



Prevention and Management of Gender-Based Violence

A Guide for Health-Care Providers

Revised October 2022



**World Health
Organization**

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Foreword

Gender-based violence (GBV) continues to be a threat to human security, peace and development. The SADC blueprint documents, namely the Revised Regional Indicative Strategic Development Plan 2015–2020 (RISDP) and the Strategic Indicative Plan for the Organ on Politics, Defence and Security Cooperation (SIPO), recognize the prevention and reduction of GBV as a catalyst to attaining an environment conducive to peace and security. Also, the revised RISDP explicitly includes the development of the regional GBV strategy as one of its priorities. In addition, the SADC Gender policy explicitly suggests that SADC’s approach to addressing GBV should go beyond addressing the act of violence; and also consider the need to develop evidence-based strategies that encompass education, prevention and victim/survivor assistance. More recent evidence suggests that GBV remains high in Botswana.

In view of the above regional approach, the Government of Botswana recognizes the need to strengthen the prevention and management of GBV. The country adopted the Revised SADC Protocol on Gender and Development (2017) and the Regional Strategy and Framework of Action for Addressing Gender-Based Violence 2018–2030. Botswana has also adopted the elimination of gender-based violence as integral to the achievement of the Sustainable Development Goals (SDGs), especially Goal 5 on achieving gender equality and empowering all women and girls. There has also been the enactment of some new policies and response efforts such as the National Policy on Gender and Development (2015); National GBV Strategy 2015–2020; and the National Guidelines on Health Services Integration (2021) to further address GBV in the country.

The National GBV Strategy highlights the key role of the health sector as a critical entry-point for addressing GBV, not only as a means for treating victims/survivors but also for prevention. It underscores the need to strengthen the capacities of health-care workers to prevent and respond to GBV, and provide strong referrals to other essential services, such as justice and social services as required by the victim/survivor. The revised protocols and service standards are therefore intended to improve the quality of care provided by health-care providers and the overall health sector response to GBV in Botswana.

This Guideline for health-care workers is an update of the previous protocols and service standards, which were developed in 2011. The revised Guidelines are aligned with the current national legal, policy, institutional and implementation frameworks; and adaptations to regional and global standards for strengthening GBV response and its integration in SRH and HIV services. The Guideline is anchored on three main thematic areas of focus, namely Prevention, Response and Management of GBV, and highlights key guiding principles of safety, confidentiality, respect, non-discrimination and honesty. The Ministry of Health presents this document as a guiding tool in its continuing efforts to integrate the prevention and management of GBV into Sexual and Reproductive Health Services.



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Acknowledgements

The revised Guidelines for health-care workers are meant to guide all stakeholders in the health-care sector, including the private sector, non-governmental organizations (NGOs) and governmental departments, on the provision of gender-sensitive and culturally appropriate sexual reproductive health (SRH) services. The success of these Guidelines will depend on the partnership with all stakeholders and clear, coordinated efforts in the operationalization of this critical document. By working together in tandem as partners, we will be able to deliver on the Ministry of Health's targets for ensuring the attainment of health by all by 2030, thereby ensuring no one is left behind.

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List of Acronyms

ARV	Antiretroviral	NGOs	Non-Governmental Organizations
BGBVC	Botswana Gender-Based Violence Prevention and Support Centre	NPGAD	National Policy on Gender and Development
BPS	Botswana Police Service	PEP	Post-Exposure Prophylaxis
CBOs	Community-Based Organizations	RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women	RPR	Rapid Plasma Reagin
ECP	Emergency Contraceptive Pill	SADC	Southern Africa Development Community
DNA	Deoxyribonucleic Acid	SDGs	Sustainable Development Goals
DT	Diphtheria and Tetanus Toxoids	SRH	Sexual and Reproductive Health
DTP	Diphtheria, Tetanus, and- Pertussis vaccine	SRHR	Sexual and Reproductive Health & Rights
EC	Emergency Contraception	STIs	Sexually Transmitted Infections
ELISA	Enzyme-linked Immunosorbent Assay	TBSA	Total Body Surface Area
FBOs	Faith-Based Organization	TIG	Tetanus Immunoglobulin
GBV	Gender-Based Violence	TOC	Theory of Change
HBV	Hepatitis B Virus	TT	Tetanus Toxoid
HCW	Health-Care Worker(s)	UB	University of Botswana
HIV	Human Immunodeficiency Virus	UN	United Nations
IASC	Inter-Agency Standing Committee	UNFPA	United Nations Population Fund
IPV	Intimate Partner Violence	WAD	Women's Affairs Department
IUD	Intrauterine Device	WAR	Women Against Rape
M&E	Monitoring and Evaluation	WHO	World Health Organization
MoH	Ministry of Health	VAW	Violence Against Women
MTP	Medical Termination of Pregnancy	VCT	Voluntary Counselling and Testing
NDP	National Development Plan		

Table of Contents

Foreword	iii
Acknowledgements	iv
List of Acronyms	v
Glossary of Definitions	viii
Situation Analysis	x
Purpose of the Guidelines	xvii
Guiding Principles when Providing Health Care to GBV Victims/Survivors	xviii

CHAPTER 1: Making Preparations to Offer Clinical Care	1
CHAPTER 2: Reception and Intake of Clients: Identifying a Victim/Survivor Subjected to Violence	5
CHAPTER 3: First-Line Support for Victims/Survivors of GBV	15
CHAPTER 4: Providing Immediate Crisis Counselling	22
CHAPTER 5: Taking the History	24
CHAPTER 6: Preparing the Victim/Survivor for Examination	26
CHAPTER 7: Collecting Forensic Evidence	28
CHAPTER 8: Performing the Physical and Genital Examination	33
CHAPTER 9: Documentation and Recording	38
CHAPTER 10: Providing Care/Treatment	40
CHAPTER 11: Counselling the Victim/Survivor	64
CHAPTER 12: Follow-up Care of Victims/Survivors	68
CHAPTER 13: Reporting Medical Findings in Court	70
CHAPTER 14: Caring for the Health-Care Provider, including Self-Care	72
CHAPTER 15: Monitoring, Evaluation & Learning (MEL)	74

Annex 1: Checklist of needs for clinical management of sexual assault victims/survivors	85
Annex 2: Survivor-centred approach	87
Annex 3: Job Aid - Helping victims/survivors cope with negative feelings	91
Annex 4: Additional guidance on preparing the victim/survivor for exam & obtaining informed consent	92
Annex 5: General tips for history-taking	93
Annex 6: Additional care for mental health: Psychological first aid & support	94
Annex 7: Additional resources: Exercises to help reduce stress	96
Annex 8: Script: Adherence counselling	97
Annex 9: Minimum care for victims/survivors of sexual assault	98
Annex 10: Sample consent form	99
Annex 11: Pictograms	101
Annex 12: Forensic evidence collection	102
Annex 13: BP FORM 73	104
Annex 14: Sample Health Facility Register for recording cases of gender-based violence (GBV)	108
Annex 15: Reference Group members	109

LIST OF TABLES

TABLE 1: Clinical conditions associated with abuse, including GBV, among women, men, and children	10
TABLE 2: Describing features of physical injuries	29
TABLE 3: Management of sexual assault at a glance	40
TABLE 4: STI prophylactic regimen	42
TABLE 5: Types available, regimens and effectiveness of emergency contraception (EC)	48
TABLE 6: Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds	50
TABLE 7: Determining pregnancy by pregnancy test	54
TABLE 8: Burn area by age in years	62
TABLE 9: List of GBV data elements to be collected at health facilities	75

Glossary of Definitions

Gender-based violence (GBV): violence that is directed at a person based on gender or sex. It includes acts that inflict physical, mental, sexual harm or suffering, threat of such acts, coercion, and other deprivations of liberty.¹ GBV is also an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. GBV is most prevalent against women and girls, but in some cases, it can also affect men and boys. This violence can take many forms:²

- **Physical violence** involves hurting or trying to hurt a person by hitting, kicking, burning, grabbing, pinching, shoving, slapping, hair-pulling, biting, denying medical care or forcing alcohol and/or drug use, or using other physical force. It may include property damage.
- **Sexual violence** is a form of GBV involving “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim/survivor, in any setting, including but not limited to home and work”.³ Some examples include rape, attempted rape, sexual abuse, causing harm during sex, forcing a person to have sex without protection from pregnancy or infection, defilement, incest and sexual exploitation amongst others.
- **Psychological violence** involves causing fear by intimidation; threatening physical harm to self, partner or children; destruction of pets and property; “mind games”; or forcing isolation from friends, family, school and/or work.
- **Emotional violence** includes undermining a person's sense of self-worth through constant criticism; belittling one's abilities; name-calling or other verbal abuse; damaging a partner's relationship with the children; or not letting a partner see friends and family.
- **Economic violence** involves making or attempting to make a person financially dependent by maintaining total control over financial resources, withholding access to money, and/or forbidding attendance at school or employment.
- **Harmful practices** such as forced/child marriage and female genital mutilation are part of a continuum of violence against women and girls that remains widespread and are a “silent and endemic crisis”.⁴

Intimate partner violence (IPV), also commonly known as domestic violence or domestic abuse, is one of the most common forms of GBV. It is the actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or former boyfriend or girlfriend, or current or former dating partner.⁵ Other terms used to describe intimate partner violence include domestic abuse, spouse abuse, domestic violence, courtship violence, battering, date rape, and, though not recognized by the law in many countries, marital rape.

¹ Sources: General recommendations made by the Committee on the Elimination of Discrimination against Women, 1992, cited in <https://asiapacific.unfpa.org/sites/default/files/pub-pdf/kNOwVAWdata%20Key%20Terminology.pdf>

² Based on: <https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence>

³ Source: Inter Agency Standing Committee (IASC), 2005

⁴ Source: Commission on the Status of Women, 2020

⁵ Source: https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf



Did you know?

Controlling behaviour by the partner may also be a red flag on IPV/GBV:

for example, if the partner doesn't allow the other partner to go out of the home, or to see family or friends, insisting on knowing where they are at all times, often being suspicious that they are unfaithful, not allowing them to seek health care without permission, or leaving the partner without money to run the home. Health-care providers can identify these red flags.

Sexual assault⁶ is an act of non-consensual sexual intercourse, including the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Any penetration is considered rape. Efforts to rape someone which do not result in penetration are considered attempted sexual assault.

Defilement:⁷ Any person who unlawfully and carnally knows any person under the age of 18 years. Or sex with any person under the age of 18.

Incest:⁸ Any person who knowingly has carnal knowledge of another person knowing that person to be his or her grandchild, child, brother, sister or parent.

Violence against women (VAW)⁹ is any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological

harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Victim/survivor¹⁰ refers to those – usually women and girls – who have experienced or are experiencing gender-based violence. The term is used to reflect both the terminology utilized in the legal process and, at the same time, to reflect the agency of those seeking essential services. This reflects an ongoing debate on the use of the terms 'victim' and 'survivor': some suggest that the term 'victim' should be avoided because it implies passivity, weakness and inherent vulnerability and fails to recognize the reality of women's resilience and agency. For others, 'survivor' is not ideal because it denies the sense of victimization experienced by people who have been the target of violent crime. Therefore, these guidelines use the term 'victim/survivor'.

⁶ Source: Botswana Penal Code

⁷ Ibid

⁸ Ibid

⁹ Source: United Nations General Assembly Declaration, 1993

¹⁰ Source: UN Essential Services Package for Women and Girls Victims of Violence <https://www.unfpa.org/essential-services-package-women-and-girls-subject-violence>

Situation Analysis

Background

Gender-based violence (GBV) is defined as any act of violence that results in, or is likely to result in, physical, sexual or mental harm or suffering of women and men, girls and boys, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life directed to a person based on their gender or sex.¹¹ GBV continues to be one of the most common and serious human rights violations. In response to the high levels of GBV, the United Nations (UN) through the Sustainable Development Goal 5 (SDG 5) indicates the need to achieve gender equality and empowerment of women and girls. At a global level, countries have been urged to develop plans for ending such human rights violations, by shifting from campaign mode to a more integrated programmatic approach in addressing GBV. Regionally, the Revised SADC Protocol on Gender and Development 2015 and the Regional Strategy and Framework of Action for Addressing Gender-Based Violence 2018–2030 have been designed to eliminate GBV at every level among member states. The causes of GBV are complex and deeply rooted in sociocultural, institutional, legal, and economic practices.

