamp

N.B: The investigating officer should sign for all specimens or items collected and sealed by
the Medical Practitioner.

PART II: MEDICAL DETAILS OF THE ALLEGED CASE

(To be completed by Medical Practitioner carrying out examination)

Personal/Patient/File No..... Date.....Time.....

GENERAL INFORMATION:

(i) Nature of complaints

.....
.....

(ii) Estimated age of the person

.....Gender.....

(iii) General physical/mental examination (e.g., general appearance, bruises, bites, use of drugs, alcohol and demeanor)

.....
.....
.....

(iv) General Medical History (including details relevant to the offence)

.....
.....
.....

(v) Condition and appearance of clothes including inner garments (e.g., presence of tears, blood stains, fluid)

.....
.....
.....

(vi) Name of the guardian and relationship with the person examined (for a minor or mental case)

.....
.....

PART III: ASSAULT, ACCIDENT AND OTHER CASES

(To be completed by Medical Practitioner)

(i) Approximate age of injuries (e.g., hours, days or weeks)

.....

(ii) Treatment (if any received prior to examination)

.....

(iii) Description of site, situation, shape and depth of injuries sustained

.....

.....

.....

.....

(iv) Type of weapon or object used

.....

(v) Immediate degree of the clinical result of the injury sustained (e.g. whether injury amounts to "harm", "grievous harm" or "maim"*)

.....

(vi) Details of specimens collected

.....

.....

Comments:

.....

.....

*Definitions:

"Harm" means any bodily hurt disease or disorder whether permanent or temporary.

"Grievous harm" means any harm which amounts to maim or dangerous harm, or seriously or permanently injures health, or which is likely so to injure health or which extends to permanent disfigurement or to any permanent or serious injury to any external or internal organ, member or sense.

"Maim" means the destruction or permanent disabling of any external or internal organ, member or sense.

PART IV: SEXUAL ASSAULT CASES

(To be completed by Medical Practitioner after Part II & III)

A: GENERAL

(i) Nature of Complaints

.....

.....

(ii) Estimated age of person examined

B: FEMALE

(i) Describe the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix, and anus and establish evidence of penetration

.....

.....

(ii) Note the presence of venereal infections or any discharge, blood from genitalia/anus

.....

.....

(iii) Details of specimen or smears collected including pubic hairs, and blood

.....

.....

C: MALE

(i) Describe the physical state of and any injuries to genitalia including anus and establish penetration in case of anal intercourse

.....

.....

(ii) Note the presence of venereal infections or any discharge around anus and penis

.....

.....

(iii) Details of specimen or smears collected including pubic hairs and blood

.....
.....

MEDICAL PRACTITIONER'S REMARKS:

.....
.....
.....
.....

Name and Signature of Medical Practitioner:

Name.....Qualifications.....

Registration Number.....

Signature.....

Date..... Official

Stamp

Session 2.5: Psychosocial Care and Support

Total session time: 120 minutes

Prerequisites: None

Learning Tasks:

By the end of this session participants are expected to be able to:

- Describe psychosocial care and support for GBV and VAC survivors.
- Describe the importance of psychosocial care and support to GBV and VAC survivors.
- Identify psychosocial needs of GBV and VAC survivors.
- Use different approaches for provision of psychosocial care and support to GBV and VAC survivors.
- Conduct trauma counseling to GBV and VAC survivors.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/white board and chalk/whiteboard markers, computer, LCD.
- Scripts for role-players (These need to be given to the role-players in advance for preparation).

SESSION OVERVIEW

Step	Time (Min.)	Activity/Method	Content
1	5	Presentation	Presentation of session title and learning tasks
2	10	Presentation	Definition of psychosocial care and support
3	20	Presentation	Importance of psychosocial care and support for GBV and VAC survivors
4	30	Presentation Buzzing Role-play	Basic psychosocial needs
5	45	Presentation	Conducting trauma counseling for GBV & VAC survivors
6	5	Presentation	Key Points
7	5	Presentation	Evaluation
Total	120		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

READ or ASK participants to read the learning tasks and clarify.

ASK participants if they have any questions before continuing.

STEP 2: Definition of psychosocial care and support (10 min.)

PRESENTATION

- **Psychosocial care and support** is the process of meeting a person's emotional, social, mental, and spiritual needs that are essential elements of positive human development. This support is intended to help the individual achieve wellbeing with regard to his/her connections within the community, as well as determine how a person, adult or child, feels and thinks about himself or herself and about life.
- Survivors of GBV and VAC often develop psychological problems. The extent of psychological consequences depends on several factors, including the individual degree of trauma and resilience.
- Appropriate psychosocial care and support helps VAC and GBV survivors and their families overcome challenges and builds coping mechanisms, trust, and hope for their future.

Step 3: Importance of psychosocial care and support for GBV and VAC survivors (20 min.)

PRESENTATION

Psychosocial care and support provides the following:

- Helps to meet emotional and spiritual needs in addition to meeting GBV and VAC survivors' other material needs, such as food, clothes, shelter, and medical care.
- Helps in the development of the survivor's self-esteem.
- Creates psychological autonomy for GBV and VAC survivors.
- Brings about a sense of personal mastery/control and capacity for behavioral regulation.
- Facilitates negotiation and bargaining life skills to approach problems in an adaptive and acceptable manner.
- Brings a sense of self-acceptance and confidence to VAC and GBV survivors.
- Helps reduce the impact of stigma as a result of the survivor's socioeconomic status.

NOTE: Psychosocial care and support in GBV and VAC is essential to providing ongoing psychological assistance, which requires the training and ongoing supervision of social workers, health workers, community services workers, the police, and justice workers, who confidentially gather and document client data and facilitate referrals to other services.

Remember: Social workers are case managers who have skills in how to handle survivors' cases and to manage linking and referring survivors accordingly. These case managers also make use of multisectoral collaboration between local and international nongovernmental organizations to provide medical, legal, security/protection, psychosocial and community support services; to build the capacity of individuals and systems to address the causes of GBV and VAC through a coordinated, integrated multi-disciplinary approach among the health, psychosocial, protection, and legal justice sectors; and to promote the full participation of the target communities.

Step 4: Basic psychosocial needs of GBV and VAC survivors (30 min)

PRESENTATION

Identification of psychosocial needs of GBV and VAC survivors

ACTIVITY: Buzzing (5 min.)

ASK them to buzz on the basic psychosocial needs of GBV and VAC survivors for 3 minutes.

ASK a few of them to present their responses in 2 minutes.

CLARIFY their responses using the information below.

- **Physiological needs:** These are basic needs that include food, nutrition, shelter, health services, and care (especially for a child survivor), which a survivor may not be able to easily access on his/her own. These are the primary or material needs any human being should receive.
- **Safety and security needs:** This is the second category of needs that any survivor must be assured of, especially child survivors. Many children have problems that derive from their past experiences of insecurity. These children need protection and care from their parent/caregivers. Women may also be vulnerable due to cultural influences that force them to suffer in silence.
- **Need for a sense of belonging:** Children who are separated from their biological parents can experience pain. This deprivation compels them to seek a sense of belonging.
- **Achievement needs:** A child needs to be given opportunities where s/he can see the achievement of his/her own deeds. This crucial psychological need can only be fulfilled by the parent or a substitute caregiver who plays the role of parent. Deprivation of opportunity constrains development of the child's potential or can delay her/his full development. Therefore, this need is very important for the child's intellectual development.
- **Self-esteem:** These are the resources that enable an individual to develop feelings about herself or himself. People with good self-esteem have confidence in their abilities and the expectation that they will be successful. Children develop their own way of thinking, making decisions, and behaving. Thus if not properly guided, they become a source of problems rather than joy in their families.

- **Self-actualization:** Psychologically, humans are driven by an urge or desire to perform well. Through this an individual affirms what he has achieved and that he expects to be successful. However, this is largely influenced by the existing home or community environment. In this regard, families play a crucial role in ensuring that the child grows up positively.

STEP 5: Conducting trauma counseling to GBV and VAC survivors (45 min.)

Trauma counseling is a short-term intervention when a person has suffered a traumatic incident. Trauma comes in degrees of severity; it can include events such as divorce, job loss, death, mugging, armed robbery, rape, car accident, illness, failing an exam, losing one's car or house—in fact any event that a person regards as negative and that changes his/her view of his/herself and the world.

- Trauma counseling supports a person in identifying and coming to terms with the feelings and emotions s/he may feel during and after a traumatic experience. These emotions will vary from individual to individual, but the most commonly experienced emotions are anger and fear.
- Medical care for survivors of rape or sexual violence includes referral for psychological and social problems, such as common mental disorders, stigma, isolation, substance abuse, risk-taking behavior, and family rejection.

Steps in trauma counseling

- Establishing therapeutic alliance
- Remembrance and mourning
 - Story-telling transforming
 - Traumatic memories.
- Reconnection
 - Reconnecting with self, family, community, and support networks
 - Assessing and focusing on strengths, interests, goals
 - Building confidence, self-worth, self esteem
 - Establishing and developing positive coping strategies.


Techniques for facilitating communication in counseling

- **Nonverbal language:** Provides information on the emotional state of the client, as well as the relationship established with her/him. It concerns:
 - Facial expressions
 - Body posture
 - Physical distance between the counselor and the client
 - Tone of voice
 - The appearance of the counselor and the way s/he is dressed

- Questioning
 - Open-ended questions
 - Closed-ended questions
- Summarizing/reflecting client's words
- Reframing events, ideas/thoughts, and emotions/feelings

The Phases of Assessment: The GATHER Model

- **Greet:** Establish rapport, clarify goals of meeting, and explain confidentiality.
 - Give your name and ask by what name s/he would like to be called.
 - Carefully introduce yourself. Explain who you are and what your responsibilities are.
 - Avoid technical language.
- **Ask:** Ask the client for a brief explanation of how you may assist him/her (i.e., why s/he is seeking assistance). Ask specific questions about the exposure to violence.
 - Begin by saying what you already know about the person, such as "I know you were sent to me by the women's group...."
 - Ask a broad question to start.
- **Tell:** If the survivor acknowledges experiences of violence, offer validation and support. Reassure him/her that you will try to assist him/her.
 - Reassure the survivor that you will stay with him/her "for as long as it takes."
 - Repeat, if necessary, the confidentiality rule.
 - Acknowledge that you are a stranger, a new person in his/her life, but that you are ready to listen and to make sure that s/he is ok.
 - Use small support statements when needed:
 - *"I'm glad you came here."*
 - *"It's good you are telling me these things."*
 - *"I'm sorry this happened to you."*
 - *"You are safe here" (if this is true).*
 - *"What would it take for you to feel safe here?"*
 - *"It's okay to feel..."*
 - *"Your feelings are not any different than any other woman (girl, boy, man)."*
 - *"You are not to blame."*
 - *"It's not your fault."*
 - *"You aren't responsible for what happened."*
 - *"What you are feeling is normal for someone who has been through what you have."*
 - *"If you want to stop at any time, we can. Just tell me."*
 - *"If you remember anything else, we will stop what we're doing and talk."*

- **Help:** Once rapport has been established and you have identified the basic concerns of the survivor, it is important to conduct a more thorough assessment to better understand her/his experiences of GBV and to identify related needs.
 - Use active listening skills to help the survivor to tell his/her story
 -  Refer to Handout 2.5.1 on "Disconnect Exercise."
 - Start with broad questions, followed by specific questions for clarification.
 - Reassure the survivor that you will be patient and s/he should not hurry through the account:
 - *"We can take as long as you need."*
 - *"I'll wait."*
 - *"That's okay, take your time."*
 - Never say that you "understand how s/he feels" or that you "know." It is impossible to know how the survivor must feel.
- **Educate:** Reflect back to the survivor what you have understood his/her needs are and what you have heard as possible stress reactions. Provide information to the survivor that will help normalize his/her reactions.
 - Summarize what you understood the survivor's needs are.
 - Emphasize his/her strengths:
 - *"You had the courage to come here today."*
 - *"You managed to tell your story and to tell me what you need."*
 - Work with the survivor to identify coping mechanisms to respond to stress.
 - Reassure the survivor that his/her feelings and needs are normal.
- **Refer, Return, Review:** Be prepared with a list of referrals that may assist the survivor. Schedule a follow-up if possible. Review the plan with the survivor.

How to manage resistance

- Accept the client (and her/his ambivalences and contradictions).
- Highlight the client's ambivalence (ask suggesting question, analyze good and bad reasons).
- Highlight contradictions through reframing.
- Reconstruct the reality (the facts and the feelings) in order to construct a more realistic point of view.
- Invite the client to take into consideration other points of view.
- Empower her/his self-efficacy.
- Facilitate self-motivating assumptions.
- Accept failure.

Activity: Role-play: Conducting Trauma Counseling

GET the class ready for role-play and assign roles.

ASSIGN the role of observer to the rest of the participants.

ALLOW The role-players (who had been prepared before) to conduct the role-play while others observe.

STOP the role-play when the skills for trauma counseling to the survivor have emerged/displayed (at about 20 min.).

LET the role-players evaluate themselves and share their feelings during role-play.



REFER participants to Handout 2.5.2: Observer's Checklist for Counseling Skills

LET the observers also provide comments.

PROVIDE feedback for the role-play.

DEROLE the players.