The Government of Botswana's 11th National Development Plan (NDP11), Vision 2036, various National Health Policies, and their corresponding strategic frameworks articulate action towards the achievement of the country's development goals, including health and gender equality. The country subscribes to the SDGs and is signatory to several international and regional conventions that address GBV. The national legal framework for the response to GBV includes the Constitution of Botswana, the Penal Code and the Domestic Violence Act,

the Marriage Act and the Abolition of Marital Power Act, among others. The Botswana National Strategy Towards Ending GBV by 2020 serves as a policy document intended to guide a national multisectoral, decentralised and multilevel response to GBV.

GBV remains high in Botswana, with 37 per cent of the women reporting experiencing GBV at least once in their lifetime (emotional, physical and sexual) including intimate partner and non-partner violence. Meanwhile a third (33 per cent) of men indicated that they have perpetrated GBV in their lifetime.¹² Women of reproductive age are more likely to experience intimate partner violence than older women. Domestic violence increased during the COVID-19 outbreak ([UNFPA, 2020](#)). Botswana Gender-Based Violence Prevention and Support Centre (BGBVC) and Women Against Rape (WAR) reported an exponential increase in the demand for counselling, consultations, and safe spaces in April and May of 2020 during the national lockdown. However, the national relationship study has also shown that most people do not report cases of GBV due to stigma or shame, but often present to health facilities with injuries or vague symptoms, without explicitly indicating/identifying themselves as victims/survivors of GBV.

The increased risk for adverse sexual reproductive health (SRH) outcomes is heightened when victims/survivors of GBV (especially sexual violence/assault) do not receive comprehensive victim/survivor-centred services including clinical management of rape such as access to post-exposure prophylaxis to prevent unintended pregnancies, STIs and HIV infection. Barriers to addressing GBV include limited national capacity for provision of client-centred quality assured and sustainable prevention

¹¹ <https://www.un.org/womenwatch/daw/vaw/reports.htm#declaration>

¹² Botswana National Relationship Study, 2018

of GBV services for victims/survivors. This highlights the key role the health sector plays as a critical entry-point for addressing GBV, not only as a means for treating victims/survivors, but also for prevention. It underscores the need to strengthen capacities of health-care workers to effectively prevent and respond to GBV and provide strong referrals to other essential services (police, justice and social services) as needed and requested by the victim/survivor.

The Government of Botswana has worked, since 2011, to improve the quality of care given by health-care providers and overall health services response to GBV in Botswana through the development of Protocols and Service Standards for the Health Sector. The current Protocol is an update of the 2011 version,¹³ and brings important updates as these align with the current national legal, policy, institutional and implementation frameworks; and also contains adaptations to regional and global standards for strengthening the response to violence against women (VAW) and its integration in SRH and HIV services.

Gender-based violence as a public health issue

GBV has been linked to many serious health problems, both immediate and long-term. More often than is recognized, GBV can be fatal, as in the case of femicide or killing of women, usually after escalating bouts of intimate partner violence. It can also result in non-fatal health issues such as injury, chronic pain syndromes, gastrointestinal disorders; and a range of mental health problems, including anxiety and mood disorders. The often chronic nature of GBV also predisposes individuals to STIs including HIV, unwanted pregnancy, miscarriage/low birth weight, sexual dysfunction, and unsafe abortion. It also increases a variety of

negative behaviours, such as indulging in or resorting to the use of habit-forming drugs and their abuse.

Consequences of GBV on health

GBV, in particular physical and/or sexual violence/assault by an intimate partner, has been associated with a number of adverse health consequences.¹⁴ Such violence may result in fatalities, including homicide, suicide, maternal mortality, or AIDS-related death. It may lead to injuries, functional impairment, and other health effects such as headaches, stress, anxiety or depression, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health. It may also lead to unintended/unwanted pregnancies, induced abortions, maternal health problems (miscarriage, stillbirth, low birth weight, prematurity), gynaecological problems and STIs, including HIV. Such forms of violence may lead to depression, post-traumatic stress disorder, sleeping difficulties, eating disorders, emotional distress, and suicide attempts. Sexual violence/assault, particularly during childhood, may lead to misuse of drugs and alcohol, and at-risk sexual behaviours in later life.

In addition to the physical injuries, global data indicates that women exposed to intimate partner violence are 1.5 times more likely to have HIV; twice as likely to experience depression; and 16 per cent more likely to have low birth weight babies.

Gender-based violence as a human rights issue

GBV violates several principles enshrined in international and regional human rights instruments, including the right to life, equality,

¹³ Protocols and Service Standards for Prevention and Management of Gender-based Violence for Healthcare Providers, 2011

¹⁴ Prevalence and health effects of intimate partner violence and non-partner sexual violence, WHO, 2013

security of person, freedom from torture and other cruel, inhumane, or degrading treatment. It also poses a challenge to traditional human rights work as it frequently occurs in arenas traditionally considered to be 'private', including the family and the home. In this area, government's responsibility is not simply to abstain from human rights violations, but to find proactive means of protecting women's dignity, health, and well-being.

GBV violates principles of the UN Universal Declaration of Human Rights:

- Article 1: "All human beings are born free and equal in dignity and rights"
- Article 5: "Everyone has the right to life, liberty and security of person"

- Article 5: "No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment"

(United Nations General Assembly, Geneva, 1948).

International and regional agreements and charters

Botswana has ratified several important international legal instruments to address GBV over the years. The legal and policy instruments provide an important framework for social equality, justice, and development and provide a platform to develop and monitor legislation and related programmes. Such instruments can also be used to hold the government accountable for violations. The following are particularly important international and regional conventions that are used to address GBV:

1979	Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)
1993	World Conference on Human Rights, Vienna
	United Nations Declaration on the Elimination of Violence Against Women
1994	International Conference on Population and Development, Cairo
1995	United Nations Fourth World Conference on Women, Beijing
1998	Southern African Development Community (SADC) Addendum to the 1997 Declaration on Gender and Development on the Prevention and Eradication of Violence Against Women and Children, Grand Baie, addresses legal, social, economic, cultural and political measures; services; education, training and awareness building; integrated approaches; and budgetary allocations
2005	African Continental Policy Framework on Sexual and Reproductive Health and Rights adopted at the 2 nd Ordinary Session of the Conference of African Ministers of Health in Gaborone
2006	Maputo Plan of Action adopted by African Ministers of Health in Maputo, which operationalizes the Continental Policy Framework and focuses on the integration of Sexual and Reproductive Health services into primary health care
2007	Africa Health Strategy 2007–2015 with the theme of "strengthening health systems for equity and development"; and emphasizes gender into health policy and the elimination of violence against women
2008	CRPD – Convention on Rights of Persons with Disabilities
2015	The Sustainable Development Goals encourage countries to adopt and strengthen policies and legislation for the promotion of gender equality and the empowerment of all women and girls at all levels. More specifically, its Goal 5 addresses gender equality and empowerment of women and girls, with concrete targets including ending violence, trafficking, and harmful practices; and ensuring universal access of women and girls to SRH services
2017	Revised SADC Protocol on Gender and Development
2018	SADC Regional Strategy and Framework of Action for Addressing Gender-Based Violence 2018–2030

National legislation and policy frameworks

1966	<p>The Constitution of Botswana: every person in Botswana is entitled to certain fundamental rights and freedoms irrespective of their race, place of origin, political opinion, colour, creed or sex. These include the right to:</p> <ul style="list-style-type: none"> » Life, liberty, security of the person and the protection of law » Freedom of conscience, of expression and of assembly and association » Protection for the privacy of his home and other property and from deprivation of property without compensation
1964	<p>Penal Code: The Government of Botswana, as seen in the Penal Code and other relevant legislation and policies, is committed to upholding the human and sexual rights and access to health care of victims/survivors of sexual and gender-based violence (see details¹⁵ of the various acts within the Penal Code).</p>
2008	<p>Domestic Violence (DV) Act: The Women’s Affairs Department (WAD), Ministry of Labour and Home Affairs, Domestic Violence (DV) Act No. 15 of 2007 passed by Parliament in 2008, augments the Penal Code (commencement date 15th August 2008 with the police being the implementers of the Act). To ensure that health-care providers and first responders in Botswana have the necessary knowledge and skills to provide appropriate care for GBV victims/survivors and refer cases of GBV to provide health, psycho-social, protection or legal services, an entire strategy should be developed, followed by a programme for awareness raising and sensitizations, capacity buildings of medical personnel and first responders, advocacy for adaptation of BPHS and EPHS to include GBV care, development of a national treatment protocol including training and supervision, establishment of integrated multisectoral system, funding mechanism and monitoring and evaluation.</p>
2009	<p>Children’s Act: Enacted to promote and protect the rights of the child, for the promotion of the physical, emotional, intellectual and social well-being of children and for the protection and care of children.</p>
2011	<p>Revised National Health Policy: This has the main goal of raising and allocating resources and making appropriate payment arrangements so that all people living in Botswana have access to a range of cost-effective health interventions at an affordable price regardless of their economic status. The Policy indicated the need to remove all financial barriers to access of health services, and consequently, all health services are accessed for free or at a nominal charge of 1 USD by all the citizens of Botswana. This is done through innovative measures, social protection and universal access to essential health services.</p>
2013	<p>Medicines and Related Substances Act: Provides for the registration, regulation of the sale, distribution, importation, exportation, manufacture and dispensing of medicines and related substances, and matters incidental thereto.</p>
2014	<p>Forensic Procedures Act 31, S.I. 142: Provides for the procedures for obtaining forensic material; the retention, storage and disposal of forensic material and the use of forensic material for scientific analysis during criminal or other investigations; the establishment of a national DNA database system and National DNA Database Advisory Board and connected matters.</p>
2015	<p>National Policy on Gender and Development: Anchors the national gender response within the broader national socioeconomic and political development framework. The Policy priorities and results contribute to the achievement of the goals of National Vision, the National Development Plan and Botswana’s commitment to the Sustainable Development Goals.</p>
2015	<p>National Gender-Based Violence Strategy 2015–2020: Guides multiple, integrated actions to eliminate GBV. A men’s sector under the Ministry of Gender, Nationality and Immigration engages men as critical partners in promoting gender equality.</p>
2016	<p>Vision 2036: Emphasizes the value of Botho, while recognizing the equal contributions of women and men to the socioeconomic, political and cultural development of the nation. It recognizes gender equality as a value to be pursued for national development and commits to domesticate relevant human rights treaties that promote gender equality and empower women, as well as to make deliberate efforts to end gender discrimination and GBV.</p>

¹⁵ The full content of the Penal Code is available at: <https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/61336/92021/F138317428/BWA61336.pdf>

2017	<p>National Development Plan 11: Provides a roadmap and a framework for development for the period 2017–2023, including the articulation of all sexual and reproductive health issues. Given that the majority of Botswana’s population is in the reproductive and productive ages, this presents an opportunity to accelerate socioeconomic development. The NDP 11 emphasizes the need for deliberate and strategic investments for gender equality and empowerment of women of reproductive age, as well as expanding the potential returns on education and health sectors. It also identifies key indicators of performance and requires regular updates on these SRH services.</p>
2021	<p>National Guidelines on Health Services Integration: Integrates health services, including SRHR, HIV/AIDS and GBV services.</p>

Prevalence of GBV

GBV is a major public health and human rights concerns, with IPV and sexual violence being among its most pervasive forms. The Botswana National Relationship Study (2018) showed that GBV remains high in Botswana, as seen in the data points below:

- 37 per cent of women interviewed reported that they experienced GBV at least once in their lifetime (emotional, physical and sexual) including intimate partner and non-partner violence; women of reproductive age (18–49 years old) were more likely to experience intimate partner violence than older women;
- 30 per cent of the interviewed men reported perpetrating GBV in their lifetime;
- 15 per cent of women who have ever been pregnant reported having experienced GBV during pregnancy;
- Women with disabilities were two to three times more vulnerable to GBV than men. A higher lifetime IPV experience was reported by women with disabilities related to functional mobility and visual disability.