Guidelines for follow-up appointments

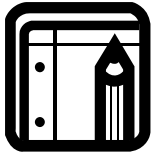
- Receive the client in a welcoming manner.
- Let him/her tell you if there are changes in her/his situation (by starting with an open-ended question).
- Evaluate changes in physical, psychological, and socioeconomic circumstances, coping strategies, and actions taken and their results.
- Let the person express feelings, memories, ideas, needs, desires, and plans.
- Acknowledge and empower the client, reflect with her/him on what is helpful and what is not.
- Assist the client to redefine the problem, set up new or the same priorities, reach viable solutions.
- Define the agreement.
- Explain your feedback modality (how you will provide feedback to the client).
- Thank the client.
- Register the case.

STEP 6: Key Points (5 min.)

- Psychosocial care and support to GBV and VAC is essential to provide ongoing psychological assistance.
- Psychosocial counseling follows the same format typical of counseling sessions, but goes deeper in the phases of listening, analyzing, and giving feedback.
- Always seek to refer the survivor to other services, if s/he agrees to them.
- Creating a good referral network prevents you from feeling like you must meet all the survivor's needs alone. It also helps the survivor to integrate or reintegrate into his/her community.

STEP 7: Evaluation (5 min.)

- What is psychosocial care and support?
- What are importance of psychosocial care and support to GBV and VAC survivors?
- What is counseling?
- What are the types of counseling?



Handout 2.5.1: Disconnect Exercise

A 19-year-old girl came to your center. After an interview you find out that she was raped two days ago while going home. She also discloses that she was wearing a “mini” skirt that left half of her thighs visible. The survivor then asks you the following questions:

Guiding Questions	Column A: Responding to the survivor’s statement	Column B: How you honestly feel about the survivor	Column C: A response that is more honest and sensitive to the survivor’s emotional state
Why me?			
Was this my fault?			
What if my family knows?			
Is there a God?			
Who will accept to marry me?			



Handout 2.5.2: Observer's Checklist for Counseling Skills

Observation Item	Yes	No
Reception of survivor at the clinic—welcoming approach		
Establishment of trust		
Interpersonal communication skills (e.g., listening skills, encouragement, and positive support)		
Fostering comfort		
Family planning/contraception advice and information on range of contraceptives available		
Involvement of the survivor in decision-making		
Counseling skills: showing concern, paraphrasing, nodding, smiling		
Information for follow-up services		

MODULE 03: PREVENTION OF GBV AND VAC

This module is aimed at refreshing participants on aspects of prevention of GBV and VAC. Module 3 comprises three sessions:

- 3.1: Prevention and Behavior Change Communication in GBV and VAC
- 3.2: Life Skills in the Prevention of GBV and VAC
- 3.3: Multisectoral Approach to Prevention of GBV and VAC

Session 3.1: Prevention and Behavior Change Communication (BCC) for GBV and VAC

Total session time: 120 min.

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Explain levels of GBV and VAC prevention.
- Define the term behavior change communication.
- Describe BCC model in prevention of GBV and VAC.
- Explain challenges of BCC.
- Use BCC model to change behavior in GBV and VAC prevention.

Resources Needed

- Marker pens, masking tape, flipchart or chalk/whiteboard, chalk/whiteboard markers.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction to the session and learning tasks
2	30 min.	Presentation	Explain levels of GBV and VAC prevention
3	30 min.	Presentation	Definitions of BCC
4	20 min.	Presentation	Stages of behavior change and approach
5	10 min.	Presentation	Challenges of BCC
6	15 min.	Presentation	Use of BCC in changing community behavior in relation to GBV and VAC
7	5 min.	Presentation	Key Points
8	5 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Introduction to the session and learning tasks (5 min.)

READ or **ASK** participants to read learning tasks.

ASK participants if they have any questions before continuing.

STEP 2: Levels of GBV and VAC prevention (30 min.)

GBV Prevention

Prevention of GBV can be addressed at four levels: primordial, primary, secondary, and tertiary.

Primordial Prevention

Primordial prevention includes all actions taken before the occurrence of a problem in a population. The purpose in this level is to avoid the emergence and establishment of the social, economic, and cultural patterns of living that are known to contribute to the occurrence of GBV and VAC. Possible interventions may include:

- Advocate for gender equality to enhance the status of women and promote gender equity and equality.
- Mainstream gender into existing programs (e.g., school health programs, voluntary counseling and testing, care and treatment centers).

Primary Prevention

Primary prevention can be defined as all actions taken to reduce the chances for emergence of more cases of the problem. The purpose of primary prevention is to reduce the incidence of GBV health-related problems by addressing the precipitating causes and determinants. These factors can be addressed in different ways, such as:

- Sensitize and advocate for raising community awareness of various aspects of GBV, (e.g., domestic violence and intimate partner violence) and their negative consequences for women, men, families, and the community at large.
- Strengthen communities' networking (protection work force) through better planning, training, and support.
- Help communities organize GBV committees to reduce harmful traditional practices, behaviors, and customs contributing to GBV.
- Create open dialogue with community members about GBV issues at all levels in the community.

Primary Prevention for Children

- Primary prevention strategies often seek to strengthen family functioning.
- Primary prevention supports children to know and advocate for their rights.

- The philosophy behind primary prevention is that keeping children safe from abuse and neglect is the responsibility of the entire community.
- The long-term goal of primary prevention is to educate the entire community to create social change that is intolerant of child maltreatment.

Examples of Primary Prevention Strategies

- Educate parents to increase their knowledge and understanding of children's growth and development and to teach them about managing homes and families.
- Educate parents to increase their knowledge and understanding of how their own upbringing influences occurrence of GBV and VAC.
- Encourage communication between parents and their children to enhance bonding.
- Increase parents' skills in coping with the stresses of caring for children with special needs.
- Conduct life skills training that helps children and young adults learn interpersonal communication skills.

Secondary Prevention

Defined as all actions done to halt the progress of the problem at its incipient stage and prevent complications. The purpose is to ensure early detection and management of GBV health-related problems. Possible interventions may include:

- Screening patients/clients to detect forms of GBV.
- Managing physical injuries and psychological effects on survivors.
- Managing the underlying mental health problems of perpetrators.

Secondary Prevention for Children

Possible secondary prevention strategies may include:

- Link parents or guardians of abused children to resources or services in the community (e.g., legal sector, police, and social welfare) for support.
- Refer parents with depression or substance abuse issues for psychosocial support when it appears that they have been involved in abusing their children.

Tertiary Prevention

Defined as all the measures available to reduce or limit impairments and disabilities, and to promote GBV survivors in adjustment to irremediable conditions.

The purpose of tertiary prevention is to limit disabilities and to rehabilitate affected individuals. Possible interventions include: counseling, shelter provision, legal support, and establishment of crisis centers for GBV survivors. In places where these interventions are available, mitigation of impact of violence helps to reduce the cycle of violence.

Tertiary Prevention for Children

Tertiary prevention focuses on increasing protection for children who have experienced abuse and will require more intensive or long-term care to promote recovery and reintegration. Preventive strategies to mitigate the impact of violations include:

- Conduct individual and family counseling aimed specifically at the child's recovery and reintegration. Seek alternative care for children removed from their families of origin.
- Support specialized health services, such as post-rape care, and specialized education services, particularly for children who have missed years of school.
- Refer parents/guardians of the children for legal support to bring charges against perpetrators and facilitate permanent placement for children removed from their families.

STEP 3: Definitions of BCC (30 min.)

ACTIVITY: Buzzing (2 min.)

ASK participants to buzz in pairs for 2 minutes on the "meaning of BCC."

ALLOW participants to respond.

WRITE answers from a few pairs on the flipchart/board and allow others to fill in the gaps.

CLARIFY their answers using the information below.

Behavior Change Communication

- BCC is a process that motivates people to adopt and sustain healthy behaviors and lifestyles.
- Sustaining healthy behavior usually requires a continuous investment in BCC as part of an overall health program.
- Many health and development programs use BCC to improve people's health and wellbeing, including GBV and VAC.

The Role of BCC

BCC is an integral component of a comprehensive GBV and VAC prevention, care, and support program. It has a number of different but interrelated roles. Effective BCC can:

- **Increase knowledge:** BCC can ensure that people are given the basic facts about GBV and VAC in a verbal or visual medium (or any other medium that they can understand and relate to).
- **Create demand for information and services:** BCC can spur individuals and communities to demand information on GBV and VAC from the appropriate services.
- **Advocate:** BCC can lead policymakers and opinion leaders toward effective approaches against GBV and VAC.
- **Improve skills and sense of self-efficacy:** BCC programs can focus on teaching or reinforcing new skills and behaviors, such as condom use, negotiating safer sex, and safe

injecting practices. It can contribute to development of a sense of confidence in making and acting on decisions.

Main Methods of BCC

- Interpersonal communication is the preferred choice for targeted interventions as it involves sustained contact and communication with the target population.
- Mass media can be used to support interpersonal communication efforts and the creation of an enabling environment.

Guiding Principles of BCC

BCC should be conducted in line with the following principles:

- Reinforcement follows behavior and is contingent upon it. Performance produces the reinforcement.
- Seek and reinforce positive or appropriate behaviors, and if possible, ignore inappropriate behaviors. For example, much of student behavior (appropriate and inappropriate) is reinforced by attention received from others.
- Reinforcement should be immediate. Immediate reinforcement has the greatest strengthening effect on behavior. If the reinforcement is delayed, it will probably influence some behavior other than the one specified.
- Reinforcement should be contingent on accomplishment rather than obedience. Wording is very important. When you reinforce accomplishment, you help the survivor build independence. Rewards for obedience lead to continued dependence.
- Reinforce small approximations to the goal. Make initial requirements easy to achieve—not too difficult, too long, too precise, or too complex. Establish early success. Then increase requirements until the ultimate goal is reached.
- Reinforce frequently with small amounts. Small but frequent reinforcements are more effective than a few big ones. This is especially true in the early stages of learning any new skill or behavior pattern.
- Start with the action closest, asking supporters to build a chain of connected behaviors. This means start with the last action of the chain and build by adding elements backward which are increasingly further from the reinforcement.
- Be consistent—follow through every time with the plan you develop.
- Monitor performance; evaluate and adjust plans. Keep a chart of the behavior change and share it with the survivor. Change the plan when a goal is achieved or when the current plan is clearly not working satisfactorily.
- Be patient.

STEP 4: Stages of behavior change and approach (20 min.)

1. **Precontemplation:** Encourage awareness and value change.
2. **Early contemplation:** Promote benefits of the new behavior.
3. **Late contemplation:** Reduce the costs involved in adopting new behavior (including financial costs and barriers to access), foster social support, and teach relevant skills necessary for the behavior change.
4. **Preparation for action:** Personalize risks and benefits, start deliberate decision making, and increase self-efficacy and self-esteem and perception of positive change among the peer group.
5. **Action:** Reward and support change.
6. **Maintenance:** Continue support of the behavior change.

Stage 1—Precontemplation: This is about fostering the power within ourselves to address the connection between violence against women and HIV and AIDS—engaging only a small selection of additional community members.

Stage 2—Contemplation: This stage is about awareness, which engages the community to become aware of men’s power over women and how the community’s silence about this power imbalance perpetuates violence against women and its connection to GBV and VAC.

Stage 3—Preparation for action: This is about engaging the community in offering support to one another—joining their power with others to confront the dual pandemics of GBV and VAC.

Stage 4—Action and maintenance: The action phase is about using one’s power *to* create positive change. Its engages the community in using their power *to* take action, with an aim to normalize shared power and non-violence, demonstrate their benefits, and as a result, prevent GBV and VAC.

Example: Campaigns such as “Tuko Wangapi” and “Kuwa Mfano wa Kuigwa.”

STEP 5: Challenges of BCC (10 min.)

ACTIVITY: Buzzing

ASK participants to buzz in pairs for 2 minutes on “challenges of behavior change communication.”

ALLOW participants to respond.

WRITE a sample of their answers on the flipchart/board.

CLARIFY their responses using the information below.

Culture

- Understand culture
 - Beneficial (promote)
 - Existential (leave as is)
 - Negative (replace, eliminate)
- Be clear about which behavior to change.
- Be a facilitator of change and not dictator of change.

Behaviors

- Understand behaviors
 - Deeply rooted behavior—use interpersonal approach.
 - New behavior—use mass media.
 - Promote interactive approaches.
 - Reinforce messages from multiple trusted sources.
 - Compare adopters and non-adopters—why the difference?
 - Start with strategies that work!
 - Start with those who are close to adopting behavior (90 percent, 80 percent).
 - Move to the next level (higher knowledge and positive attitudes).
 - Think about new ways of addressing those with entrenched behaviors.
- Other challenges
 - Economic—situations that can hinder positive decisions for behavior change
 - Environmental—circumstances that may cause resistance
 - Social—norms that go against certain required changes
 - Beliefs—beliefs that advocate against certain behaviors, such as use of condoms
 - Myths and misconceptions—acceptance of wrong facts, such as condoms have viruses.

STEP 6: Use of BCC in changing community behavior in relation to GBV and VAC (15 min.)

- Raising awareness and changing attitudes, cultural and social norms, and behaviors are essential for preventing and responding to GBV and VAC.
- BCC programs can contribute to improving the community response to GBV and VAC in developing support systems to facilitate survivors' access to assistance.
- BCC programs could be made more effective by recognizing that many health focus areas—such as HIV or family planning—are linked to GBV and VAC, hence problems should be addressed simultaneously.
- BCC strategies complement other GBV and VAC prevention and response initiatives by changing the social environment and raising women's awareness of services.