It was also documented that some forms of GBV, such as Intimate Partner Violence, did increase during the COVID-19 outbreak (UNFPA, 2020).¹⁶ The Botswana Gender-Based

Violence Prevention and Support Centre (BGBVC) and Women Against Rape (WAR) reported an exponential increase in the demand for counselling, consultations, and safe spaces in April and May 2020 during the national lockdown. However, most people do not report cases of GBV due to stigma or shame, but often present to health facilities with injuries, without explicitly indicating themselves as victims/survivors of GBV.¹⁷

Sexual violence is often underreported, hence there is limited data on the extent of this type of violence in Botswana. There is a need to strengthen adequate generation, collection and use of disaggregated data on GBV prevalence to ensure that no one is left behind.

Persons with disabilities are more vulnerable to GBV

Globally, persons with disabilities are three times more likely to experience physical violence, sexual violence, and emotional violence than persons without disabilities.¹⁸ Women with disabilities are estimated to be up to 10 times more likely to experience sexual violence, and between 40 and 68 per cent of young women with disabilities will experience sexual violence before the age of 18. Boys and men with disabilities are twice as likely as boys and men without disabilities to be sexually abused in their lifetime.

¹⁶ <https://botswana.unfpa.org/en/news/much-more-needs-be-done-ending-gender-based-violence-botswana>

¹⁷ Botswana National Relationship Study, 2018

¹⁸ Source: UNFPA Global Study <https://www.unfpa.org/publications/young-persons-disabilities>



Men and boys may also be victims/survivors of IPV, sexual assault and other forms of GBV

While GBV is much more prevalent among women and girls, who are more frequently the victims/survivors of sexual violence, severe physical violence, and control from male partners, men and boys also may be victims/survivors of GBV, such as IPV and sexual assault. This guideline therefore applies to victims/survivors of GBV more broadly, including women and girls, and men and boys who suffered IPV, sexual assault and other forms of GBV.

Gender-based violence response by the health sector

Health-care providers can play a unique role in identifying, assessing and responding to GBV victims/survivors – in part due to the obvious effects of GBV on an individual's health, but also due to the position of health service providers as the primary, perhaps only, point of contact with professionals equipped to recognize and intervene in the situation.

In Botswana, most women (and some men) access health-care services at some point during their lives – whether for routine health care, pregnancy and childbirth, illness, injury, or in the role of caretaker for children or older people.¹⁹ Therefore, it is important that health-care providers be alert to the physical, psychological and behavioural signs and symptoms associated with GBV.

The Ministry of Health, through its SRH Division, coordinates integrated efforts to prevent and manage the rise of GBV in Botswana, and the gaps in health and health-related services. The intention is to offer a comprehensive, client-centred, standardized set of guidelines/protocol for GBV victims/survivors at health-care facilities in Botswana. The Health Sector

counts on several documents to implement this vision, including this protocol which is a review of the 2011 Protocols and Service Standards for Prevention and Management of Gender-Based Violence for Health-Care Providers.

Current challenges in GBV service provision

The provision of GBV services has faced some challenges. In general, capacity gaps and/or limited knowledge/understanding of current protocols, guidelines, norms and service standards of care for GBV victims/survivors may result in the following challenges experienced by the clients in health facilities:

- Lack of confidentiality/respect during the consults.
- Lack of privacy.
- Discrimination in access to health services for vulnerable populations (e.g., adolescents and young people, persons with disabilities, key populations).

¹⁹ Please note that while The World Health Organization does not recommend universal screening for violence of women attending health care, WHO does encourage health-care providers to raise the topic with women who have injuries or conditions that they suspect may be related to violence

- Limited availability of commodities for management of GBV at facility level (such as ECPs and PEP) due to weak Supply Chain Management.
- Health-care workers may be reluctant to provide GBV care due to fear of having to testify in court.
- Limited understanding on the part of health-care workers of protocols for medical examinations and how to document cases of sexual assault/violence to the justice system.
- Limited capacity/lack of tools to collect, update and use GBV data.
- Limited or no referrals of the victims/survivors to the other GBV services (police, social services, shelters etc.).

In response to these challenges, these Guidelines were developed with an overall aim of strengthening the health sector's capacity to provide client-centred, quality, rights-based integrated health care and referrals to victims/survivors of GBV.

Other challenges in the GBV services more broadly may also affect the provision of health care. For example, if the police officer who brings the victim/survivor is in a hurry to complete the case, or the perpetrators, who are family members, remain with the victim/survivor during the entire process at the health-care facility, then the victim/survivor will be uncomfortable to provide information due to possible repercussions or other reasons. If the victim/survivor is a child, or young adolescent, the situation is more difficult and leads to heightened anxiety. Other factors include limited availability and accessibility of psycho-social services on-site for immediate GBV crisis counselling, and unclear GBV service referral pathways for victims/survivors.

Purpose of the Guidelines

The Guidelines for Prevention and Management of Gender-Based Violence are aimed at directing and guiding health-care workers in the provision of comprehensive, rights-based, quality integrated prevention and responses to victims/survivors of GBV. The Guidelines outline the elements of an effective health sector response to GBV.

Target audience

- **Health-care providers:** The Guidelines offer detailed guidance and practical tools for the management of GBV victims/survivors.
- **Health managers:** The Guidelines give an overview of the basic package of care to GBV victims/survivors and provide basic outlines on the organization of GBV-care into a primary health facility.
- **Health facilities:** The Guidelines provide basic recommendations and tools for GBV care and can therefore be used in both public and private health-care sectors. These may be linked to the MoH, to NGOs, or to the private health sector.

Guiding Principles when Providing Health Care to GBV Victims/Survivors

Safety: The safety and security of victims/survivors and their children are the primary considerations.

Privacy: provision of care, treatment, and counselling should be conducted in a private space, away from others.

Confidentiality: Assure the victim/survivor that confidentiality is guaranteed by all persons involved in their care (doctor, midwife, nurse) and that no information will be released without his/her consent. Victims/survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.

Respect: All actions taken should be guided by respect for the choices, wishes, rights and dignity of the victim/survivor. The role of helpers is to facilitate recovery and provide resources to aid the victim/survivor. Adopting a respectful attitude towards the victim/survivor is fundamental to the development of a relationship of trust. The victim/survivor has suffered a traumatic experience. His/her ability to survive the violence and their courage in seeking medical help merit the staff member's full respect. The victim/survivor might also feel shame, a lack of self-worth, isolation, and rejection by their partner or family circle at the time when he/she arrives at the health structure. The respect shown will help in their recovery.

Non-judgemental attitude: The role of the health-care provider is not to prove/disprove any allegations, nor whether sexual assault has occurred. It is important to stress that GBV is a violation of a victim/survivor's human rights and that it is the perpetrator who is the guilty party. Health staff should not judge the victim/survivor based on the reaction experienced during the

assault (e.g., no resistance) or after the assault (e.g., not seeking help). When people are paralysed by fear or are unable to escape from the attack, they are often in shock and reacting in the only way possible for them at the time; any lack of resistance may result in a non-fatal outcome. Therefore, listening with an open-minded and accepting attitude will enable the victim/survivor to express herself/himself more freely.

Self-determination: Respect the integrity and authority of victims/survivors' life choices to make their own decisions including sexual and reproductive decisions; entitled to refuse medical procedures and/or take legal action.

Information: Victims/survivors have the right to know what information has been collected about their health and have access to this information, including their medical records.

Non-discrimination: Victims/survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.

Long-term continuity care within the health-care system: Attempt to engage victims/survivors in long-term continuity care within the health-care system to support patients through the process of attaining greater safety and control.

The above principles can help HCWs to provide survivor-centred care. To learn more about the Survivor-Centred Approach, and how it applies to adult and child victims/survivors please visit Annex 2 of this Protocol.

CHAPTER 1

Making Preparations to Offer Clinical Care

The health-care service must prepare to respond thoroughly and compassionately to people who have been victims/survivors of GBV. The health administrators should ensure that health-care providers (doctors, clinical officers, nurses, midwives, laboratory technicians, and others) are trained to provide appropriate care and have the necessary equipment and supplies.²⁰ Female health-care providers should be trained as a priority since most victims/survivors are female. However, lack of trained female health-care providers should not prevent the health service from providing care for victims/survivors. In setting up a service, the following questions and issues need to be addressed to ensure adherence to standard procedures.

What should the community be aware of?

Members of the community should know:

- What services are available for people who have experienced GBV, and where to go for services.
 - Why/what would GBV victims/survivors benefit from seeking clinical care/why should they report.
 - How soon should the GBV victim/survivor seek services after the violence (life-saving services should be provided as soon as possible, and key interventions for sexual assault victims/survivors should be provided ideally within a window of **72 hours**).
- That GBV victims/survivors should come for care immediately or as soon as possible after the incident, without bathing or changing clothes. GBV is a life-saving issue and should be treated as such.
 - That GBV victims/survivors can trust the service to treat them with dignity, maintain their security, and respect their privacy and confidentiality.
 - When services are available; they should preferably be provided 24 hours a day, 7 days a week.

²⁰ WHO has a manual for health managers that includes guidance on the assessment of service readiness to identify crucial needs. Source: <https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf?sequence=1>

What does the law say?

- Which health-care provider should provide what type of care? If the person wishes to report the sexual assault officially to the authorities, Botswana law requires that a registered, licensed medical officer provide medical management to the victim/survivor and complete the medical records and police reports (please see Chapter 7 on Forensic Evidence and Annex 13 - BP Form 73)
- What are the legal requirements regarding forensic evidence?
- What are the legal requirements regarding reporting?

What resources and capacities are available?

- What laboratory facilities are available for forensic testing (DNA analysis, acid phosphatase, Microscopy) or screening for disease (STIs, HIV) if the syndromic treatment of STIs is not available?
- What counselling services are available?
- Equipment and supplies for documenting and collecting forensic evidence?
- Which vaccines are available?
- Is emergency contraception available?
- What possibilities are there for referral of the victim/survivor to a secondary health-care facility (counselling services, surgery, paediatrics, or gynaecology/obstetrics services)?

Where should care be provided?

- All health facilities should offer prevention and management for victims/survivors of GBV – based on the minimum package of integrated services for each level of care, and according to the available skills mix.

- Additional services may be needed. In such cases, the HCWs should refer victims/survivors to a higher-level facility (clinic, referral hospital, etc), social services, police, and/or civil society organizations that provide GBV services.

Who should provide care?

All staff in health facilities dealing with victims/survivors, from reception staff to health-care professionals, should be sensitized and trained according to their intervention level with the victim/survivor. They should always be compassionate and respect confidentiality. Building the capacity and changing the attitudes and clinical practice of health-care providers is a long-term endeavour requiring consistent investment. This requires that training health-care providers on prevention and management of GBV should be an ongoing process, rather than a one-off event.

How should care be provided?

Care should be provided:

- According to this Guide which includes guidance on medical, psychosocial and ethical aspects as well as on collection and preservation of forensic evidence and on counselling/psychological support and follow-up care.
- In a comprehensive, confidential and non-judgmental manner.
- With a focus on the victim/survivor and their needs.
- With an understanding of the provider's own attitudes and sensitivities, the sociocultural context, and the community's perspectives, practices and beliefs.

What is needed?