REFER participants to Handouts 3.1a and 3.1b on stages of change and ecological model of behavior change.

STEP 7: Key Point (5 min.)

- Explain the use of BCC in GBV prevention and response.

STEP 8: Evaluation (5 min.)

- What is BCC?
- What are the stages of the BCC approach?
- Mention the importance of BCC in GBV prevention and response.



Handout 3.1a: BCC Poster 1

WE MUST WORK TOGETHER TO STOP WIFE-BEATING

Wife-beating is spoiling our communities and our country.
This is not a private family matter. We must all help to stop it.

WHAT CAN MEN DO?

Do not hit your wife or children.

Learn how to “Take it Easy” and control your temper (see next section).

Tell people in your community about the problems that wife-beating causes, and that it is against PNG's laws.



Help stop wife-beating when you see it happening.



Offer help to women whose husbands hit them, like a safe place to stay for a while.



Take strong action against men who hit their wives.
Get a **Preventive Order** from the Village Court, or District Court, or report to police.

“Take it Easy”

When you feel yourself starting to get angry, **STOP** and **THINK!**



Go away until you feel calm again.



DO something to cool down, like go walking, talk with someone you respect, dig the garden, or read the Bible.

Do NOT drink alcohol.

Come back and talk with your wife.
LISTEN to each other.



Remember:

A real man does not hit women. He knows how to deal with problems by talking.

Hitting only causes more problems.

Information for Men

MEN HAVE THE POWER TO STOP WIFE-BEATING



WIFE-BEATING HURTS OUR FAMILIES



Department of Health



Handout 3.1a: BCC Poster 2

WIFE-BEATING HURTS CHILDREN

In families where the father hits the mother, health workers find that the children's health suffers, and they do not grow so well.



The children are worried, their school work suffers, and they may have behaviour problems.



Wife-beating teaches children to accept violence as normal, and to be violent themselves.



If the mother is hit when she is pregnant, it will hurt the unborn baby, and it can affect the birth.

WIFE-BEATING HURTS WOMEN'S HEALTH

Injuries to the woman's body mean she cannot look after herself or the family properly.



If she is hit on the head, this can cause brain damage, or it can make her become deaf or blind.



It affects her mental health. She is afraid and worried, and may lose interest in life.

Wife-beating is against the Law

Men and women have the same rights under the National Law of PNG.

Paying brideprice does not give a man the right to hit his wife.

WIFE-BEATING HURTS FAMILIES

Wife-beating causes families to break up.



If the man forces the woman to have sex, she may have children too close together. This makes the woman and the children weak.



If the man has an STI (sexual sickness from having sex with other people) he can give it to his wife if he makes her have sex. This can stop her from having children.



If the man has the HIV or AIDS sickness and has sex with a woman, she will get it too. The baby can also get the sickness.

Source: UNFPA. 2010. ADDRESSING VIOLENCE AGAINST WOMEN AND GIRLS IN SEXUAL AND REPRODUCTIVE HEALTH SERVICES: A REVIEW OF KNOWLEDGE ASSETS

Session 3.2: Life Skills in the Prevention of GBV and VAC

Total session time: 90 minutes

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Define life skills.
- Identify essential life skills in prevention of GBV and VAC.
- Demonstrate appropriate life skills in prevention of GBV and VAC.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers, Computer and LCD.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	15 min.	Buzzing Presentation	Define life skills
3	30 min.	Presentation Small group activity	Identify essential categories of life skills in prevention of GBV and VAC
4	30 min.	Presentation Large group activity	Demonstrate appropriate life skills in prevention of GBV and VAC
5	5 min.	Presentation	Key points
6	5 min.	Presentation	Evaluation
Total	90 min.		

SESSION CONTENT

Step 1: Presentation of session title and learning tasks (5 min.)

INTRODUCE the session, including the title and duration.

READ or ASK participants to read the learning tasks.

CLARIFY each objective.

STEP 2: Define life skills for prevention of GBV and VAC (15 min.)

ACTIVITY: Buzzing (2 min.)

ASK participants to buzz in pairs for 2 minutes on the “meaning of life skill.”

ALLOW participants to respond.

WRITE answers from a few participants.

CLARIFY their answers using the information below.

PRESENTATION

What are life skills?

WHO defines life skills as “skills and ability to adopt positive behavior so as to avoid problems that are present in everyday life.” It also means cognitive, emotional, interpersonal, and social skills that enable individuals to deal effectively with the challenges of everyday life.

- People need skills for avoiding such calamities as HIV and STIs, among others, so as to live a healthy life.
- Studies show that most children aged 0–8 years in Tanzania may not reach their full potential in growth and development. Therefore, children need support through life skills training to enable them cope with life’s challenges such as GBV and VAC. Examples of interventions include:
- Preschool enrichment and social development programs that target children early in life that can prevent aggression, improve social skills, boost educational achievement, and improve job prospects.
- Incentives for youths to complete education to increase their chances of finding employment (employed or self-employed), thus diverting them from crime.
- In practice, these types of programs often overlap; for example, preschool enrichment and social development programs are frequently combined in interventions for young children.
- Interventions targeting adolescents can include both academic enrichment and incentives for completing education.
- The evidence for preschool enrichment and social development programs is by far the most robust, with high-quality studies associating these early interventions with reduced aggressive behavior and violent crime in childhood and later in life.
- Evidence for the effectiveness of academic enrichment, incentive, and vocational training programs, however, is currently limited.

STEP 3: Identify essential categories of life skills in prevention of GBV and VAC (30 min.)

ACTIVITY: Brainstorming (5 min.)

ASK participants to brainstorm for 5 minutes in a large group on how life skills can be applied by youth and adolescents.

CLARIFY points and emphasize those applied in GBV and VAC as indicated in the points below.

Life skills categories

Life skills are important because they give children and young people more control to improve their lives. The life skills program work can have an impact on the behavior and choices made by children. While focusing on teaching life skills, it is important to keep an eye on the three other key areas that work with life skills. Ten life skills can be grouped into three broad categories:

- Skills for self-awareness
- Skills for thinking
- Skills for interpersonal relationships

Skills for self-awareness

- Developing self-awareness
- Coping with emotions
- Coping with stress

Self awareness is:

- Understanding who you are, your sex, environment, religion, race, your culture, together with your place in the family and society.
- Clear awareness of your responsibilities to yourself, your family, your society, your country, and the world at large.
- Understanding your needs and what your values stand for in your decisions.
- Clear knowledge of your health needs so that you can care for your body.
- Clear understanding of the relationships you want so that you can set boundaries in those relationships.
- Ability to make decisions that guard you and enough assertiveness to defend your decisions.

Skills in self-awareness will enable the individual to understand his/her responsibilities in the following areas:

- Take responsibility for yourself to retain good health—Remember your body is the most valuable item in the whole world.
- You need to do all that is required of you by your family.

- You have responsibility to your society. If you are a civil servant, religious leader, young person, or adult citizen, there are responsibilities that you owe the society. Identify them and meet them.
- Acting on your responsibility gives you peace of mind and therefore good health.

Furthermore, self-awareness will enable the individual to understand his/her values:

- Values are a measure of your inner worth.
- Values guide the beliefs and opinions that you stand for and help you to know what you do not want.
- Your values determine who you are, what you decide, and how you behave.
- Values are things you are for (you support) or against (you do not support).
- Proper application of your values results in respect, love, good health, and good habits.
- Your values help define who you are and help determine the choices you make.
- Values develop during growth. Your family and environment influence the development of your values.
- In addition, religion and culture contribute to the development of values.
- Values therefore will differ between people of different families, societies, communities, countries, and races.

Self-awareness in health

Health is physical, mental, spiritual, and psychological wellbeing, and not only absence of infirmity in the body.

- You have the responsibility of guarding your health and the health of your friends, family, and the society at large.
- Women are more vulnerable to many health risks.
- It is important to identify and avoid what could create a health risk in everyday life.

STEP 4: Demonstrate appropriate life skills in prevention of GBV and VAC (30 min.)

ACTIVITY: Brainstorming

ASK participants to brainstorm for 5 minutes in a large group on how life skills can be applied to preventing GBV and VAC.

CLARIFY points and emphasize those applied in GBV and VAC as indicated in the points below.

PRESENTATION

Coping with emotions

- Emotions are very high excitements, and may be great joy or happiness, anger, unusual disturbances, and the like. Emotions are internal driven pressure.
- Emotions will always cool down—it may take a long time or a short time but they will eventually subside.
- Never make any decision when you have emotional stress.

- Wait until you have calmed down, analyze the situation that caused the emotions, and make a decision.

Coping with stress

- Stress is a state when there is more than one situation for an individual that needs immediate attention.
- In a stressful situation very many problems face you at the same time, and in fact, these are external driven pressure.
- Do not attempt to solve them all at once.
- Prioritize them and solve them according to your priority list.

Skills for thinking

These skills are subdivided into four areas as follows:

- Critical thinking
- Creative thinking
- Problem solving
- Decision making
- **Critical thinking:** Critical thinking is the objective analysis and evaluation of an issue in order to form a judgment.
 - It is the ability to see that elders or seniors in a position are not always right.
 - They may try to use their position to take advantage of you.
- **Creative thinking:** Creative thinking is the ability to think "outside the box" and find new ways for solving an immediate new and unexpected challenge. In addition, creative thinking is:
 - Ability to generate new ideas by combining, changing, or reapplying existing ideas.
 - A way of looking at problems or situations from a fresh perspective that suggests unorthodox solutions (which may look unsettling at first). Creative thinking can be stimulated both by an unstructured process such as brainstorming, and by a structured process such as lateral thinking
 - Thinking that can bring a new perspective to innovation, problem-solving and managing change. It focuses on exploring ideas, generating possibilities, looking for many right answers rather than just one.
 - Creativity is also about attitude, and ability to accept change and newness, a willingness to play with ideas and possibilities, a flexibility of outlook, the habit of enjoying the good, while looking for ways to improve it.
- **Problem-solving:** This is the ability to identify the problem and determine an acceptable solution.
- **Decision-making:** The ability to make correct decisions and accept the results of those decisions.
 - Correct decision-making leaves you with no regrets and therefore makes you free.
 - Making decisions involves knowing and accepting the consequences.

- Making correct decisions is a key to problem solving.
- Making decisions helps one to set life goals.

Skills for interpersonal communication: These skills are also categorized into three levels:

- Interpersonal relationships
- Empathy
- Communication skills
- **Interpersonal relationships:** Interpersonal relationships make one feel wanted, accepted, and able to get help when need arises. Good interpersonal relationships are built with the following five factors:
- **Respect:** Showing that you care for another person, you care for his/her feelings, and you respect his/her opinions even when they are different from yours.
- **Responsibility:** Being dependable. You can differentiate good from bad and you have the ability to care for yourself and the other person.
- **Understanding:** Understanding another person fully including his/her feelings and opinions. Have the ability to put yourself in the other person's position in order to understand him/her well.
- **Working for the relationship:** Making efforts to build and maintain the relationship. To offer all you have including time, strengths, or even resources for your friend.
- **Setting boundaries:** Having boundaries that are open and explicit in relationships.
- **Empathy:** Empathy is the ability to put oneself in the other person's position in order to understand him/her and why s/he does what s/he does.

In other words, it is the ability to see the other person's viewpoint in an issue.

With empathy you will never blame other people, but ask yourself, "What would I do in that situation?"

- **Communication skills:** The ability to transmit your feelings to the other person effectively; it involves active listening and providing and getting feedback.

STEP 5: Key Points (5 min.)

- Prevention of GBV and VAC can be addressed at four levels, namely, primordial, primary, secondary, and tertiary.
- Life skills include cognitive, emotional, interpersonal, and social skills that enable individuals to deal effectively with the challenges of everyday life.
- Skills for self-awareness, interpersonal relationships, and thinking are key to managing life's challenges.

Step 6: Evaluation (5 min.)

- What are the specific considerations in preventive measures against VAC?
- What do "life skills" mean?
- How can one avoid and manage the difficult life challenges such as GBV and VAC experiences?

Session 3.3: Multisectoral Approach to Prevention of GBV and VAC

Total session time: 120 minutes

Prerequisites: None

Learning Tasks

By the end of this session, the participant will be able to:

- Identify the pillars of a multisectoral approach to prevention of GBV and VAC.
- Identify various stakeholders and their roles in prevention of GBV and VAC.
- Explain mechanisms of coordination and networking in GBV and VAC prevention.
- Explain referral and feedback mechanisms for GBV and VAC survivors.

Resources Needed

- Flipcharts, marker pens, masking tape, computer, LCD, String/rope and name tags, A4 plain paper.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and session learning tasks
2	40 min.	Group activity	Multisectoral approach to prevention of GBV and VAC
3	25 min.	Group activity	Coordination and networking in GBV and VAC
4	40 min.	Presentation and role-play	Referral and feedback mechanisms for GBV and VAC Survivors
5	5 min.	Presentation	Key Points
6	5 min.	Presentation	Evaluation
Total	120 min.		

STEP 1: Presentation of session title and learning tasks (5 min.)

READ the learning tasks to students.

ASK students if they have any questions before continuing.

STEP 2: Multisectoral approach in prevention of GBV and VAC (40 min.)