- As far as possible, all the health-care services for a victim/survivor should be provided in one place within or outside a health-care facility, so that the victim/survivor does not have to move from place to place.
- All supplies from the checklist (Annex 1) should be available, ready to be used, and kept in an area close to treatment rooms. All health-care providers should know how to access these items at all times.

How to coordinate with others

- Intersectoral coordination should be established to ensure comprehensive care for victims/survivors of GBV.
- Be sure to include representatives of social and community services, protection, the police or legal justice system, security and community stakeholders. Depending on the services available in the particular setting, any other relevant organizations may need to be included.

As a multisectoral team, establish referral networks, communication systems, coordination mechanisms, and follow-up strategies.

See Annex 9 for the minimum care that can and should be made available to victims/survivors even in the lowest-resource settings.



Remember: the victim/survivor's autonomy and right to make his/her own decisions should always be respected.

Safety in the health facility

Health facilities should adapt safety strategies to protect GBV clients.

- If the perpetrator is posing immediate danger to the victim/survivor, the health facility staff or the safety of others, call the facility security personnel/the police.
- Where possible the health-care provider of the same sex should remain with the client during the examination.
- Ensure the client is in a safe place while awaiting police (i.e., consulting room or cubicle).
- Document in the medical record that an official police report was made (include date, time, name of police officer and badge number).
- A separate report of injuries must be submitted by the health-care provider to the police, as may be required by the Penal code and Domestic Violence Act (DV ACT).

Security

When organizing care for victims/survivors of GBV it is crucial to revise and adjust or, if necessary, develop and implement security policies and procedures to ensure both the security of the victims/survivors and the staff of the health facility. A risk assessment should be made involving all stakeholders (management, security guards and health staff) followed by the identification of different scenarios on what to do to prevent incidents and what to do when something goes wrong. All staff need to be informed and trained on the security procedures (how to take responsibility, how to be vigilant, how to ask questions, what to do in case of threat or suspicious event, who to call and whom to report any threats or suspicious events).

Although all staff members have a role to play, the management of the health facility has the responsibility of putting in place security procedures for the health facility.

Respecting confidentiality is an important measure to ensure the security of both the victim/survivor and the health-care provider. Privacy during the consultation (identification and clinical management) and confidentiality of data collection, record keeping, reporting and information sharing will decrease the potential for exposure of both patient and health-care providers.

At the beginning of each consultation and before inquiring about GBV, each health-care provider should make a quick security check for risks or imminent threats of harm (e.g., from violent husbands, family members) to both the patient and/or staff members.

If a health-care provider feels uncomfortable or at risk, a referral may be made to another health-care provider within the same health care facility or to the next level of care. Referral to the next level of care may only be made when the referral is considered feasible in all the circumstances and safe for the patient. Health-care providers at the secondary health-level may be less exposed to threats from family, community, or police. In case of direct threat, security procedures should be followed, and security guards may need to be alerted.

Any threats or acts of violence against health-care providers must be reported to management and documented so that appropriate measures might be taken to guarantee the safety of all staff members.

CHAPTER 2

Reception and Intake of Clients: Identifying a Victim/Survivor Subjected to Violence

It is important for health-care providers to be aware that a person's health problems may be caused or made worse by GBV. They may be facing ongoing or previous abuse at home. Or they may have suffered a sexual assault recently or in the past.

Persons subjected to violence in relationships often seek health care for related emotional or physical conditions, including injuries. However, often they do not tell you about the violence due to shame or fear of being judged or fear of their partner.

A victim/survivor can be male, female, elderly, a child or mentally/physically impaired. For any victim/survivor, seeking medical care can be difficult and shameful. Be mindful of their need to be reassured and respected.

Identification of self-reporting victims/survivors

Reception personnel must be sensitive and responsive to the physical and emotional trauma, shame or fear the victim/survivor may be experiencing or have experienced. Some situations may present themselves as obvious abuse, and the victim/survivor may openly state that his/her partner caused the injuries. In which case, health personnel should recognize the victim/survivor and/or parent/guardian based on their behaviours, symptoms and signs.

Recommended actions

- Calmly, quietly and privately record the victim/survivor's details.
- As quickly as possible, escort the victim/survivor to a room that is fit for purpose and provides adequate privacy. Depending on the type of health facility, all measures must be taken to ensure that the victim/survivor will not be required to move to multiple service points or locations to have investigations, receive medical care, HIV services, and other treatments.
- If the victim/survivor has a severe or life-threatening condition, refer for emergency treatment immediately (emergency treatment should avoid destroying any evidence where possible). The forensic and medical services can be provided once the victim/survivor has stabilized.
- Provide first-line support (as described in the next chapter).

After these steps, the service provider should ask the victim/survivor if they have already reported to the police.

If the victim/survivor **has** already reported to the police:

- Ensure that they have been given both Medical Report and Victim/Survivor Assessment Forms.
- If not, provide the forms for completion by attending medical staff.

If the victim/survivor **has not** reported yet to police:

- Ask if they would like to have the police brought in.
- If police involvement is requested, contact the nearest police post. The police officers will meet the victim/survivor at the health facility.
- Each facility should keep a directory of available places of safety, police contact persons, legal and social services etc.
- If police involvement is not desired, provide the victim/survivor with a Medical Report and Victim/Survivor Assessment Form to be completed during examination. Explain to the victim/survivor that by completing these forms, the victim/survivor still retains the option of reporting the case in the future.

All medical personnel must be aware that:

- No police report is required to provide health-care services to victims/survivors.
- Children can receive treatment in any health facility and linked to further care where necessary. It is important to have providers who are experienced in working with children and/or who have been trained to do so.

Identification of non-self-reporting GBV victims/survivors:

Many victims/survivors, however, will keep the true cause of the injuries secret. Reasons for secrecy include fear of further

injury from partner, being told by the partner not to reveal the true cause, fear for his/her children if they are with the partner, fear that he/she will not be believed, fear that the partner will be told, and not having help available to him/her and children.

The World Health Organization does not recommend universal screening for GBV on clients attending health care. Health-care providers are encouraged to raise the topic with clients who have injuries or conditions that they suspect may be related to violence.

You may suspect that a person has been subjected to violence if he/she has any of the following*:

- ongoing emotional health issues, such as stress, anxiety or depression
- harmful behaviours such as misuse of alcohol or drug
- thoughts, plans or acts of self-harm or (attempted) suicide
- injuries that are repeated or not well explained
- repeated sexually transmitted infections
- unwanted pregnancies
- unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)
- repeated health consultations with no clear diagnosis.



** please refer to Table 1 for a list of comprehensive conditions associated with abuse*

You may also suspect a problem of violence if a client's companion/partner is intrusive during consultations, if he/she often misses their own or their children's health-care appointments, or if their children have emotional and behavioural problems.

In such cases, the health-care worker should take note of inconsistencies in the victim/survivor's story; and look for indicators of control and abuse as below:

Indicators of control/abuse

If the victim/survivor:

- is tense, fearful, apprehensive
- looks to companion for direction; is unable to make decisions alone and or leaves decisions totally to their companion, even those regarding physical needs and health
- is overly concerned about the partner and/or children and has little or no concern for their own health needs
- minimizes the seriousness of the injury or how it occurred.

If the companion:

- interrupts or constantly explains their version of the victim/survivor's injuries
- hovers over the victim/survivor and is reluctant to leave them alone, even for examinations
- is pushy or demanding of the victim/survivor or medical staff for information
- appears more concerned about him/herself than the health issues for the victim/survivor.

Indicators of physical abuse

- injuries, some of which may be visible such as bruising, cuts, burns, choke marks, black or swollen eyelids
- any injuries, with no or questionable explanation(s) as to how they occurred
- unattended injuries may be apparent such as old untreated fractures
- serious bleeding injuries, especially to the face, head, and internal organs
- breasts, chest and abdomen are often target areas, especially if the woman is pregnant.

Indicators of psychological abuse

- Reports of severe crying spells or feelings of isolation or inability to cope
- depression, at times accompanied by suicidal thoughts
- reports of acute anxiety attacks
- the intermittent or continual presence of stress reactions such as tension, hyperactivity, headaches, insomnia, pain in the back, chest or stomach which often have no clear physiological cause
- the intermittent or continual presence of fear, anxiety, depression, hopelessness
- inconsistency between cognitive and emotional levels
- presence of any or all above indicators with statements that the situation is alright and/or hopefulness that the situation will improve
- injuries which are trivialized by the victim/survivor and/or their partner
- harmful behaviours such as misuse of alcohol or drugs.

When a healthcare provider notices that a patient exhibits one or more of the above-mentioned conditions, **the following guidelines should be considered:**

- Find a way to see the person alone: ask the companion/partner to stay in the waiting room while you take the patient to a private room.
- If the companion/partner insists on accompanying the client, assure them that they will be called immediately should a need arise. If the companion/partner objects, you can use for example the following approaches:
 - Ask the companion to go out to get something.
 - Ask the client to come with you for a test, advising them that it is standard procedure to examine the victim/survivor alone; and firmly but calmly advise the companion/partner to wait outside.
- If they become difficult, let them know that authorities will be contacted.

Ensure strict privacy

Even if the patient is with another woman, that woman could be the mother or sister of an abuser. Hence, the overarching principle guiding the provider in the decision to ask about GBV should be safety of the patient and his/her privacy. It is important to recognize that patients who disclose their experience of violence can have their safety compromised if the perpetrator finds out that they have disclosed to the provider.

- Never ask about GBV when anybody else is present.
- Make sure you cannot be overheard.
- Make sure you won't be disturbed.
- Take time to talk to the person, don't rush the person.

- Don't push a person to reveal the GBV.
- Think of your conversation as the start of a process, not a one-off event.
- Never assume that someone else will take care of GBV issues – you may be the person's first and only contact.

Potential questions for the assessment of abuse

If you do ask the patient about violence, do it in an empathic, non-judgemental manner. Use language that is appropriate and relevant to the culture and community you are working in. Some patients may not like the words "violence" and "abuse". Cultures and communities have ways of referring to the problem with other words. It is important to use the words that they themselves use.

- Does your partner criticize or insult your thoughts or actions?
- Does your partner ever follow you, check your whereabouts, or call you regularly to make sure you are at home or work?
- Do you stop saying or doing what you believe because you are fearful of your partner's reaction?
- During arguments, are you ever afraid of what he/she might do?
- Has your partner ever physically held or restrained you from going somewhere or doing something he/she objected to?
- During arguments are you ever hit, slapped, punched or pushed?

Continue probing in a sensitive manner if you suspect abuse:

- ask the victim/survivor if they are afraid to talk about it
- assure them that the information shared will not be passed on to the partner

- let them know the information stays within the facility and no-one will act without their permission.

You need to let the victim/survivor know that if you are concerned that they may cause self-harm – or that of someone else – that you may have to act without their permission, but that action involves keeping them in a safe place and not disclosing information to the partner.

- Ask the victim/survivor if they think the actions are abuse (victims/survivors may not perceive that what they are experiencing is abuse).
- Be prepared to ask clear, specific questions as well as approaching him/her from your understanding of the many complexities that exist for him/her.

Index of suspicion for life threat/harm to the victim/survivor:

- Previous history of injuries and present injuries are more serious, indicating frequency and/or severity of abuse is increasing.
- Extremely controlling, aggressive, suspicious or stalking behaviour on the part of the partner.
- Direct threats or statements by the partner that he/she intends to harm or kill the victim/survivor.
- The victim/survivor states that there are weapons in the home; the abuser has threatened to use weapons and/or has used weapons in the past.
- The victim/survivor states that police have been involved, charges have been laid, or partner has been convicted of assault or related charges.
- Partner has history of suicide and/or has history of deterioration emotionally and physically at the possibility of losing him/her.

- Assessment indicates that the victim/survivor “can’t take it anymore” and has history of suicide attempts or admissions to hospital and/or psychiatric facility.

Response when a patient discloses violence

If a patient reveals that he/she has been a victim/survivor of GBV, appropriate responses are important to assist in obtaining the care and help that he/she needs. Disclosing GBV is a big step for the victim/survivor and often carries an element of risk.

- Be sensitive to the emotional distress or fear the victim/survivor may be experiencing.
- Affirm that the client has made an important step by talking about the violence.
- Ensure confidentiality.
- Listen to what he/she is saying.
- Acknowledge what he/she has told you *“That must have been frightening for you.” “You are a strong person to have survived that ...”*
- Validate the victim/survivor’s feelings. (For example: when a victim/survivor explains he/she is angry with the perpetrator, you could say “it is ok to feel angry...”.
- Reassure the victim/survivor that his/her reaction to the abuse is normal (e.g., physical, emotional, behavioural reactions).
- Reinforce with the victim/survivor that the violence is not their fault, that there is no excuse for violence and that the responsibility lies with the perpetrator.

After the initial response to a victim/survivor’s disclosure of any form of violence, the victim/survivor should, as a minimum, be offered first-line support (see next chapter). If the identifying health-care provider is not trained or is otherwise unable to provide first-line support, then an immediate referral to a qualified health-care provider should be made.

What to do if you suspect violence, but he/she doesn't disclose it

- Do not pressure them. Give the patient time to decide what he/she wants to tell you.
- Tell him/her about services that are available if he/she chooses to use them.
- Offer information on the effects of violence on women's health and their children's health.
- Offer them a follow-up visit.

TABLE 1

Clinical conditions associated with abuse, including GBV, among women, men, and children

Clinical conditions associated with violence	yes/no
1. Physical violence	
» Bilateral injuries, especially to extremities	
» Injuries at multiple sites, pattern injuries, injuries suggesting a defensive posture	
» Central distribution of injury (chest, breast, abdomen, face, neck, throat, and genitals)	
» Fingernail scratches, cigarette burns, rope burns	
» Bite marks, strangulation	
» Abrasions, minor lacerations, welts	
» Subconjunctival haemorrhage suggests a vigorous struggle between victim/survivor and assailant	
» Patient explanation inconsistent for extent or type of injuries	
» Violence during pregnancy	
2. Sexual violence	
» Unexplained chronic gastrointestinal symptoms	
» Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction	
» Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes	
» Unexplained genito-urinary symptoms, including frequent bladder or kidney infections	
» Repeated vaginal bleeding and sexually transmitted infections	
» Chronic pain (unexplained)	
» Traumatic injury, particularly if repeated and with vague or implausible explanations	
» Problems with the central nervous system – headaches, cognitive problems, hearing loss	
3. Mental health signs associated with violence	
» Symptoms of depression, anxiety, PTSD, sleep disorders	
» Suicidality or self-harm	
» Alcohol and other substance abuse	
» Sleep disturbance	
» Withdrawal from touch	

Table 1 (cont'd)

Clinical conditions associated with violence	yes/no
4. Observations during consultation	
» Repeated health consultations with no clear diagnosis	
» Intrusive partner or husband in consultations, partner continually speaks for the client and/or insists on remaining with the client	
» Patient is evasive or embarrassed about injuries	
Men	
In general, men who have experienced some form of GBV are not likely to seek medical attention, unless they suffer significant physical injuries. Moreover, GBV against men is culturally very sensitive in Botswana. Some cases of domestic violence against men have been reported but are considered very rare. Sexual violence against men prisoners on the other hand, is considered common, although no clear data exist currently in Botswana.	
Some clinical conditions which are associated with GBV in men:	
» Physical injuries in the anogenital area	
» Rectal injuries	
Common mental health problems because of sexual assault are:	
» Depression, anxiety and PTSD	
» Suicidal ideation and attempts	
» Anger/hostility	
» Sexual and relationship problems	
Men are likely to be particularly concerned about:	
» Their masculinity	
» Their sexuality	
» The opinions of other people (i.e., afraid that others will think they are homosexual)	
» The fact that they were unable to prevent the sexual assault	
Children	
Children of any age can be physically, emotionally or sexually abused, including babies. While most perpetrators of sexual abuse are male, victims/survivors can be of either sex. In Botswana, the following children are at particular risk:	
» Orphans and those without parental protection	
» Street children	
» Children in detention	
» Children who have previously been sexually abused	
» Children born of sexual assault	

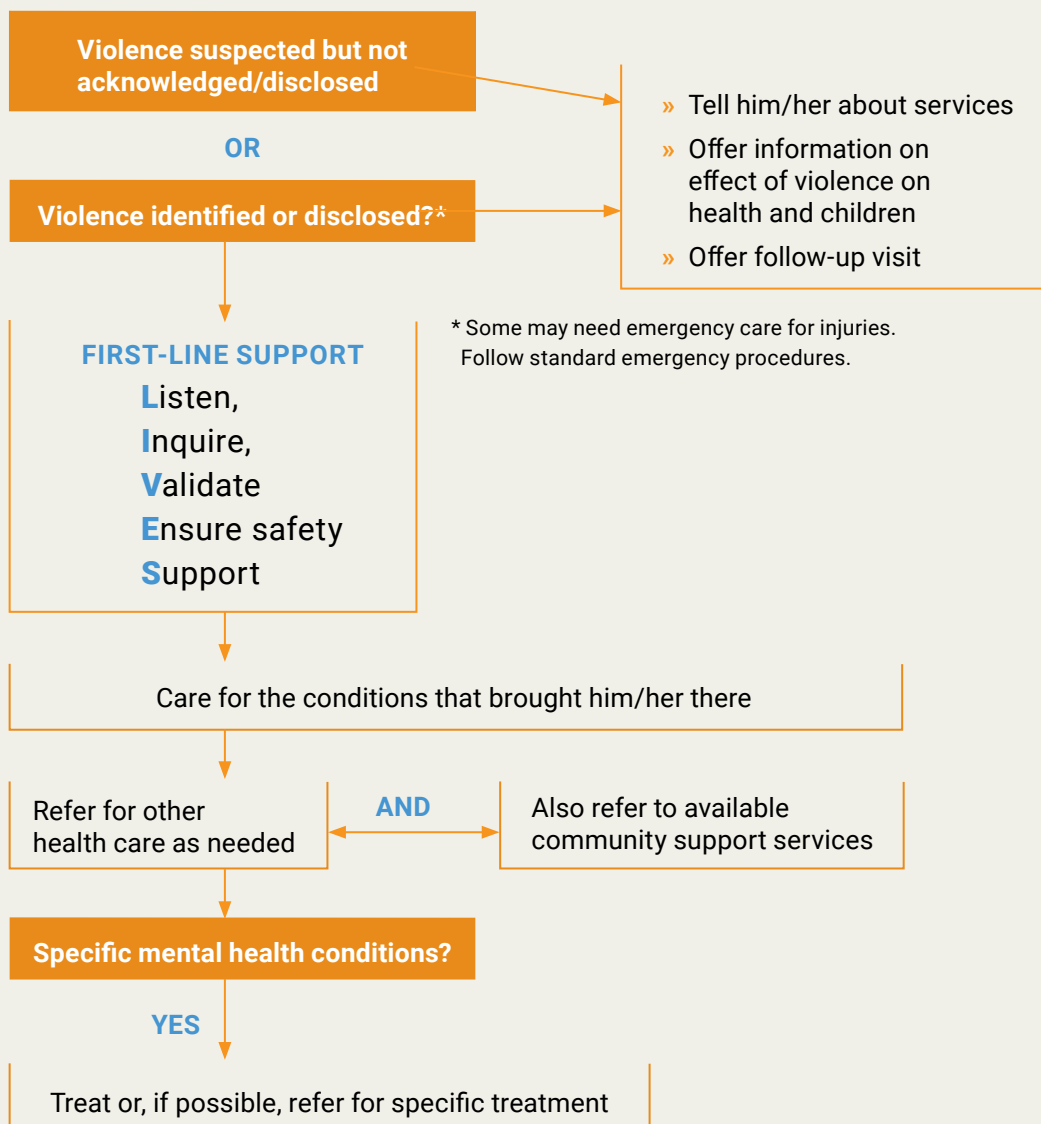
Table 1 (cont'd)

Clinical conditions associated with violence	yes/no
Clinical conditions associated with violence in children:	
1. Physical abuse:	
The signs of physical abuse may include:	
» Physical injuries like cuts, bruises, burns, broken bones, head injuries, and abdominal injuries may point to physical abuse when:	
• They are unlikely to have been caused by an accident	
• Explanations change or do not account for how an injury occurred	
• Evidence shows that injuries have occurred previously	
• Medical care for the injury is delayed	
» Human bite marks	
» Scalds, with upward splash marks	
» Multiple burns with a clearly demarcated edge	
Changes in behaviour that can also indicate physical abuse:	
» Fear of parents being approached for an explanation	
» Aggressive behaviour or severe temper outbursts	
» Flinching when approached or touched	
» Reluctance to get changed	
» Withdrawn behaviour	
» Running away from home	
2. Emotional abuse:	
Emotional abuse can be difficult to measure, as there are often no outward physical signs.	
Changes in behaviour which can indicate emotional abuse include:	
» Neurotic behaviour e.g., sulking, hair twisting, rocking, being unable to play	
» Fear of making mistakes	
» Sudden speech disorders	
» Self-harm	
» Fear of parent being approached regarding their behaviour	
» Developmental delay in terms of emotional progress	
3. Sexual abuse:	
The physical signs of sexual abuse may include:	
» STIs: STIs in children beyond the neonatal period suggest sexual abuse but the significance varies by pathogen. Postnatally acquired gonorrhoea; syphilis; and non-transfusion, non-perinatally acquired HIV are usually diagnostic of sexual abuse. Sexual abuse should be suspected when genital herpes is diagnosed.	
» Pregnancy	
» Pain, sores, bruising, bleeding and injury in the genital area	
» Vaginal discharge or infection	

Table 1 (cont'd)

Clinical conditions associated with violence	yes/no
» Stomach pains	
» Discomfort when walking or sitting down	
Several behaviours occur almost exclusively in children who have experienced sexual abuse:	
» Age-inappropriate interest in sex	
» Seduction behaviour	
» Sexual harassment of other children (beyond normal limits)	
» Compulsive masturbation	
» Inappropriate sexual play	
» Sexual drawings	
Other behavioural signs indicate distress in a child, which may point to sexual abuse or other causes:	
» Secondary anal incontinence	
» Encopresis/enuresis	
» Compulsive washing	
» Anorexia	
» Inappropriate emotional responses to stressful situations	
» Gender identity difficulties	
» Secretiveness	
» Overreaction to mistakes	
» Physical, mental, emotional development delay, regression or disturbance	
» Antisocial behaviour, telling obvious lies, stealing	
» Repeated running away	
» Disruptive behaviour	
» Hostile/aggressive/bullying behaviour	
» Hostility towards men	
» Truancy (being absent without leave or permission)	
» Signs of fear such as nightmares, fear of specific situations or people, extraordinary fear, reluctance to go to school or to go home after school	
» Relationship difficulties such as isolation, overly compliant, extreme passivity or aggression, poor peer relationships, attention-seeking, lack of trust	
» Concentration difficulties	
» Sudden changes in behaviour	
» Low-self-esteem	

Pathway for care for violence by intimate partner



²¹ Source: https://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf, 2014

CHAPTER 3

First-Line Support for Victims/ Survivors of GBV²²



What is first-line support?

First-line support provides practical care and responds to a client’s emotional, physical, safety and support needs, without intruding on their privacy. Often, first-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client. First-line support has helped people who have been through various upsetting or stressful events, including being subjected to violence.






Remember: This may be your only opportunity to help this victim/survivor.