ACTIVITY: Group Discussion (20 min.)

DIVIDE participants into groups of 4.

GIVE each group one blank sheet of flip chart paper and one marker pen.

INSTRUCT the groups—each group should get an assignment as follows:

- Groups 1 and 2: Discuss the pillars of a multisectoral approach to prevention of GBV and VAC
- Groups 3 and 4: Discuss various stakeholders and their roles in prevention of GBV and VAC
- Group 5: Discuss coordination and networking in GBV and VAC prevention

SELECT some groups to present. Allow questions and discussions for discussion.

SUMMARIZE presentations while harmonizing the answers in the participant's manual.

Pillars of a multisectoral approach

Pillar 1: Political level

- High-level political will is an important element in addressing GBV- and VAC-related policies, laws, regulations, strategies, and action plans.
- The government has created policy guidelines and management guidelines for the management of GBV and VAC survivors, national action plans for addressing GBV and VAC, and the Law of the Child Act No. 21 (2009) and its regulations.
- The Ministry of Health and Community Development, Gender, Elderly, and Children; the Ministry of Home Affairs (especially the police); and the Ministry of Education, Science, Technology, and Vocational Training are the other key ministries involved in prevention of GBV and VAC.

Pillar 2: Legal and judicial sectors

- The legal and judicial sectors are the key sectors that ensure enforcement of the laws consistently and reliably at all levels.
- The entire judicial system must be trained to ensure appropriate interpretation and application of the laws in relation to GBV and VAC.

Pillar 3: Health sector

- GBV and VAC are health crises that result in physiological and psychological damage, both of which can increase HIV risk directly and indirectly.

- The health system must be integrated and strengthened, so that HIV and AIDS services can work together with family planning/contraceptive and sexual and reproductive health services.
- It is important to recognize the signs and symptoms of GBV and VAC and to provide survivors with high-quality health care, forensics investigations, and referrals to social protection and legal services.

Pillar 4: Education sector

- Children are frequently at risk of violence while traveling to or from school or while on school grounds.
- Education is one of the most cost-effective and successful GBV and VAC prevention interventions.
- Yet children who are unsafe are less likely to go to school, putting them at greater risk of GBV and VAC.
- The educational system must universally incorporate a “safe schools” agenda that complements comprehensive evidence-based sexuality and VAC and GBV education.

Pillar 5: Community

- GBV and VAC persist in part because of social norms that teach people to look the other way when witnessing abuse.
- The community should be mobilized to make sure local leaders, religious leaders, advocates, and survivors speak out against violence and support those experiencing it.
- Such systems have been used successfully for HIV prevention and treatment outreach and these efforts should be linked, particularly given links between GBV and VAC.

Pillar 6: Media

- Governments have an important role to play in setting norms. They should publicly denounce GBV and VAC through mass media, utilizing the voices of opinion makers of all types.
- The international community should reinforce these efforts by conducting its own outreach and supporting national governments.
- Widespread marketing efforts should be made to demonstrate political commitment and lay the groundwork for systemic change.
- The link between HIV and AIDS and GBV and VAC should be made prominently.

Pillar 7: Social welfare

- The psychological impacts of violence often result in an unending cycle of violence.
- Social welfare systems, psychosocial care, and comprehensive economic empowerment programs accessible by the vulnerable groups in need are essential to reducing GBV and VAC.
- Ensure GBV and VAC survivors receive counseling services.
- Link survivors to other services according to their need.

STEP 3: Coordination and networking in GBV and VAC services (25 min.)

Coordination

- Coordination is the operationalization of multisectoral, interagency action.
- In GBV and VAC prevention, coordination means promoting participation; identifying and filling gaps; advocating for action (at all levels), including by mainstreaming GBV and VAC prevention and response actions into all sectors; prioritizing urgent needs as defined by the beneficiary population (especially survivors and those most at risk for experiencing GBV and VAC); and assigning roles and responsibilities.
- Service providers should be aware of the GBV and VAC services available in their area, stakeholders and key people. They should establish a strong network to ensure that available services are maximized in caring for the survivors.

Networking

- Networking is an efficient tool for the exchange of knowledge and information among different stakeholders.
- It should be based on survivors' needs and their motivation to face challenges.
- Networking can also be a tool to disseminate information and knowledge.
- By defining common ground and joining forces, networking strengthens stakeholders' capacities and negotiating abilities.

Roles of different sectors in preventing and responding to GBV and VAC in humanitarian settings

Health sector

- Provides compassionate emergency medical examination and treatment for survivors of GBV, including the provision of PEP and ECP where appropriate, for survivors of sexual violence.
- Facilitates survivors' access to other services in the community through referrals.
- Collects forensic evidence (ensuring survivors safety) when appropriate and provide testimony when needed.
- Raises awareness of the health consequences of GBV in the community.

Social services sector

- Provides emotional support through culturally appropriate and sustainable mechanisms.
- Promotes survivors' safety, including by offering them safe haven when possible.
- Offers income generation and skills-building opportunities and training to women and girls (and ensures that men do not have control over the resources generated).
- Conducts community-based education on GBV prevention and availability of services, targeting key stakeholders.

Legal sector

- Provides free or low-cost legal assistance and representation to survivors.
- Trains law enforcement agents, including peacekeepers and members of the judiciary.

- Advocates for the revision of laws and policies that reinforce gender discrimination and violence.
- Raises awareness of existing legislation.

Security sector

- Implements a zero tolerance policy for police, military, and peacekeeping staff who perpetrate GBV.
- Ensures that refugee camps are designed to ensure the physical safety of its inhabitants, particularly of girls and women.
- Builds or rebuilds law enforcement capacity to assist survivors of GBV without further victimization.
- Conducts community policing and education.

STEP 4: Referral and feedback mechanisms for GBV and VAC survivors (40 min.)

Referrals for GBV and VAC are tailored to meet the needs of three groups, namely survivors referred from other facilities, those referred within the health facility to connect with other services, and those referred to other health facilities or other non-health sector services.

- **Survivors referred from other facilities:** These survivors are mostly received as referrals from lower level facilities, including communities, to upper level health facilities to get services not provided by the lower levels. Survivors referred from lower levels may come accompanied or not, but all must come with documentation about the problem they have, initial services they have already received, and the service they need from the higher level.
- **Survivors referred within the health facility to connect with other services:** These survivors get a referral from one unit/department/firm in a health facility to another unit/department/firm; for example, from trauma and injuries unit to HIV care and treatment unit. This type of referral is geared to connect the survivor with other services within the health facility.
- **Survivors referred to other health facilities or other non-health sector services:** These survivors are mostly referred by lower level facilities to upper level health facilities or other key stakeholders to get services not provided by the referring health facility. The other key stakeholders include legal or police desks, social welfare workers, or counselors.

ACTIVITY: Referral Procedures (20 min.)

Note: This activity requires a ball of yarn or string.

ASK for volunteers and distribute the name tags to the appropriate number of people. Tell them that they are actors and will be in the role of the person noted on their name tag.

SEAT the volunteers in a circle, chairs fairly close together.

ASK the remaining participants to stand outside the circle so that they can easily see the activity.

EXPLAIN that the ball of yarn represents a 20-year-old woman who was raped. Standing outside the circle, give the ball to Mother and explain that the woman has told her mother about the incident.

INSTRUCT Mother to hold the end of the string firmly, to not let go, and to throw the ball to the person you tell her. You will then tell the story of what happens to this woman. Each time an Actor is involved, the ball of string is tossed across the circle to that Actor. Each Actor who receives the ball will wrap it around a finger and then toss the ball to the next Actor as instructed.

An example of how you might play out the above referral activity is as follows:

- Mother takes woman (survivor) to Block Leader,
- Then Cell Leader,
- Traditional Birth Attendants help, but the Survivor needs more health interventions than they can provide, so Traditional Birth Attendant refers the Survivor to the Midwife.
- Midwife calls in the Doctor.
- Doctor administers treatment and sends Survivor back to Midwife.
- Midwife refers the Survivor to the Community Services Worker.
- Community Services Worker provides emotional support and contacts.
- Survivor returns to Doctor with a few more questions.
- Doctor sends Survivor to lab.
- Police contact the Doctor.
- Doctor contacts Mother and explains about other available services.
- Doctor contacts the Social Worker.
- Social Worker refers Survivor to Lawyer.
- Lawyer contacts Police.
- Police contact Prosecutor to have him speak with the Survivor.
- Prosecutor discusses with Lawyer.
- Lawyer discusses with Prosecutor.
- Prosecutor calls the Doctor about the Survivor to get information about the medical exam.
- Doctor asks to see the Survivor again because she forgot to examine something.
- The doctor refers the Survivor to Social Worker.
- The Social Worker then contacts the Police to give them some new information.
- The Police contact the UNHCR (the UN Refugee Agency) Protection Officer to report the incident.
- The Protection Officer contacts the Mother to ask questions.
- The Mother asks the Survivor additional questions.
- The Survivor goes to talk with the Community Leader because she is confused about the process.
- The Community Leader contacts the Prosecutor and the Judge to find out the status of the case.
- They refer the Community Leader to the Police, and so on.

Stop the game when every Actor has taken part in at least two communication exchanges regarding the case. There will be a large red web in the center of the circle, with each Actor holding parts of the string.

Pause to look at the web. Ask some questions to generate discussion:

- What do you see in the middle of this circle?
- Was all of this helpful for the survivor? Traumatic?
- Might a situation like this happen here?
- What could have been done to avoid making this web of string?
- Observers: How many times did the survivor have to repeat her/his story?
- Actors: How many times did you talk with this survivor—or with others about her? Do you remember the details?

Ask everyone to return to their seats. Actors should let go of the string and let it drop to the floor. Leave the red stringy chaotic mass sitting on the floor for all to see during the remainder of this session.

Referral and feedback mechanism

- In order for referral networks to be effective, organizations must not think that by making a referral they are washing their hands of the problem, but should instead create mechanisms that allow for follow-up of cases and for monitoring the progress of the referred individual.
- Before referring GBV and VAC survivors, ensure that:
 - The services/support that the survivor needs are actually offered by the identified organizations.
 - The survivor understands the benefits of the services offered.
 - There is no delay in the survivor accessing the services—survivors should be informed of the importance of time (e.g., with police and legal matters).
 - The issues of gender sensitivity and culture are taken into consideration during provision of service to GBV and VAC survivors.
- Survivors can be referred by directing or accompanying them to the services or by using different individuals in the community (e.g., community leaders, community police, religious leaders influential people, activists, relatives, neighbours, and peers) to do so.
- GBV survivors interact with a vast number of resources and contacts that are often not well trained and not well coordinated. This can be very daunting and confusing to the survivor and may discourage incident reporting or negatively impact the survivor. It is important to set up a clear response system and to have someone act as a case manager for the survivor, helping her to navigate the system.

Step 5: Key Points (5 min.)

- GBV and VAC can be prevented or mitigated through collective efforts of different stakeholders, with well-coordinated networking and collaboration.

- Health care providers and social welfare officers should take an active role in reducing GBV and VAC by creating community awareness using the existing programs, such as community outreach and school programs.

STEP 6: Evaluation (5 min.)

- What are the pillars of a multisectoral approach in prevention of GBV and VAC?
- Who are the stakeholders in prevention of GBV and VAC?
- What are the roles of the health care provider and social worker?

ASK participants if they have any comments or need clarification on any points.

MODULE 04: MANAGEMENT OF DATA FOR GBV AND VAC SERVICES

This module is designed to help participants improve their competencies in management and utilization of data for GBV and VAC services improvement.

The module is divided into three sessions:

- 4.1: Data collection and reporting
- 4.2: Supportive supervision
- 4.3: Using data for decision-making

Session 4.1: Data Collection and Reporting

Total session time: 60 minutes

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Identify relevant tools for GBV and VAC data collection.
- Describe procedures for data collection in GBV and VAC services.
- Describe procedures for data auditing and cleaning in GBV and VAC services.
- Describe proper storage of data collection tools for GBV and VAC services.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers
- Handout 5.1.2: GBV Register.

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	15 min.	Presentation	Identify relevant tools for GBV and VAC data collection
3	10 min.	Presentation	Describe procedures for data collection in GBV and VAC services
4	10 min.	Presentation	Describe procedures for data auditing and cleaning in GBV and VAC services
5	10 min.	Presentation	Describe proper storage of data collection tools for GBV and VAC services
6	5 min.	Presentation	Key points
7	5 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

INTRODUCE the session including the title.

READ or **ASK** participants to read the learning tasks.

CLARIFY each learning task.

ASK participants if they have any questions before continuing.

STEP 2: Identify relevant tools for GBV and VAC data collection (15 min.)