First-line support involves five simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word “LIVES” can remind you of these five tasks that protect lives. **The examples below are specific to women, but apply equally to all victims/survivors:**

<p>L</p>	<p>LISTEN</p> 	<p>Listen to the victim/survivor closely, with empathy, without judging</p>	<p>To give the woman a chance to say what she wants to say in a safe and private place to a caring person who wants to help. This is important to her emotional recovery.</p> <p>Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the woman’s words. It means:</p> <ul style="list-style-type: none"> » being aware of the feelings behind her words » hearing both what she says and what she does not say » paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures » sitting or standing at the same level and close enough to the woman to show concern and attention but not so close as to intrude » through empathy, showing understanding of how the woman feels.
<p>I</p>	<p>INQUIRE</p> 	<p>Assess and respond to the victim/survivor’s various needs and concerns –emotional, physical, social and practical (e.g., childcare)</p>	<p>To learn what is most important for the woman. Respect her wishes and respond to her needs.</p> <p>As you listen to the woman’s story, pay particular attention to what she says about her needs and concerns – and what she doesn’t say but implies with words or body language. She may let you know about physical needs, emotional needs, or economic needs, her safety concerns or social support she needs. You can use the techniques below to help her express what she needs and to be sure that you understand.</p>

²² Adapted from the Clinical Handbook “Health care for women subjected to intimate partner violence or sexual violence”, 2014, Source: https://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf


V	VALIDATE 	Show her that you understand and believe her. Assure her that she is not to blame	To let her know that her feelings are normal, that it is safe to express them and that she has a right to live without violence and fear. Validating another's experience means letting the person know that you are listening attentively, that you understand what she is saying, and that you believe what she says without judgment or conditions.
E	ENHANCE SAFETY 	Discuss a plan to protect herself from further harm if violence occurs again	To help a woman assess her situation and plan for her future safety. Many women who have been subjected to violence have fears about their safety. Other women may not think they need a safety plan because they do not expect that the violence will happen again. Explain that partner violence is not likely to stop on its own: It tends to continue and may over time become worse and happen more often. Assessing and planning for safety is an ongoing process – it is not just a one-time conversation. You can help her by discussing her particular needs and situation and exploring her options and resources each time you see her, as her situation changes.
S	SUPPORT 	Support her by helping her connect to information, services and social support	To connect a woman with other resources for her health, safety, and social support. Women's needs generally are beyond what you can provide in the clinic. You can help by discussing the woman's needs with her, telling her about other sources of help, and assisting her to get help if she wants it.

LISTEN

Active listening dos and don'ts	
Dos	Don'ts
How you act	
Be patient and calm.	Don't pressure the victim/survivor to tell their story.
Let them know you are listening; for example, nod your head or say "hmm...."	Don't look at your watch or speak too rapidly. Don't answer the telephone, look at a computer, or write.
Your attitude	
Acknowledge how they are feeling.	Don't judge what they have or have not done, or how he/she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived", or "Poor you".
Let him/her tell their story at their own pace.	Don't rush them.
What you say	
Give them the opportunity to say what they want. Ask, "How can we help you?"	Don't assume that you know what is best for him/her.
Encourage him/her to keep talking if they wish. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until they have finished before asking questions.


Active listening dos and don't	
Dos	Don'ts
Allow for silence. Give the victim/survivor time to think.	Don't try to finish their thoughts for them.
Stay focused on their experience and on offering them support.	Don't tell them someone else's story or talk about your own troubles.
Acknowledge what they want and respect their wishes.	Don't think and act as if you must solve their problems for them.

Learn to listen with your




Eyes

give your undivided attention



Ears

truly hearing their concerns



Heart

with caring and respect



INQUIRE ABOUT NEEDS AND CONCERNS

Techniques for interacting	
Principles	Examples
Phrase your questions as invitations to speak.	"What would you like to talk about?"
Ask open-ended questions to encourage the victim/survivor to talk instead of saying yes or no.	"How do you feel about that?"
Repeat or restate what the person says to check your understanding.	"You mentioned that you feel very frustrated."
Reflect their feelings.	"It sounds as if you are feeling angry about that..." "You seem upset."
Explore as needed.	"Could you tell me more about that?"
Ask for clarification if you don't understand.	"Can you explain that again, please?"
Help them to identify and express their needs and concerns.	"Is there anything that you need or are concerned about?" "It sounds like you may need a place to stay". "It sounds like you are worried about your children."
Sum up what they have expressed.	"You seem to be saying that."
Some things to avoid	
Don't ask leading questions, such as "I would imagine that made you feel upset, didn't it?"	
Don't ask "why" questions, such as "Why did you do that...?" They may sound accusing.	



VALIDATE

Important things that you can say:

- “It’s not your fault. You are not to blame.”
- “It’s okay to talk.”
- “Help is available.” [Say this only if it is true.]
- “What happened has no justification or excuse.”
- “No one deserves to be hit by their partner in a relationship.”
- “You are not alone. Unfortunately, many other people have faced this problem too.”
- “Your life, your health, you are of value.”
- “Everybody deserves to feel safe at home.”
- “I am worried that this may be affecting your health.”

The Job Aid in Annex 3 suggests some ways that you can help victims/survivors deal with various emotions and reactions.



ENHANCE SAFETY

Assessing safety after sexual assault

A woman who is assaulted often knows the person who assaulted her, and it often happens at home. If it was someone she knows, discuss whether it is safe for her to return home.

Assessing immediate risk of partner violence

Some women will know when they are in immediate danger and are afraid to go home. If she is worried about her safety, take her seriously. Other women may need help thinking about their immediate risk. There are specific

questions you can ask to see if it is safe for her to return to her home. It is important to find out if there is an immediate and likely risk of serious injury.

If there seems to be immediate high risk, then you can say “I’m concerned about your safety. Let’s discuss what to do so you won’t be harmed.” You can consider options such as contacting the police and arranging for her to stay that night away from home.

Questions to assess immediate risk of violence

Women who answer “yes” to at least three of the following questions may be at especially high immediate risk of violence.

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

If it is not safe for the woman to return home, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place she can go to (such as a friend’s home or church).

Making a safety plan

When a patient has been identified as a victim/survivor of GBV, an evaluation of potential risk to the safety of the victim/survivor should be carried out. Even victims/survivors who are not facing immediate serious risk could benefit from having a safety plan. If he/she has a plan, he/she will be better able to deal with the situation if violence suddenly occurs.

This is a participatory process, in which the health provider guides the victim/survivor to estimate the immediate and future risks and identify the available resources. According to the needs, the health-care provider can propose possibilities for referral and help the victim/survivor develop an individual safety plan.

The following are elements of a safety plan and questions you can ask the victim/survivor to help them make a plan.

Job aid	
Safety planning	
A safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Discuss how to stay safer at home

If they cannot avoid discussions that may escalate with their partner, advise them to try to have the discussions in a room or an area that they can leave easily.

Advise them to stay away from any room where there might be weapons.

If they have decided that leaving is the best option, advise them to make plans and leave for a safe place BEFORE letting their partner know. Otherwise, he/she may put himself/herself and their children at more risk of violence.

Avoid putting the victim/survivor at risk

Talk about abuse only when you and the patient are alone. No one older than age 2 should overhear your conversation. Never discuss it if their husband/wife or other family members or anyone else who has accompanied them – even a friend – may be able to overhear. You may need to think of an excuse to be able to see the victim/survivor alone, such as sending the partner to do an errand or fill out a form. If their children are present, ask a colleague to look after them while you talk.

Remember to maintain the confidentiality of their health records. Keep such documents in a safe place, not out on a desk or anywhere else that anyone can see them.

Discuss with the client how they will explain where they have been. If they must take paperwork with them (for the police, for example), discuss what they will do with the paper.

If the client is returning home or to a previous living arrangement, assist the client to establish safety upon discharge

- Determine a safe way to contact the client in future for follow-up (by cell phone, mail, friend, or in-person etc.).

- Suggest to the client to gather important papers, (e.g., birth certificates and other documents of identification), some money and clothing for themselves and children (if any), to support their safety plan of leave.
- Encourage the client to keep these items in an accessible, hidden place or at a friend's home in case he/she must leave home in a hurry.



SUPPORT

How to help

- Ask the client what issues are most important to them right now. You can ask him/her, "What would help the most if we could do it right away?"
- Help the client to identify and consider their options.
- Discuss social support. Does the client have a family member, friend, or trusted person in the community whom they could talk to? Do they have anyone who could help with money?

Possible resources

Find out what support and resources are available to the client in the community. It can help if you have a personal contact to refer them to at each place:

- helpline
- support groups
- crisis centre/women shelter
- legal support
- mental health counsellor
- social worker
- psychologist

It will usually not be possible to deal with all the client's concerns at the first meeting. Let him/her know that you are available to meet again to talk about other issues. Do not expect

them to make decisions immediately. It may seem frustrating if they do not seem to be taking steps to change their situation. However, he/she will need to take his/her time and do what they think is right. Always respect their wishes and decisions.

Referrals

It is imperative for the health-care worker to be cognizant of other professionals that are crucial in the care of GBV clients and should refer accordingly.

Often clients do not follow up on referrals from health-care providers. You can help make it more likely that they get the help that you have recommended.

All known or suspected victims/survivors of current GBV should be referred to psychosocial, medical and legal practitioners. If they accept a referral, here are some things you can do to make it easier for the victim/survivor:

- Tell the client about the service (location, how to get there, who they will see).
- Be sure that the referral addresses their most important needs or concerns.
- Offer to telephone to make an appointment for the client if this would be of help (for example, they do not have a phone or a safe place to make a call).
- If they want it, provide the written information that they need – time, location, how to get there, name of person they will see. Ask them to think how they will make sure that no one else sees the paper.
- If they express problems with going to a referral for any reason, think creatively with the client about solutions.
- Problems you might discuss:
 - No one to leave the children with.
 - The client's partner might find out and try to prevent it.
 - They don't have transport.

- If possible, arrange for a trusted person to accompany the victim/survivor on the first appointment.
- Always check to see if the victim/survivor has questions or concerns and to be sure that they have understood.

All referrals should then be accompanied by a GBV Form when making the referral, informing the victim/survivor that he/she can always call or come back for support or more information.

You can fill in the following chart to keep track of resources in your community. These referrals could be internal or external resources.

It is best to have formal referral agreements with organizations that you refer victims/survivors to. If possible, these agreements should specify how you will find out if the client reaches the referral resource – will you contact them, or will they contact you?



Preparing a directory of GBV services for referrals

- Identify and connect with other sectors especially justice, social welfare services and CSOs.
- Make sure health facilities are part of the referral system in place and make it available and accessible for HCW (such as a list of all available community resource centres and other service providers).
- A directory of all key stakeholders should be kept and updated for referral purposes. The list should be kept in full view of all health facility staff for easy access.
- Please note that a GBV shelter’s address is the only information that should be kept confidential. For the safety of the sheltered victims/survivors, **do not** disclose the address in a public document or directory.

Job aid

Referral chart			
What to refer for	Where / whom to refer to	Contact info	Responsibility for follow-up
Shelter/housing			
Crisis centre			
Financial aid			
Legal aid			
Support groups			
Counselling			
Mental health care			
Primary care			
Childcare			
Other			

CHAPTER 4

Providing Immediate Crisis Counselling



Without proper attention to the victim/survivor's needs, medical care can be just as traumatic as the assault itself. For the benefit of the victim/survivor and provider, it is necessary to first calm and reassure the victim/survivor. This can be done through crisis counselling.

Ensure that the victim/survivor knows that he/she is in control of the process:

Ensure that a trained health-care provider (preferably of the same sex) examines the victim/survivor, and where not possible, a trusted same sex companion should accompany the victim/survivor throughout the examination.

- a. Explain what is going to happen during each step of interviewing, history-taking and the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- b. Reassure the victim/survivor that he/she is in control of the pace, timing and components of the whole process of care.
- c. Reassure the victim/survivor that the examination findings will be kept confidential.
- d. Ask if they have any questions.
- e. Ask him/her if they would like the presence of a specific person during the whole process for support.

f. Limit the number of people allowed in the room during interviews, history-taking and examination to the minimum necessary.

g. A police officer should not be present when the victim/survivor is undressed unless he/she requests so.

h. Undertake the examination as soon as possible.

i. Do not force or pressure the victim/survivor to do anything against his/her will.

Sexual assault causes psychological and emotional trauma as well as physical injury. Victims/survivors may experience a range of post-traumatic symptoms, including:

- self-blame
- uncontrollable emotions, such as fear, anger, guilt, shame, anxiety
- mood swings that can lead to suicidal and destructive tendencies
- nightmares and sleeping disorders including incontinence, especially of urine

- male victims/survivors of sexual assault are even less likely than women to report because of the extreme embarrassment that they typically experience. While the physical effects differ, the psychological trauma and emotional aftereffects for men are like those experienced by women.

To assist the victim/survivor in coping with these symptoms:

- Tell the victim/survivor that he/she has experienced a serious physical and emotional trauma. Advise him/her about the post-traumatic symptoms (emotional and physical) that he/she may experience.

Conventionally, there is a tendency to blame the victim/survivor in cases of sexual assault. Assure the victim/survivor that he/she did **not** deserve to be assaulted, that the incident was **not** his/her fault, and that it was **not** caused by his/her behaviour or manner of dressing.

Advise the victim/survivor that part of the care they need is emotional support. Encourage him/her to confide in someone trusted and to ask for this emotional support from a family member or friend.

- Refer the victim/survivor to a counselling service for psychosocial assistance.
- Ask the victim/survivor if they have a safe place to go to, and if someone they trust will accompany them when they leave the health facility. If this is not the case, make necessary arrangements with social workers.

- In some cases, the victim/survivor is seriously traumatized and experiences severe emotional or psychological dysfunction, becoming unable to carry out day-to-day activities to meet their basic needs. Referral for psychological evaluation and more in-depth counselling is an important part of on-going care.
- When a man is exposed to anal sexual assault, pressure on the prostate can cause an erection and even orgasm. Reassure the victim/survivor that, if this has occurred during the sexual assault, it was a physiological reaction and was beyond his control. Also reassure the victim/survivor that this kind of erection is temporary and that as soon the effects of sexual assault subside, this will go.

Special considerations for pregnant women

- Women who are pregnant at the time of a sexual assault are especially physically and psychologically vulnerable. They are susceptible to miscarriage, hypertension during pregnancy and premature delivery.
- Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy.

Depending on the timing of the assault, the presentation to a health-care provider, and the age of the pregnancy, reassure pregnant women that this pregnancy is most likely not due to a recent rape.



There may be cases when a victim/survivor suffered the sexual assault during pregnancy. Sometimes this pregnancy is one that is wanted/with their partners and not necessarily as a result of rape. It is therefore important that the HCW collects information to determine the age of the pregnancy and reassures the victim/survivor and possibly her partner.

CHAPTER 5

Taking the History

Objective of the history-taking

The primary purpose of taking a medical history is to obtain information that may assist in the medical management of the victim/survivor or may help to explain subsequent findings, e.g., easy bruising, loss of consciousness, or memory loss. History-taking can also provide information that can be used to assess the psychological state of the victim/survivor.

The history-taking includes: (1) general medical information, (2) questions about the assault (only ask about what is needed for medical care (e.g., penetration, oral, vaginal, anal), (3) a gynaecological history, (4) an assessment of mental state. The history and exam form suggests suitable questions.

General guidelines

- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any documents or paperwork brought by the victim/survivor to the health centre.
- Use a calm tone of voice and maintain eye contact if culturally appropriate. Let the victim/survivor tell the story the way he/she wants to.

- Questioning should be done gently and at the victim/survivor's own pace. Avoid questions that suggest blame, such as "what were you doing there alone?"
- Take sufficient time to collect all needed information, without rushing.
- Develop a good rapport by showing empathy even if validating information gathered and documented by other people involved in the case.
- Avoid any distraction or interruption during the history-taking.
- Explain what you are going to do at every step.

General information

Take personal details such as name, address, sex, date of birth (or age in years) and other information according to standard forms.

Date and time of the examination and the names and function of any staff or support person (someone the victim/survivor may request) present during the interview and examination.

Description of the incident

Ask the victim/survivor to describe what happened. Allow him/her to speak at their own pace. Do not interrupt to ask for details; follow

up with clarification questions after the victim/survivor finishes telling the story. Explain that he/she does not have to tell you anything he/she does not feel comfortable with. When recording the victims/survivors' answers, use their words and do not use technical medical terms if he/she did not.

Victims/survivors may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health-care provider understands exactly what happened to check for injuries and to assess the risk of pregnancy and STI or HIV. Explain this to the victim/survivor and reassure them of confidentiality if they are reluctant to give detailed information.

History

If the incident occurred recently, determine whether the victim/survivor has bathed, urinated, defecated, vomited, used a vaginal douche or changed his/her clothes since the incident. This may affect what forensic evidence can be collected.

A detailed forensic interview of the date, the time and the place of the incident should be conducted and recorded.

Information on existing health problems, allergies, use of medication, vaccination and HIV status will help you to determine the most appropriate treatment to provide, necessary counselling, and follow-up health care.

Useful questions are:

- Tell me about your general health.
 - Have you seen a nurse or doctor or any other health-care provider lately?
 - Have you been diagnosed with any illnesses?
 - Have you had any operations?
 - Do you suffer from any infectious diseases?
 - Do you have any allergies?
- Are you currently taking any medications?
 - Are you currently taking any herbal preparations?
 - Are you taking any other portions?²³

Evaluate for pregnancy; ask for details of contraceptive use and date of last menstrual period. For pubescent girls, look for signs of sexual maturation, including breast buds and increased body hair to assess her risk of ovulation even if she has not yet experienced menarche/first menstrual period. Girls in this stage should be offered emergency contraceptives to prevent unintended pregnancy.

Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination.

Useful questions for previous and pre-existing pregnancy:

- When was the first day of your last menstrual period?
- Have you had sexual intercourse prior to this event and when was the last?
- Have you been pregnant before? How many times and what was the outcome of the pregnancies?
- When, where and how did you deliver?
- Were there any complications during delivery?
- How many children do you have?
- Have you had pelvic surgery before?
- Do you use contraception? What type?
- Do you have a current sexual partner?

If pregnancy *cannot* be ruled out or confirmed, provide her with information on emergency contraception to help her arrive at an informed choice.

²³ Enquire about the nature and details of the portion(s) being taken by the victim/survivor

CHAPTER 6

Preparing the Victim/Survivor for Examination

A person who has been subjected to GBV has experienced trauma and may be in an agitated or depressed state. Victims/survivors often feel fear, guilt, shame and anger, or any combination of these. The health-care provider must prepare the victim/survivor, obtain his/her informed consent for the examination, and carry out the examination in a compassionate, systematic and comprehensive manner.

To prepare the victim/survivor for the examination

- Introduce yourself.
- Establish rapport.
- Ensure that a trained support person or trained health-care provider (preferably, and where possible, of the same sex) accompanies the victim/survivor throughout the examination.
- Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- Reassure the victim/survivor that he/she is in control of the pace, timing and components of the examination.
- Reassure the victim/survivor that the examination findings will be kept confidential unless he/she decides to bring charges.
- Ask him/her if he/she has any questions.
- Ask if he/she wants to have a specific person present for support.
- Try to ask him/her this when you are alone with them.
- Review the consent form (see Annex 10) with the victim/survivor.
- Make sure he/she understands everything in it and explain that he/she can decline any aspect of the examination he/she does not wish to undergo.
- Explain to him/her that they can delete references to these aspects on the consent form.

- Once you are sure he/she understands the form completely, ask him/her to sign it. If he/she cannot write, obtain a thumb print together with the signature of a witness.
- Limit the number of people allowed in the room during the examination to the minimum necessary.
- Perform the examination as soon as possible.
- Do not force or pressure the victim/survivor to do anything against his/her will.
- Explain that he/she can decline steps of the examination at any time as it progresses.

Explain your examination findings and treatment

- Discuss with the victim/survivor the examination findings, what they may mean for their health, and any treatments provided.
- Invite them to voice questions and concerns.
- Respond in detail and check their understanding.



CHAPTER 7

Collecting Forensic Evidence

The main purpose of the examination of a sexual assault victim/survivor is to determine what medical care should be provided. Forensic evidence may also be collected to help the victim/survivor pursue legal redress where this is possible. He/she may choose not to have evidence collected. Respect their choice.

Only qualified and trained health workers should collect evidence. **Do not collect evidence that cannot be processed or that will not be used.** Medical evidence should be collected by health-care providers permitted to report medical findings in a court of law (See also chapter on reporting the case to court and refer to current national laws).

Reasons for collecting evidence

A forensic examination aims to collect evidence that may help prove or disprove a connection between individuals and/or between individuals and objects or places. Forensic evidence may be used to support a victim/survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and to identify the assailant. Proper collection and storage of forensic evidence can be key to a victim/survivor's success in pursuing legal redress. Chain of custody guidelines must be adhered to. Careful consideration should be given to the existing mechanisms of legal redress

and the local capacity to analyse specimens when determining whether to offer a forensic examination to a victim/survivor.

The requirements of the current local criminal justice system and the capacity of local laboratories to analyse evidence should be considered.



(Annex 12 provides more detailed information on conducting a forensic examination and on proper sample collection and storage techniques.)

Collect evidence as soon as possible after the incident

Documenting injuries and collecting samples, such as blood, hair, saliva and sperm, within **72 hours** of the incident may help to support the victim/survivor's story and might help identify the aggressor(s). If the person presents more than **72 hours** after the sexual assault, the amount and type of evidence that can be collected will depend on the situation. However, the **72 hours** should not be an impediment to collection of forensic evidence since every case should be considered based on its peculiarities.

For example, evidence can be collected from a woman who is keeping a dress without washing it for months or years. Whenever possible, forensic evidence should be collected during the medical examination so that the victim/survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic.

Documenting the case

- Record the interview and your findings during the examination in a clear, complete, objective, non-judgemental way.
- Use the standardized medico-legal certificate for adults or children (Refer to certificates attached in this chapter).
- It is not the health-care provider’s responsibility to determine whether a victim/survivor has been sexually assaulted. Document your findings without stating conclusions about the sexual assault. Note that in many cases of sexual assault there are no clinical findings.
- Completely assess and document the physical and emotional state of the victim/survivor. Document all injuries clearly and systematically using standard terminology and describing the characteristics of the wounds. Record your findings on pictograms (see Annex 11).
- Do not make interpretations, just describe injuries in as much detail as possible (see Table 2), without speculating on their cause, as an incorrect analysis may have profound consequences for either the victim/survivor or alleged assailant.
- Record precisely, in the victim/survivor’s own words, important statements made by him/her, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as “patient states” or “patient reports”.
- Avoid the use of the term “alleged”, as it can be interpreted as meaning that the victim/survivor exaggerated or lied.
- Make note of any sample collected as evidence.