During service delivery GBV and VAC data is collected by different types of tools, namely Health Management Information Data Registers and Tally Sheets, and medical forms. These tools are as follows:

- **Register:** This is a data collection tool for documenting groups of survivors' data, namely, biodata (name, age, parity, etc.); type of violence (sexual, emotional, physical, neglect); violence reporting (time of violence, time of reporting); and violence management (screening for HIV, STIs, and pregnancy; treatment; linkage with other services; referrals).
- **Tally Sheet:** This is a data collection tool for documenting survivor's GBV or VAC reported incidences and service provided data by age groups. The tool classifies clients into six age categories, namely, 0–59 months, 5–9 years, 10–14 years, 15–17 years, 18–24 years, and 25 years and above. Based on these age groups, the tally sheet collects GBV or VAC reported incidences and services provided data for each of the age groups by sex (male and female).
- **Consent Form:** This is a data collection tool used by service providers to document survivors' permission to conduct medical examination, to collect evidence, and to provide evidence and medical information to the police and law courts concerning the GBV or VAC case.
- **Pictogram Form:** This is a data collection tool for documenting the anatomical sites that were involved, traumatized, or injured during the violence. Using this form, the service provider labels the sites on the anterior or posterior part of the body or on the genitalia that were affected.
- **Examination Documentation Form:** This form is used for documenting key biodata information; the incident (date, time, and place of assault, number of assailants, alleged assailants, type of assault, symptoms and circumstances of incident); obstetric/gynecology history (gravidity, parity, history of sexual intercourse prior to incident, contraception); examinations made (mental, physical, genital, etc.); type of GBV encountered; and emergency treatment.
- **Tanzania Police Medical Examination Report (PF 3):** This form is used by the police force to request medical examinations for a GBV or VAC survivor. The information collected includes administrative (case file number, police station name, date of incident); general appearance of survivor; types of violence; and type of GBV or VAC.

STEP 3: Describe procedures for data collection in GBV and VAC services (10 min.)

To facilitate collection of data using the above named tools, the service provider needs to use the following procedure:

- **Observations:** This involving taking a good look at the survivor and noticing facts or issues about the survivor.
- **Asking questions:** This involves asking focused questions of the survivor in order to document issues about the assault or violence.
- **Medical examinations:** A complete health assessment of the survivor from head to toe, including the genitalia.
- **Laboratory investigation:** Conducting a laboratory investigation of specimens drawn or extracted from the survivor to establish or confirm a diagnosis.

STEP 4: Describe procedures for data auditing and cleaning in GBV and VAC services (10 min.)

Before data can be used by the health facility or higher levels for decision making, they must be verified as clean and accurate. In order to achieve this, the data need to be audited and cleaned.

- Data auditing needs to be done every day and at the end of the month by collating the number of survivors by age group, sex, and types of assaults across the registers, summary forms, and medical forms.
- When data audit mismatches are identified, they need to be corrected across the registers, summary forms, and medical forms.
- During data cleaning, all data outlays and empty spaces need to be examined, and, where necessary, the outlays replaced with correct values and the empty spaces filled with the required values (e.g., empty space for sex of survivor needs to be filled with male or female).

STEP 5: Describe proper storage of data collection tools for GBV and VAC services (10 min.)

Data collection tools are very important documents for collecting and storing GBV and VAC services data. In this respect both the empty and the filled out data collecting tools need to be stored in a dry and safe place.

- **Empty data collection tools:** These need to be stored at a dry and safe place where they can be accessed easily when required (e.g., metal boxes, office cabinet, etc.).
- **Filled data collection tools:** All filled GBV and VAC registers, tally sheets, and medical forms contain client confidential and legal information and thus need to be securely stored. This can be in a dry and safe place under lock and key in a store, metal boxes, office cabinet, etc. Accessibility to these documents needs to be controlled by the medical officer in charge of a health facility. All the registers, tally sheets, and medical forms are filled without a copy being made.

STEP 6: Key Points (5 min)

- Forensic evidence is used to: (1) determine whether an instance of GBV or VAC has happened and (2) link the perpetrator to the crime (or delink a suspect from the crime).
- Service providers must handle, store, and transport evidence in an appropriate manner.
- Health care providers and social welfare officers have the responsibility to give their evidence-based opinions in the court of law.
- Survivors should sign a written informed consent voluntarily before collection of the forensic evidence.

STEP 7: Evaluation (5 min)

- What types of specimens can be collected for forensic evidence from a GBV or VAC survivor?

Session 4.2 Procedures for GBV and VAC Data Reporting

Total session time: 60 minutes

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Identify relevant tools for GBV and VAC reporting.
- Describe procedures for report compilation in GBV and VAC services.
- Describe proper storage of reporting tools for GBV and VAC services.
- Describe procedure for GBV and VAC data dissemination and use.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers
- Hand out 5.1.2: GBV and VAC Registers, tally sheet and monthly summary form

SESSION OVERVIEW

Step	Time	Activity/ Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	15 min.	Presentation	Identify relevant tools for GBV and VAC reporting
3	20 min.	Presentation	Describe procedures for report compilation in GBV and VAC services
4	10 min.	Presentation	Describe proper storage of reporting tools for GBV and VAC services
5	5 min.	Presentation	Key Points
6	5 min.	Presentation	Evaluation
Total	60 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min)

INTRODUCE the session including the title.

READ or ASK participants to read the learning tasks.

CLARIFY each learning task.

ASK participants if they have any questions before continuing.

STEP 2: Identify relevant tools for GBV and VAC reporting (5 min.)

All health facilities providing GBV and VAC services generate a monthly performance report using a GBV and VAC HMIS Monthly Summary Form. This form is filled by consolidating information from all service delivery tally sheets that had been filled during the reporting month.

STEP 3: Describe procedures for report compilation in GBV and VAC services (20 min.)

Report compilation is guided by the prescribed format presented in the Monthly Summary Form. This form consolidates data for each GBV or VAC incident and services by age group, by sex, and total for each facility per month. The age groups include 0–59 months, 5–9 years, 10–14 years, 15–17 years, 18–24 years, and 25 years and above. The report further captures aggregated total values for GBV or VAC incidence and services by sex (male and female). This form is filled in triplicate, original to be submitted to the Municipal Council headquarters, duplicate is filed in the facility box file, and the third copy left in the Monthly Summary Form book (see Table 4.1).

Table 4.1. Sample Monthly Summary Form for Compilation of GBV and VAC Services

	Incidences and Services	Age Groups						Total
		0–59 months	5–9 years	10–14 years	15–17 years	18–24 years	25 years+	
1								
2								
3								

STEP 4: Describe proper storage of reporting tools for GBV and VAC services (10 min.)

The Monthly Summary Form is a very important document for storing and reporting summary GBV and VAC services data. In this respect both the empty and completed forms. Monthly Summary Form should be stored in a dry and safe place.

- **Empty Monthly Summary Forms:** These need to be stored in a dry and safe place where they can be accessed easily when required (e.g., metal boxes, office cabinet, etc.).
- **Completed Monthly Summary Forms:** All filled GBV and VAC Monthly Summary Forms contain important data for decision making at both the facility and higher levels and thus need to be stored securely. They can be stored in a dry and safe place under lock and key in a store, metal boxes, office cabinet, etc. Accessibility to these documents needs to be controlled by the medical officer in charge of a health facility.

STEP 5: Key Points

- There are several data collection tools that must be completed clearly.
- Completed Monthly Summary Forms are key to generating reports at all levels.
- When filling out Monthly Summary Forms, care should be taken to ensure that the entered data are accurate.
- The filled data collecting tools and monthly reports must be kept confidential in a secure setting.

STEP 6: Evaluation

- What are the age groups used in reporting GBV and VAC data?
- Describe the flow of data from the facility level to national level.
- Why is it important to clean data?

Session 4.3: Procedures for Supportive Supervision

Total session time: 40 minutes

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Describe the GBV and VAC component of the reproductive, maternal, neonatal, child and adolescent health (RMNCAH) integrated supportive supervision tool.
- Describe procedures for supportive supervision.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers
- Copies of the Integrated RMNCAH (Reproductive, Maternal, Newborn, Child, and Adolescent Health) Supportive Supervision Tool
- Handout 4.3.1: GBV Register

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	15 min.	Presentation	Describe the GBV and VAC component of the RMNCAH integrated supportive supervision tool
3	20 min.	Presentation	Describe procedures for supportive supervision
4	5 min.	Presentation	Key Points
5	5 min.	Presentation	Evaluation
Total	40 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min)

INTRODUCE the session including the title.

READ or ASK participants to read the learning tasks.

CLARIFY each learning task.

ASK participants if they have any questions before continuing.

STEP 2: Describe the GBV and VAC component of the RMNCAH integrated supportive supervision tool (15 min.)

The MOHCDEC has developed an integrated supportive supervision tool for tracking the performance of RMNCAH services. This tool, among others, has components for tracking the provision of comprehensive GBV and VAC services according to guidelines. To facilitate this, the tool verifies the availability of the following:

- The national policy guidelines for health sector prevention and response to GBV and VAC
- Providers' job aids and other relevant forms for service provision
- Trained service providers to provide GBV and VAC services
- Equipped with essential GBV and VAC equipment and supplies
- List of institutions for GBV/VAC networking
- The tool verifies that the facility does the following:
 - Provides services to GBV and VAC survivors according to GBV guideline
 - Conducts community sensitization meetings
 - Complies to the National GBV and VAC M&E system
 - Has GBV and VAC (service provision) guidelines
 - Is equipped with essential GBV equipment
 - Documents GBV and VAC services offered
 - Provides services in a one-stop center where applicable.

STEP 3: Describe procedures for supportive supervision (20 min.)

The integrated supportive supervision tool is designed for use at health facilities at all levels (hospitals, health centers, and dispensaries/clinics). Every planned supportive supervision task should start by reading the previous supervision report, and the supervision will normally be conducted quarterly. It is recommended that before commencement of supervision, the host authorities should be notified, preferably a month before.

The tool can be used by supervisors from all levels (National/Ministry, Region/Regional Health Monitoring Team (RHMT), Council/Council Health Monitoring Team (CHMT), and health facility as follows:

- **National/ministry supervisors:** The integrated supportive supervision tool will be conducted by representatives from all the RMNCAH sections and National and Zonal Reproductive and Child Health Co-Coordination. This group from the national level will team up with supervisors from the regions and districts. Duration for supportive supervision will be 14 days per region and will be conducted twice a year.
- **Region/RHMT supervisors:** RHMT will conduct RMNCAH supervision of districts. The team will comprise RHMT staff, including co-opted members (including Regional Reproductive and Child Health Coordinators) who will team up with supervisors from the districts. The supervision will be conducted quarterly and the duration will not be less than five days per district.

- **Council/CHMT supervisors:** The Council Health Monitoring Team will conduct RMNCAH supervision of district hospitals, health centers, and dispensaries quarterly. The team will comprise CHMT staff inclusive of co-opted members (including District Reproductive and Child Health Coordinators and the duration will not be less than 10 days per quarter.
- **Health facility supervisors:** The supervisor from the health facility will conduct supervision of community health workers (CHWs) including the Village Health Committee/Primary Health Care Committees. The supervision will be conducted quarterly and the duration will not be less than three days per village. The process for supervising the community involves planning, actual supervision, report writing, and feedback. Supervision plans for RMNCAH supportive supervision of the communities' needs to be planned and a timetable prepared showing dates and names of villages to be supervised and who will be responsible. Before conducting GBV and VAC supervision of the villages, the health facility needs to inform the community leaders.

Step 4: Key Points (5 min.)

- The supportive supervision tool can be used at all levels of GBV and VAC service provision, including the community.
- The supportive supervision tool can be used by supervisors from various levels (national to facility).
- Before any supportive supervision, the supervisors should plan for the event.
- Supportive supervision should be concluded by a report showing action points and timelines.

Step 5: Evaluation (5 min.)

- Describe the procedure for a supportive supervision activity.

Session 4.4: Using Data for Decision-Making

Total session time: 120 min

Prerequisites: None

Learning Tasks

By the end of this session, participants are expected to be able to:

- Interpret routine data for service improvement.
- Disseminate GBV and VAC services data.
- Use data for GBV and VAC services for appropriate decision-making.

Resources Needed

- Flipcharts, marker pens, masking tape, chalk/whiteboard, chalk/whiteboard markers
- Hand out 5.1.2: GBV Register

SESSION OVERVIEW

Step	Time	Activity/Method	Content
1	5 min.	Presentation	Introduction and learning tasks
2	45 min.	Presentation Group Activity	Interpret routine data for service improvement
3	20 min.	Presentation	Describe procedures for GBV and VAC data dissemination and use
4	20 min.	Presentation	Reporting procedures for data in GBV and VAC activities
5	20 min.	Presentation	Indicators used in GBV and VAC services
6	5 min.	Presentation	Key Points
7	5 min.	Presentation	Evaluation
Total	120 min.		

SESSION CONTENT

STEP 1: Presentation of session title and learning tasks (5 min.)

INTRODUCE the session including the title.

READ or ASK participants to read the learning tasks.

CLARIFY each learning task.

ASK participants if they have any questions before continuing.

STEP 2: Interpret routine data for service improvement (45 min.)

- Data interpretation is the process of assigning meaning to the collected information and determining the conclusions, significance, and implications of the findings. It involves application of statistical procedures in analysis.
- There are a number of basic methods that help to organize, analyze, and present data in order to support quality improvement of GBV and VAC services. The methods depend on the type of data, whether quantitative (numerical) or qualitative (categorical).

Preparation of data tables

A table is a key tool for summarizing and presenting numerical data. A table consists of three major components, namely the title, horizontal axis subtitle, and the vertical axis subtitle (see Table 4.2).

Table 4.2: Distribution of Number of GBV Survivors by Age Group and Sex

	Sex	Age Groups						Total
		0–59 months	5–9 years	10–14 years	15–17 years	18–24 years	≥25 years	
1	Female	807	1,089	1,728	2,851	7,959	17,159	31,593
2	Male	538	780	1,102	1,086	2,026	4,627	10,159
3	Total	1345	1,869	2830	3,937	9,985	21,786	41,752

Analyzing numerical (quantitative) data

- Raw numerical data from the HMIS GBV and VAC data collection tools (registers and tally sheets), medical forms, and the Monthly Summary Forms may be hard to absorb, thus basic statistics techniques are used to organize and summarize information from this data set. This helps to describe what is happening in the community and health facility and can help to guide the need for further analysis.

Basic statistics techniques for summarizing data

- Counts and sums
 - *Counts* are simply a sum of how many items or observations you have in your sample; e.g., the number of GBV or VAC survivors receiving clinical care.
 - *Sums* are made by adding up the numbers in each set of observations; e.g., 20 GBV or VAC survivors responding to the survey feel that current processes for counseling are inadequate.
- Ratios and percentages
 - Ratios and percentages help to standardize data so that they are expressed in a meaningful way that can be readily compared with other data.
 - A ratio is a fraction, expressed in its simplest terms, that describes two groups relative to one another; e.g., the ratio of females to males from the data collected may be 3 to 2, meaning that for every three females there are two males.

- Choosing methods of expression of data will depend on the nature of the data and the plans to use them. Ratios and percentages are useful for comparing datasets. For example, they can be used to compare populations within your health service to see where problems lie, or to make comparisons before and after a quality improvement initiative.

ACTIVITY: Demonstration of tables preparation process

DEMONSTRATE how to prepare a table to present GBV and VAC service. (5 min.)

ACTIVITY: Demonstration of data interpretation process

DEMONSTRATE how to calculate basic statistics like sums, counts, ratios, and percentages. (5 min.)



Refer participants to **Worksheet 4.4.1: Calculating the Basic Statistics of a Health Facility.**

ASK participants to calculate the basic statistics just demonstrated above for other remaining facilities. (10 min.)

DEMONSTRATE how one can achieve analysis of qualitative data.

GROUP participants in pairs, then instruct one participant to ask the other the remaining questions; document as you demonstrate by recording the answer for each question in a separate flipchart you have just distributed to them. (15 min.)

COLLECT the flip charts with answers and affix them to the wall using masking tape. (5 min.)

SUMMARIZE the responses in the flip charts by organizing the same answers together. (15 min.)

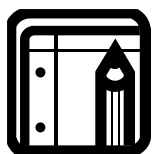
STEP 3: Describe procedures for GBV and VAC data dissemination and use (20 min.)

GBV and VAC data collected at a facility can be disseminated and used at all levels. More importantly, the health facility can use this data at facility and community levels as follows:

- **At the facility level**, the GBV and VAC data collected need to be used by service providers to plan how to improve the provision of services based on current data.
- **At the community level**, the data collected by the facility can be disseminated to community members through their village health committees and ward health committees. This information sharing (feedback) to the lower levels, if properly articulated in the health committees agendas, can be used as a powerful tool for mitigating GBV and VAC incidence in the communities.

Step 4: Reporting procedures for data in GBV and VAC activities (20 min.)

- The reporting procedures for GBV and VAC information do not create a parallel system with the overall system of the Ministry of Health, Community Development, Gender, Elderly, and Children.
- The relevant elements for reporting have been included in the data flow for the Health Management Information System (HMIS)/Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya (MTUHA) as indicated in the diagram in Figure 4.1.



Worksheet 4.4.1: Calculating the Basic Statistics of a Health Facility

The table shows the number of GBV and VAC cases attended in health facilities during the period of seven months as reported.

Note: <18= VAC cases >18= GBV cases

FACILITY	Jan		Feb		March		April		May		June		July	
	<18	>18	<18	>18	<18	>18	<18	>18	<18	>18	<18	>18	<18	>18
Nyamatwa Dispensary	7	14	4	5	12	5	1	10	6	9	4	7	7	5
Bupua Health Center	10	3	8	5	10	3	12	7	11	3	8	8	10	7
Vikindwa Dispensary	0	1	10	10	5	5	3	9	7	2	6	8	5	6
Kisijoto Health Center	14	9	16	12	14	12	10	15	14	10	16	10	17	9

Tasks

Facilitator should demonstrate how to calculate the basic statistics in the following questions for Nyamatwa Dispensary.

1. What is the *sum* of VAC and GBV cases attended in Nyamatwa Dispensary in the period of seven months as reported?
2. What is the *percentage* of VAC and GBV cases attended in Nyamatwa Dispensary in the period of seven months as reported?
3. What is the ratio of GBV to VAC cases reported in Nyamatwa Dispensary as reported in the period of seven months?

THEN ask the participants in three groups to do the same for the Bupua, Vikindwa, and Kisijoto health facilities.

Figure 4.1: Data Flow Diagram

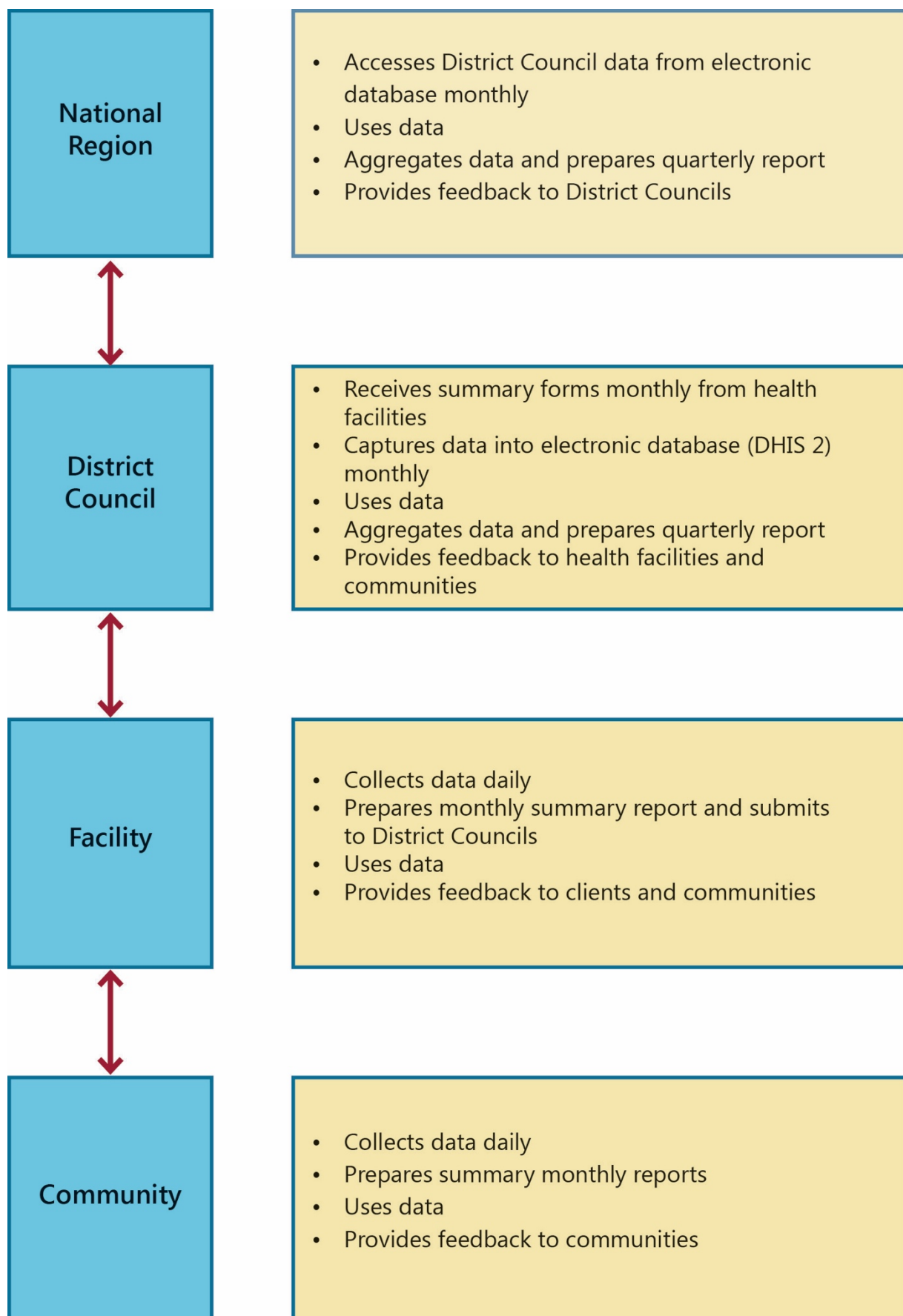


Figure 4.1 shows the process of compiling and summarizing the data collected, in order to send it to a higher level. *The following tasks are done on a monthly basis:*

- Health facilities prepare and submit monthly summary forms to the district council during the *first week* of the following month (1st– 7th day of next month).
- District Councils capture data from the health facility monthly summary forms into the electronic data base, District Health Information System (DHIS 2), and clean the data during the *second week* of following month (8th – 14th day).
- Regions and national levels access cleaned data in the electronic data base (DHIS 2) through the internet monthly during the *third week* of the following month (14th – 21st), and advise/provide feedback to District Councils accordingly.
- The Regions compile quarterly reports and submit to Reproductive and Child Health (RCH) zone offices and MOHCDGEC/RCHS.
- The national level (MOHCDGEC/RCHS) compiles quarterly reports based on the inputs from the electronic data base (DHIS 2), and quarterly reports submitted by Regions and RCH Zone offices, and provide feedback to the lower levels on a quarterly basis.
- The national level (MOHCDGEC/RCHS) compiles an annual RCH report based on the contents of the National Quarterly reports. This report is then shared during an annual RCH meeting that brings together MOHSW/RCHS Managers, RCH Zone Managers, and Regional RCH Coordinators. This meeting provides an overall feedback to Zones, Regions, and District Councils on the performance of RCH services during the previous year.

STEP 5: Indicators used in GBV and VAC services (20 min.)

GBV and VAC health sector response interventions have 18 indicators that are used to measure performance as outlined in the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence. This list also includes indicators that are collected at the community level. GBV and VAC indicators are described as follows:

Facility Level

- Number of persons provided with GBV services at a health facility by type of services, age, and sex
- Number of health care providers trained to provide GBV services
- Number of health care providers oriented on GBV management guidelines.

District Level

- Number of persons provided with GBV services at a health facility by type of services, age, and sex
- Proportion of health facilities with health care providers trained to provide GBV services
- Proportion of health facilities with health care providers oriented on GBV management guidelines

- Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of GBV
- Proportion of health facilities that have essential supplies and equipment for the management of GBV.

Regional Level

- Number of persons provided with GBV services at the district level by type of services, age, and sex
- Proportion of health facilities with health care providers trained to provide GBV services by district
- Proportion of health facilities with health care providers oriented on the GBV management guidelines by district
- Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of GBV by district
- Proportion of health facilities that have essential supplies and equipment for management of GBV by district.

Ministry Level

- Number of persons provided with GBV services at regional level by type of services, age, and sex
- Proportion of health facilities with health care providers trained to provide GBV services by region
- Proportion of health facilities with health care providers oriented on the GBV management guidelines by region
- Proportion of health facilities that have documented and adopted the National Management Guidelines for the Health Sector Response to and Prevention of Gender-Based Violence (GBV) by region
- Proportion of health facilities that have essential supplies and equipment for the management of GBV by region.

Community Level Indicators

- Proportion of women aged 15–49 who ever experienced physical violence from an intimate partner
- Proportion of women aged 15–49 who ever experienced physical violence from someone other than an intimate partner
- Proportion of women aged 18–24 who were married before age 18
- Proportion of women who are circumcised (female genital mutilation).

STEP 6: Key Points (5 min.)

- **Monitoring** is the routine process of data collection and measurement of progress toward program objectives.
- **Evaluation** is the use of research methods to systematically investigate a program's effectiveness. It addresses relevance, effectiveness, impact, and sustainability of the services provided.
- **An indicator** is a measurable or tangible sign that something has been done or that something has been achieved. It is a variable that measures a specific aspect of a program or project.
- **An M&E Framework** is a plan that indicates the process of monitoring and evaluation. It shows what and when to monitor, and when and how to evaluate.
- **Research** is a systematic investigation/study conducted using scientific methods in order to establish facts and reach new conclusions. Moreover, it is the systematic investigation into and study of materials and sources in order to establish facts and reach new conclusions. It can also be defined as any gathering of data, information, and facts for the advancement of knowledge.

STEP 7: Evaluation (5 min.)

- What is monitoring and evaluation?
- What is an indicator?
- What are the three examples of facility level indicators?
- How the data flow of the reporting system is organized?



Handout 4.3.1: GBV Register

The updated Health Facility Client Register that has been customized to the National HMIS/MTUHA structure collects 23 key data elements as described in the matrix and guideline/*mwongozo* below. The guidelines on how to use the register follow the table.

REJESTA YA UKATILI WA KIJINSIA NA UKATILI DHIDI YA WATOTO																																												
*	1	2	3		4	5	6	7			8	9	10	11	12	13	14	15	16	17					18	19					20		21		22	23								
Hu dh uri o la Kw anz a	Na.	Tarehe	Mw ak a	N a m b a	Ji n a la M te ja	Ji ns i	Nd oa	Umri			Anaishi na Nani	Uzito (Kg)	Urefu (cm)	Kazi kuu ya Kumpatia kipato	Ana watoto wangapi	Hatarishi (Vulnerable)	Mah ali Ana pois hi (Kijij i/Mt aa)	Jina la M/kit i Serik ali za Mitaa /Kito ngoji	Maswali ya utambuzi (Screening)	Aina ya Ukatili					Ameika Kituoni ndani ya saa 72 baada tukio	Huduma za kimatibabu baada ya tukio (0 = hakupata huduma; 1 = ndani ya saa 72; 2 = baada ya saa 72)					Majibu Baada ya Kufanyiwa Vipimo		Huduma nyingin ezo (0 = hakupata huduma; 1 = amepata huduma)		Am ep ata ule ma vu wa ki m wili wa ku du mu	Rufaa								
						M E/ KE	1/2 /3/ 4/5	s i k u	M ie zi	m ia k a						1 / 2 / 3			1 / 2	P V	S V	E V	N G	N / H / S	F I	I M	C	P E P	S T I	E C	F P	P T	H I V	S T I	P	L A	S W S	N/ H	Ku to ka nj e	N d a ni	Kw en da nje			

MWONGOZO WAREJESTA YA UKATILIWA KIJINSIA NA UKATILI DHIDI YA WATOTO

Mwongozo huu ni kwa ajili ya kukusanya tarifa za ukatili wa kijinsia na ukatili dhidi ya watoto. Taarifa zote kuhusu huduma hizi zitarekodiwa katika rejesta hii. Mwongozo huu utajazwa kwa kufuata utaratibu ufuatao:

Safu ya (*):Hudhurio la kwanza la Mteja kwa mwaka: Weka alama ya nyota (*) kama ni hudhurio la kwanzakwa mwaka kwenye kituo hiki cha huduma. Zingatia mtoa huduma amuulize Mteja kama amewahi kupata huduma ya GBV/VAC katika kituo chochote cha kutolea huduma za afya nchini kwa mwaka huo. Kama hajawahi kupata huduma ya GBV/VAC katika kituo kingine chochote cha huduma za afya kwa mwaka huo weka alama ya nyota(*). Kama amewahi kutibiwa usijaze acha wazi sehemu hiyo. Lengo la Wizara ya Afya na Usitawi wa Jamii ni kupata Idadi ya Watanzania wanaotumia huduma za afya nchini.

Safu ya (1):Namba ya kuandikwa:Jaza namba ya kuandikwa katika tarakimu tatu, mfano 001; Namba ya kuandikishwa ianze 001 kila mwezi.

Safu ya (2):Tarehe: Andika tarehe mteja aliyoona kwa mara ya kwanza. Tarehe iandikwe kwa tarakimu mbili na herufi tatu za mwezi mfano 03 Jan

Safu ya (3):Namba ya Usajili anayopewa mteja. Namba ya usajili ina sehemu mbili. Sehemu ya kwanza ni tarakimu mbili za mwisho wa mwaka. Kwa hiyo, 2013 itaandikwa 13 kwa kila mteja atakayeandikishwa mwaka huo, na hii itajazwa sehemu ya kwanza ya safu hii. Sehemu ya pili ni namba ya kuandikishwa. Kila mteja apewe namba zinazofuatana kuanzia namba moja. Kila rejesta kwa kila mwezi ianze na namba 001(moja).Kila hudhurio linapewa namba.Toa namba moja tu ya hudhurio hata kama mteja atakuwa na diagnosis zaidi ya moja.

Safu ya (4): Jina la mteja. Andika majinamatatu ya mteja kwakwa usahihi.

Safu ya (5):Jinsi ya mteja:Andika KE kama ni mwanamke na ME kama ni mwanaume.

Safu ya (6): Ndoa: Andika hali ya Ndoa ya Mteja kwa Tarakimu; yaani 1 = Mtoto, 2=Hajaolewa/Hajaoa, 3 = Ameoa/Ameolewa 4= Mjane/Mgane 5 = Wametengana/mtalaka

Safu ya (7): Umri: Umri wa mteja uandikwe kwa siku, miezi au miaka kamili kwa kuzingatia safu za umri kwa siku, miezi au miaka.Iwapo mteja ana umri chini ya mwezi mmoja, andika umri kwa siku (0 hadi 28), iwapo mteja ana umri wa mwezi mmoja hadi miezi 11, andika umri kwa miezi (1 hadi 11); na ikiwa mteja ana umri wa mwaka mmoja na kuendelea, andika umri kwa miaka. Kumbuka, watoto wa umri wa mwakawatu wazima wote wataandikwa umri wao kwa miaka iliyo kamili.

Safu ya (8): Anaishi na Nani: Andika **1**= Anaishi na Mke/Mume; **2** =Anaishi na Baba na Mama, **3** =Anaishi na Baba pekee, **4** = Anaishi na Mama pekee, **5** =Anaishi na Baba na Mama wa Kambo, **6** = anaishi na Mama na Baba wa Kambo, **7** =anaishi na Mjomba, **8** = anaishi na Shangazi, **9** = anaishi na kaka, **10** = anaishi na Dada, **11** = anaishi na Ndugu wengine, **12** = anaishi na jirani na **13** = anaishi peke yake mwenyewe.

Safu ya (9): Uzito: Andika uzito wa mteja kwa kilo baada ya kupima (*watoto chini ya miaka mitano andika uzito kamili wa kilo pamoja na gramu mfano 4.9kg, 12.8kg umri zaidi ya miaka mitano andika uzito kwa kilo bila gramu mfano 46kg*)

Safu ya (10): Urefu: Andika urefu wa mteja kwa sentimita. Mfano 45cm, 160cm, 140cm n.k

Safu ya (11): Kazi: Andika kazi/shughuli anayofanya mteja

Safu ya (12): Ana watoto wangapi?: Andikaidadi ya watoto hai alionao mteja

Safu ya (13): Mazingira Hatarishi: Andika tarifa muhimu za mteja; iwapo mtoto ni yatima andika 1, iwapo ni mtoto wa mitaani andika 2 na iwapo mtoto ni wa mitaani na yatima andika 3.

Safu ya (14): Mahali anapoishi: Andika jina la sehemu mteja anapoishi ndani ya mtaa, kijiji au kitongoji.

Safu ya (15): Jina la Mwenyekiti wa Serikali za Mitaa/Kitongoji: Andika Jina kamili la Mwenyekiti wa Serikali za Mitaa/Kitongoji.

Safu ya (16): Maswali ya utambuzi (screening): Weka namba '1' iwapo mteja ameulizwa maswali ya utambuzi kuhusu ukatiliwa kijinsia au ukatili dhidi ya watoto na namba '2' iwapo mteja hakuulizwa.

Safu ya (17): Aina ya ukatili: Weka alama ya tiki (✓) chini ya safu husika kulingana na aina ya ukatili:- PV- Ukatili wa kimwili (Physical Violence), SV- Ukatili wa kingono (Sexual Violence), EV- Ukatili wa kihisia (Emotional Violence) au/na NG- Kutelekezwa (Neglect)

Safu ya (18): Amefika Kituoni ndani ya saa 72; weka herufi N = Ndiyo kama amefika Kituoni ndani ya saa 72 tangu tukio la unyanyasaji kutokea; andika herufi H = Hapana kama amefika Kituoni katika kipindi cha zaidi ya saa 72 tangu tukio la unyanyasaji kutokea; na andika S=Sijui kama mteja hajui ni muda gani umepita tangu tukio la unyanyasaji kutokea (weka herufi 'S' baada ya jitihada zote za kuuliza muda wa tukio kushindikana kabisa).

Safu ya (19): Huduma za kimatibabu baada ya tukio: Weka namba '0' kamahakupata huduma; weka namba '1' kama amepata huduma ndani ya saa 72; au weka namba '2' kama amepata huduma baada ya saa 72. Weka namba husika chini ya safu kulingana na aina ya huduma iliyotolewa:- FI- Uchunguzi wa ushahidi wa kisheria (Forensic Investigation), IM- Matibabu ya majeraha (Injuries Management), C- Unasihi (Counseling), PEP- Matibabu ya kinga (Post Exposure Prophylaxis), STI- Matibabu ya Magonjwa ya ngono (Sexually Transmitted Infections), EC- Kupatiwa njia ya uzazi wa mpango ya dharura (Emergency Contraceptive) au/na FP- Kupatiwa njia ya uzazi wa mpango (Family Planning)

Safu ya (20): Majibu Baada ya Kufanyiwa Vipimo. Mteja anaweza kufanyiwa vipimo vya aina tatu, yaani kupima Mimba, Virusi vya UKIMWI na maambukizi ya Magonjwa ya Ngono/Kujamiiiana. Kwa mteja aliyepimwa Mimba, Virusi vya UKIMWI na maambukizi ya Magonjwa ya Ngono/Kujamiiiana; majibu yanaweza kuwa ni **P**=Positive, **N**=Negative au

U=Hayajulikani/amekataa Kupima/Hakupima. Weka alama P, N au U katika eneo husika kulingana na vipimo husika.

Safu ya (21): Huduma nyinginezo: Weka namba '0' kama hakupata huduma; au weka namba '1' kama amepata huduma. Weka namba husika chini ya safu kulingana na aina ya huduma iliyotolewa:- P- Polisi (Police), LA- Msaada wa kisheria (Legal Aid), SWS- Ustawi wa jamii (Social Welfare Services)

Safu ya (22): Amepata ulemavu wa kimwili wa kudumu: Weka herufi 'N' kama amepata ulemavu wa kimwili wa kudumu kutokana na tukio hili; weka herufi 'H' kama hakupata ulemavu wa kimwili wa kudumu kutokana na tukio hili.

Safu ya (23): Rufaa: Andika jina la kituo chini ya safu husika kulingana na aina ya rufaa:- Kutoka nje kwa rufaa zote zinazotoka nje ya kituo, ndani kwa rufaa za kwenda au kutoka eneo la huduma/idara moja kwenda nyingine ndani ya kituo na kwenda nje kwa rufaa kwenda nje ya kituo.

REFERENCES

- Arnold, R. 2010. "Gender-Based Violence: An Advocacy Guide for Grassroots Activities in Burundi." Bujumbura, Burundi: CARE Burundi.
- Betron, Myra, Elizabeth Doggett, Laura Skolnik, Halima Shariff, and Cynthia Greene. 2008. "Gender-based Violence in Tanzania: An Assessment of Policies, Services and Promising Interventions." Washington, DC: U.S. Agency for International Development.
- Bloom, S.S. 2008. "Violence against Women and Girls: A Compendium of Monitoring and Evaluation Indicators." Washington, DC: USAID.
<http://www.cpc.unc.edu/measure/resources/tools/gender/violence-against-women-and-girls-compendium-of-indicators>
- Bott, Sarah, Andrew Morrison, and Mary Ellsberg. 2005. "Preventing and Responding to Gender-Based Violence in Middle- and Low-Income Countries: A Global Review and Analysis." World Bank Policy Research Working Paper No. 3618. Washington, DC: World Bank.
- Bruce, Nigel, Daniel Pope, and Debbi Stanistreet. 2008. *Quantitative Methods for Health Research: A Practical Interactive Guide to Epidemiology and Statistics*. W. Sussex, UK: John Wiley and Sons, Ltd.
- Centers for Disease Control and Prevention (CDC). 2004. "Sexual Violence Prevention: Beginning the Dialogue." Washington, DC: CDC.
- Children's Dignity Forum (CDF). 2013. "Preventing and Eliminating Of Child, Early and Forced Marriage in Tanzania." Dar es Salaam: CDF.
- Du Mont, J., and D. Parnis. 2000. "Sexual Assault and Legal Resolution: Querying the Medical Collection of Forensic Evidence." *Medicine and Law* 19:779–92.
- Ellsberg, M., and L. Heise. 2005. "Researching Violence against Women: A Practical Guide for Researchers and Activists." Washington, DC: World Health Organization and PATH.
- Farrington, D.P. 2007. "Childhood Risk Factors and Risk Focused Prevention." In M. Maguire, R. Morgan, and R. Reiner, eds., 602– 640. *The Oxford Handbook of Criminology*, 4th ed. Oxford UK: Oxford University Press.
- Fatusi, Adesegun, and Bolanle Oyeledun. 2002. "Gender-Based Violence Challenges the Public Health Community." Seattle, WA: University of Washington School of Public Health and Community Medicine.
- Finkelhor, D. 1994. "The International Epidemiology of Child Sexual Abuse." *Child Abuse & Neglect* 18 (5): 409–17.

- Garcia-Moreno, Claudia, and Charlotte Watts. 2011. "Violence against Women: An Urgent Public Health Priority Bulletin of the WHO." Geneva: World Health Organization. 89:2-2. doi:10.2471/BLT.10.085217.
- Glassier A., A.M. Gülmezoglu, G.P. Schmid, C.G. Moreno, and P.F. Van Look. 2006. "Sexual and Reproductive Health: A Matter of Life and Death." *Lancet* 368: 595–607.
- Global AIDS Alliance. 2008. "Scaling Up for Zero Tolerance: Civil Society Leadership in Eliminating Violence against Women and Girls in Ghana, Rwanda, and South Africa." Washington, DC: Global AIDS Alliance.
- Grove, Gregory. 2012. "The Healing Grove: Counseling." <http://www.thehealinggrove.co.za/Trauma-Counseling/trauma-counseling.html>
- Guedes, A. 2004. "Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: A Literature Review and Analysis." Washington, DC: Interagency Gender Working Group (IGWG)/USAID Bureau for Global Health.
- Heise, Lori, and Garcia Moreno. 2002. "Intimate Partner Violence." In *World Report on Violence and Health*, edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, et al., Chapter 4, pp. 87–121. Geneva: WHO.
- Human Rights Watch. 2013. "'Treat Us Like Human Beings': Discrimination against Sex Workers, Sexual and Gender Minorities, and People Who Use Drugs in Tanzania." Chicago, IL, USA: Human Rights Watch.
- IASC (Inter-Agency Standing Committee). 2010. "General and Psychosocial Modules: Participant Manual" In *Caring for Survivors Of Sexual Violence in Emergency*. Geneva: IASC.
- . 2010. "Caring for Survivors: General and Psychosocial Module." Handout for participants. Geneva: IASC.
- IGWG (Interagency Gender Working Group). 2006. "Addressing Gender-based Violence through USAID's Health Programs: A Guide for Health Sector Program Officers." Washington, DC: IGWG/USAID Bureau for Global Health.
- IRC and UNICEF (International Rescue Committee and United Nations Children's Fund). 2012. "Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings." New York: IRC.
- Irish Joint Consortium on Gender-based Violence. 2008. "Keeping Gender on the Agenda: Gender-based Violence, Poverty and Development." An Issues Paper from the Irish Joint Consortium on Gender Based Violence, Dublin, National University of Ireland.
- Jewkes, R., P. Sen, and C. Garcia-Moreno. 2002. "Sexual Violence." In *World Report on Violence and Health*, 147–82. Geneva: World Health Organization.

- Johnson, C. F. 2004. "Abuse and Neglect of Children." In R. E. Behrman, R. M. Kliegman, and H. B. Jenson (Eds.), *Nelson Textbook of Pediatrics* (17th ed.), pp. 126–132. Philadelphia, PA: WB Saunders Company.
- Kiwasila, H. 2002. "Promoting Local Level Dialogue on Traditional Practices Affecting Women's Health: The Case of Female Genital Mutilation among the Vidunda of Kilosa District— A Proposal for a Community Action-Oriented Research Project." Dar es Salaam: Women in Research and Development Programme, Dar es Salaam University.
- L.A. Department of Public Safety and Corrections. "Evidence Handling Guide." Los Angeles, CA: Office of State Police, Crime Laboratory.
- Laisser, R.M. 2011. "Prevention of Intimate Partner Violence: Community and Health Care Workers' Perceptions in Urban Tanzania." Umea TZ: Umea University.
- Laisser, R.M. 2011. "Prevention of Intimate Partner Violence: Community and Healthcare Workers' Perception in Urban Tanzania." Doctoral thesis, Department of Public Health and Clinical Medicine, Umeå University, Sweden.
- Laisser, R.M. 2011. *Prevention of Intimate Partner Violence: Community and Healthcare Workers' Perceptions in Urban Tanzania*. Umea, Sweden: Umea University.
- Lampe, A. 2002. "The Prevalence of Childhood Sexual Abuse, Physical Abuse and Emotional Neglect in Europe." *Zeitschrift fur Psychosomatische Medizin und Psychotherapie* 48: 370–80.
- Lemoyne, Roger. 2006. "World Report on Violence against Children and International Human Rights Law and Standards." UNICEF/HQ05-1931.
- Magesa, Daniel J., Leah J. Mtui, Mariam Abdul, et al. 2014. "Barriers to Men Who Have Sex with Men Attending HIV Related Health Services in Dar es Salaam, in Tanzania." *Journal of Health Research* 16 (2).
- Michau, L. 2008. "The SASA! Activist Kit for Preventing Violence against Women and HIV." Kampala, Uganda: Raising Voices.
- MOH (Ministry of Health). 2005. "National Infection Prevention and Control Guideline for Health Care Services in Tanzania." Dar es Salaam: MOH.
- MOHCDGEC (Ministry of Health, Community Development, Gender, Elderly, and Children). 2001. "National Plan of Action in Tanzania for the Prevention and Eradication of Violence against Women and Children 2001–2015." Dar es Salaam: MOHCDGEC.
- MOHSW (Ministry of Health and Social Welfare). 2011a. "National Management Guidelines for the Health Sector Prevention of and Response to Gender-based Violence." Dar es Salaam: MOHSW, United Republic of Tanzania.
- . 2011b. "Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services." Dar es Salaam: MOHSW.

- . 2013. "Final Draft National Aids Control Programme, October, 2013." In *Ministry of Health and Social Welfare Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017*. Dar es Salaam: MOHSW, United Republic of Tanzania.
- NACP (National AIDS Control Program). 2010. "HIV Behavioral and Biological Surveillance among Female Sex Workers in Dar es Salaam, 2010." Dar es Salaam: NACP.
- . 2012. "National Guidelines for Management and Care of HIV and AIDS." Dar es Salaam: NACP/Ministry of Health and Social Welfare.
- . 2013. "HIV and STI Biological and Behavioral Surveys: Female Sex Workers in Seven Regions: Dar es Salaam, Iringa, Mbeya, Mwanza, Shinyanga, Tabora and Mara." Dar es Salaam: NACP.
- . 2015. "Sec. 5.2.5, Post Exposure Prophylaxis (PEP)." *National Guidelines for the Management of HIV and AIDS, 5th ed.* Dar es Salaam: Ministry of Health and Social Welfare, United Republic of Tanzania.
- NBS (National Bureau of Statistics). 2015/16. *Tanzania Demographic and Health Survey 2015/16*. Dar es Salaam: NBS Tanzania and ICF Macro.
- NBS (National Bureau of Statistics). 2011a. *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS Tanzania and ICF Macro.
- . 2011b. "Violence against Children National Survey, 2011." Part of the *Tanzania Household Demographic Survey*. Dodoma: NBS.
- . 2011c. *Tanzania Demographic and Health Survey 2010*. Dar es Salaam: NBS Tanzania and ICF Macro.
- . 2011d. *Tanzania Household Demographic Survey*. Dodoma: National Bureau of Statistics.
- National Center for Knowledge on Men's Violence against Women (NCK). 2008. "Guide to Care Following Sexual Assault." Uppsala University, TZ: NCK.
- New South Wales Health Department. 2000. "Gender Equity in Health: Better Health, Good Health Care." State Health Publication No: (HSP) 000015. www.health.nsw.gov.au. Erişim tarihi:07.2005ISBN: 0 7347 3132 9.
- Oladepo, O., Yusuf O.B., and O.S. Arulogun. 2011. "Factors Influencing Gender-based Violence Among Men and Women in Selected States in Nigeria." *African Journal of Reproductive Health* 2011 Dec 15(4):78–86.
- Population Council. 2008. "Sexual and Gender-based Violence in Africa: A Literature Review." Washington, DC: Population Council.
- Putnam, F.W. 2003. Ten-Year Research Updates Review on Child Sexual Abuse. *Journal of the American Academy of Child and Adolescent Psychiatry* 42 (3): 269–78.

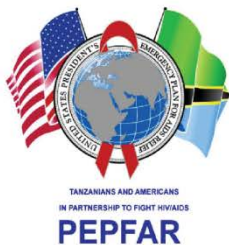
- SADC (Southern Africa Development Community). 1998. "Prevention and Eradication of Violence against Women and Children" (Addendum to the 1997 SADC Declaration on Gender and Development).
- . 2013. "HIV and STI Biological and Behavioral Surveys: Female Sex Workers in Seven Regions: Dar es Salaam, Iringa, Mbeya, Mwanza, Shinyanga, Tabora and Mara." Dar es Salaam: NACP.
- Saltzman, L.E., J.L. Fanslow, P.M. MacMahon, and G. A. Shelley. 2002. "Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0." Atlanta, GA: U.S. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- Umeå University. 2009. "Psychosocial Counseling and Social Work with Clients and Their Families in the Somali Context: A Facilitator's Guide." GRT version 1. Umeå University, Sweden.
- United Nations (UN). 1949. *"Universal Declaration of Human Rights."* New York: UN.
<http://www.un.org/Overview/rights.html>.
- . 1994. "General Assembly Declaration on the Elimination of Violence Against Women." Women 1995: Fourth World Conference on Women. New York: UN.
- . 1995. "Beijing Declaration and Platform for Action." Women 1995: Fourth World Conference on Women. Beijing China, September 1995. New York: UN.
<http://www.un.org/womenwatch/daw/beijing/platform/>
- UNFP (United Nations Population Fund). 1994. International Conference on Population and Development Program of Action. New York: UN.
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf
- . 2007. "Viet Nam: Gender-Based Violence Programming Review." New York: UNFPA.
- . 2012. "Programming Module on Working with the Health Sector to Address Violence against Women and Girls." New York: UN Women and UNFPA.
- UNICEF (United Nations Children's Fund). 2009. "Training of Trainers on Gender-Based Violence: Focusing on Sexual Exploitation and Abuse." New York: UNICEF.
http://www.un.org/en/pseataforce/docs/unicef_training_of_trainers_on_sea_participant_manual.pdf.
- . 2011. "Child Disciplinary Practices at Home: Evidence from a Range of Low- and Middle-Income Countries." New York: UNICEF.
- . 2014. *"Ending Violence Against Children: Six Strategies for Action."* New York: UNICEF.

- UNICEF, CDC, and *Muhimbili* University of Health and Allied Sciences. 2011. "Violence against Children in Tanzania: Findings from a National Survey." Dar es Salaam: UNICEF Tanzania.
- USAID (United States Agency for International Development). 2008. "Gender-Based Violence in Tanzania: An Assessment of Policies, Services and Promising Interventions." Washington, DC: USAID. http://pdf.usaid.gov/pdf_docs/PNADN851.pdf
- URT (United Republic of Tanzania). 2013a. "Multi Sector National Plan of Action to Prevent and Respond to Violence Against Children, 2013–2016." Ministry of Community Development, Gender, and Children, United Republic of Tanzania, United Republic of Tanzania, Dar es Salaam.
- . 2013b. "Third National Multi-Sectoral Strategic Framework for HIV and AIDS 2013/14–17/18" [NMSF III]. Prime Minister's Office, United Republic of Tanzania, Dar es Salaam.
- . 2014. United Republic of Tanzania. "National Guideline for Comprehensive Package of HIV Interventions for Key Populations." Dar Es Salaam: URT.
- U.S. Department of Health (USDH). 2005. "Responding to Domestic Abuse: A Handbook for Health Professionals." Washington, DC: USDH.
- Ward, Jeanne, and Julie Lafreniere. 2010. "Handbook for Coordinating GBV Interventions in Humanitarian Settings." Gender-based Violence Area of Responsibility Working Group, Global Protection Cluster, European Commission and Australian Government.
- World Health Organization (WHO). 1997. "Life Skills Education for Children and Adolescents in Schools: Introduction and Guidelines to Facilitate the Development and Implementation of Life Skills Programs." Geneva: WHO.
- . 2000. "Health Complications of Female Genital Mutilation including Sequelae in Childbirth: A Systematic Review." Geneva: WHO.
- . 2002. "World Report on Violence and Health: Summary." Edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, et al. Geneva: WHO.
- . 2005. "WHO Multi-Country Study on Women's Health and Domestic Violence against Women." Geneva: WHO.
- . 2006. "Global Estimates of Health Consequences Due to Violence against Children." Background Paper to the *UN Secretary-General's Study on Violence against Children*. Geneva: WHO.
- . 2008. "The Global Burden of Disease: Update." Geneva: WHO.
- . 2010a. "Preventing Intimate Partner and Sexual Violence against Women: Taking Action In Generating Evidence." Geneva: WHO.

- . 2010b. "Repositioning Family Planning: Guideline for Advocacy Action." Geneva: WHO.
- . 2013. "Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines." Geneva: WHO.
- . 2014a. "Guidelines on Post-Exposure Prophylaxis for HIV and the Use of Co-Trimoxazole Prophylaxis for HIV-related Infections among Adults, Adolescents and Children: Recommendations for a Public Health Approach." December 2014 Supplement to the 2013 *Consolidated Guidelines on the Use of Antiretroviral Drugs For Treating and Preventing HIV Infection*. Geneva: WHO.
- . 2014b. "Global Status Report on Violence Prevention." Washington and New York: WHO, United Nations Development Program, and United Nations Office on Drugs and Crime.
- WHO/ILO (World Health Organization/International Labor Organization). 2009. "Joint WHO/ILO Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection, 2009. Joint United Nations Programme on HIV/AIDS (UNAIDS).
- World Health Organization and London School of Hygiene and Tropical Medicine. 2004. "Preventing Intimate Partner and Sexual Violence Against Women: Taking Action and Generating Evidence." Geneva: WHO.
- WHO/UNAIDS. 2013. "Sixteen Ideas for Addressing Violence Against Women in the Context of the HIV Epidemic: A Programming Tool." Geneva: WHO.
http://apps.who.int/iris/bitstream/10665/95156/1/9789241506533_eng.pdf
- WHO/UNHCR. 2004. "Clinical Management of Rape Survivors." Geneva: WHO.
- Wong, Margaret. 2004. "Stop Domestic Violence: A Template for Best Practice." Harmony House Presentation on 19 May 2004 at Domestic Violence Training Workshop, organized by the HK Council of Social Service. Hong Kong SAR, China: Harmony House.



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