TABLE 2

Describing features of physical injuries

Feature	Notes
Classification	Use accepted terminology wherever possible, i.e., abrasion, contusion, laceration, incised wound, gunshot
Site	Record the anatomical position of the wound(s)
Size	Measure the dimensions of the wound(s)
Shape	Describe the shape of the wound(s) (e.g., linear, curved, irregular)
Surrounds	Note the condition of the surrounding or nearby tissues (e.g., bruised, swollen)
Colour	Observation of colour is particularly relevant when describing bruises
Course	Comment on the apparent direction of the force applied (e.g., in abrasions)
Contents	Note the presence of any foreign material in the wound (e.g., dirt, glass)

Table 2 (cont'd)

Feature	Notes
Age	Comment on any evidence of healing. (Note that it is impossible to accurately identify the age of an injury, and great caution is required when commenting on this aspect)
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used
Depth	Give an indication of the depth of the wound(s); this may have to be an estimate

Samples that can be collected as evidence:

- Injury evidence: physical and/or genital trauma can be proof of force and should be documented and recorded on pictograms.
- Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g., if replacement clothing is not available) describe its condition.
- Foreign material (soil, leaves, grass) on clothes or body or in hair may corroborate the victim/survivor's story.
- Hair: foreign hairs may be found on the victim/survivor's clothes or body. Pubic and head hair from the victim/survivor may be plucked or cut for comparison.
- Seminal fluid: swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis. Specimens from children should be taken only by those experienced in treating children.
- DNA analysis, where available, can be done on material found on the victim/survivor's body or at the location of the sexual assault, which might be soiled with blood, semen, saliva or other material from the assailant (e.g., clothing, sanitary pads, handkerchiefs,

condoms), as well as on swab samples from bite marks, semen stains, and involved orifices, and on fingernail cuttings and scrapings. In this case, blood from the victim/survivor must be drawn to allow his/her DNA to be distinguished from any foreign DNA found.

- Blood or urine may be collected for toxicology testing (e.g., if the victim/survivor was drugged). Forensic evidence should be collected during the medical examination and should be stored in a confidential and secure manner. The consent of the victim/survivor must be obtained before evidence is collected. Work systematically according to the medical examination form (see Annex 13).

Explain everything you do and why you are doing it. Evidence should only be released to the authorities if the victim/survivor decides to proceed with a case.

The medical report

Medical care of a victim/survivor of sexual assault includes preparing a medical and a police report (provided he/she wants to report the case to the police). These are important legal documents.

It is the responsibility of the health-care provider who examines the victim/survivor to make sure that such documents are completed.

The medical record and police report constitute elements of proof and are often the only material evidence available, apart from the victim/survivor's own story.

The victim/survivor may request for a medical report that they may use later after the event to seek justice or compensation. It is however important to advise victims/survivors to seek legal action as soon as possible. The health-care provider should keep copies locked away with the victim/survivor's file, to be able to certify the authenticity of the document supplied by the victim/survivor before a court, if requested. The victim/survivor has the sole right to decide whether and when to use these documents.

The medical report is a confidential medical document that the doctor must hand over to the victim/survivor. The medical report constitutes an element of proof and is often the only material evidence available, apart from the victim/survivor's own story.

The medical report may be handed over to legal services or to organizations with a protection mandate only with the explicit agreement of the victim/survivor.

A medical report must include:

- The name and signature of the examiner*
- The name, age and sex of the victim/survivor*
- The exact date and time of the examination*
- The victim/survivor's narrative of the sexual assault, in his/her own words
- The findings of the clinical examination
- The nature of the samples taken
- A conclusion

** If the report is more than one page, these elements should be included on every page of the document. If the report is shared with human rights organizations for advocacy purposes, without the consent of the victim/survivor, his/her name must be removed from every page.*

Referral²⁴

At primary health care level, the conditions required for obtaining forensic samples will rarely be met. Therefore, a referral should be proposed to the next level of care and depending on the informed decision of the victim/survivor, a referral can be made.

However, in all cases it is possible to obtain a minimum of proofs confirming the facts stated by the victim/survivor:

- Record the victim/survivor's story in a medical file.
- Note your observations during the clinical examination.
- Complete a medical report.

Referral to forensic examination

- Inform the victim/survivor about their legal rights and about the forensic examination or a clinical examination followed by a medical report.
- Propose a referral for forensic examination.
- It is the victims/survivors' decision to accept or decline the proposition for referral for forensic examination. Respect their choice.
- The informed voluntary consent of the victim/survivor must be obtained before referral is made.
- If appropriate, offer an initial dose of HIV PEP before forensic evidence is obtained.

²⁴ WHO Guidelines

- Only in cases of confirmed oral sex, an oral swab should be taken before offering the initial dose of HIV PEP.

Evidence collection, preservation and maintenance

Steps in collecting evidence samples:

- Refer to Botswana Police Service (BPS) protocols and guidelines on evidence collection.
- Explain the procedure of forensic data and evidence-collection to the victim/survivor and obtain their consent.
- Collect and label the samples and put them in a secure and appropriate/lockable storage e.g., refrigerator, cabinet/safe for post-legal examination.
- Caution and accountability must be taken in receiving and handing over samples i.e., legible signatures with printed full name are mandatory.
- Preserve any physical evidence (e.g., damaged/soiled clothing, jewellery, weapons) by storing each item in a separate specific container, (that would not compromise the texture of the samples).
- Provide temporary clothing and personal care kit.
- All efforts should be made to prevent tampering with the samples.

Reporting (Laws and Policies)

Mandatory reporting laws for GBV do not exist in Botswana and this approach is in line with relevant WHO recommendations²⁵ relating to principles of confidentiality and security for both patient and health-care provider. Consequently, health-care providers are NOT obliged to report matters of GBV to the police or any other competent authority.

- However, if the victim/survivor of GBV is a child, the law requires mandatory reporting.
- In that case, HCW can violate confidentiality clause to protect the child as this supersedes their client confidentiality.
- HCW ethical code of conduct – ethics and law.

The reporting should be aligned to the Penal Code (Cap 08:01); Domestic Violence Act (2008); Children's Act (2009), and other relevant legislation to give guidance on the execution of duty on GBV.

²⁵ Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, 2013

CHAPTER 8

Performing the Physical and Genital Examination

The primary objective of the examination is to determine what medical care should be provided to the victim/survivor. Work systematically according to the medical examination form. What is included in the examination will depend on how soon after the sexual assault he/she presents to the health facility.

Follow the steps in Part A below if he/she presents within **72 hours** of the incident; Part B is applicable to victims/survivors who present more than **72 hours** after the incident. The general guidelines apply in both cases.

General guidelines

- Make sure the equipment and supplies are prepared.
- ***Always inspect the victim/survivor first, before you touch him/her,*** and note the appearance and mental state.
- ***Always tell him/her what you are going to do and ask his/her permission before you do it.***
- Assure the victim/survivor that he/she is in control, can ask questions, and can stop the examination at any time.
- Always maintain a gentle and kind manner.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).

- The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital.
- Such complications might include extensive trauma (to genital region, head, chest or abdomen), asymmetric swelling of joints (septic arthritis), neurological deficits and respiratory distress.

The treatment of these complications is not covered in this document. Provide treatment according to your medical training.

- Obtain voluntary informed consent for the examination and for obtaining the required samples for forensic examination (see sample consent form in Annex 10).
- Record all your findings and observations as clearly and completely as possible on a standard examination form (see Annex 13).

VICTIM/SURVIVOR PRESENTS WITHIN 72 HOURS OF THE INCIDENT

Physical examination

- Always maintain a gentle and kind manner.
- Never ask the victim/survivor to undress or uncover completely. Examine the upper half of his/her body first, then the lower half; or give him/her a gown to cover him/herself.
- Minutely and systematically examine the patient's body. Start the examination with vital signs and hands and wrists rather than the head since this is more reassuring for the victim/survivor. Do not forget to look in the eyes, nose, and mouth (inner aspects of lips, gums and palate), in and behind the ears, and on the neck. Check for signs of pregnancy. Take note of the pubertal stage.
- Look for signs that are consistent with the victim/survivor's story, such as bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or torn eardrums, which may be a result of being slapped (according to the procedures for collecting evidence above). If the victim/survivor reports being throttled, look in the eyes for petechial haemorrhages. Examine the body area that was in contact with the surface on which the sexual assault occurred to see if there are injuries.
- Note all your findings carefully on the examination form and the body figure pictograms (see Annex 11), taking care to record the type, size, colour and form of any bruises, lacerations, ecchymoses and petechiae.
- Take note of the victim/survivor's mental and emotional state (withdrawn, crying, calm, etc.).
- Take samples of any foreign material on the victim/survivor's body or clothes (blood, saliva, and semen), fingernail cuttings or scrapings, swabs of bite marks, etc., according to the forensic evidence collection protocol above.

Examination of the genital area, anus and rectum

In cases where a genital examination is required:

- Begin with the vitals, then carry out the physical examination.
- Take your time before introducing the genital examination.
- Be extra sensitive in respecting the modesty of the victim/survivor.
- Use a sheet to cover the abdominal area and legs.
- Even when genitalia are examined immediately after a sexual assault, it may be difficult to find medical evidence related to the assault.
- Carry out a genital examination as indicated below.
- **Collect evidence as you proceed, according to the evidence collection protocol.** Note the location of any tears, abrasions and bruises on the pictogram and the examination form.
- Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen:
 - Note any scars from previous female genital mutilation or childbirth.
 - Look for genital injuries, such as bruises, scratches, abrasions, and tears (often located on the posterior fourchette).
 - Look for any sign of infection, such as ulcers, vaginal discharge or warts.
 - Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.
 - Hymenal tears are more common in children and adolescents. Please note that the so-called virginity (or 'two-finger')

testing has no scientific validity and is not recommended. (see “Special Care for child victims/survivors”, p. 57).

- Take samples according to the evidence collection protocol. If collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva, to avoid contamination.
- For the anal examination, the patient may have to be in a different position than for the genital examination. Write down his/her position during each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination). Note the shape and dilatation of the anus. Note any fissures around the anus, the presence of faecal matter on the perianal skin, and bleeding from rectal tears.
- If indicated by the history, collect samples from the rectum according to the evidence collection protocol.
- If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline (*do not use a speculum when examining children*; see “Care for child victims/survivors”):
 - Under good lighting, inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
 - Take swabs and collect vaginal secretions according to the evidence collection protocol.
- If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.

- If indicated, do a rectovaginal examination and inspect the rectal area for trauma, rectovaginal tears or fistulas, bleeding and discharge. Note the sphincter tone. If there is bleeding, pain or suspected presence of a foreign object, refer the patient to a hospital.
Note: In some cultures, it is unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. In this case, you may have to limit the examination to inspection of the external genitalia unless there are symptoms of internal damage.

Special considerations for elderly women

Elderly women who have been vaginally sexually penetrated are at increased risk of vaginal tears and injury, and transmission of STI and HIV.

Decreased hormonal levels following menopause result in reduced vaginal lubrication and a thinner and more friable vaginal wall. Use a thin speculum for genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

Special considerations for men^{26,27}

It is very important to recognize that men and boys also experience GBV e.g., sexual assault. Male victims/survivors are even less likely than women to report the incident, because of extreme embarrassment, shame, criminalization of same sex-relationships and slowness of institutions and health workers to recognize the extent of the problem. While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

The needs of male victims/survivors are essentially the same as those of females, but oftentimes the subject is even more sensitive,

²⁶ Guidelines for Health Staff Caring for Gender-based Violence victims/survivors, Including Protocol for Clinical Management of Rape

²⁷ Clinical management of rape victims/survivors: developing protocols for use with refugees and internally displaced persons – Revised ed. 2004

and many providers are uncomfortable. The key to providing good care to male victims/survivors is to be calm and professional and to convey to the victim/survivor your respect. Take the four guiding principles into account when taking care of male victims/survivors too.

In most cultures, society perceives men as being capable of defending themselves. Being unable to do so may make a man question his manhood. Male victims/survivors may prefer to have a consultation with a female health-care provider. Make sure to ask the victim/survivor at the beginning of the consultation if they want to consult with a female or male medical practitioner.

Men may have difficulty expressing their emotions as many societies discourage them from doing so. Male victims/survivors may feel guilty if they had an erection and ejaculated during forced anal intercourse.

- Reassure these men that these are normal reflexes they could not control as this can happen from stimulation of the prostate.

When a man is anally penetrated, pressure on the prostate can cause an erection and even orgasm. Reassure the victim/survivor that, if this has occurred during the sexual assault, it was a physiological reaction and was beyond his control.

Tell them: “This was a terrible thing that happened to you. The body reacts in ways we cannot control during such an attack, including getting an erection and even ejaculating. It does not mean that you liked it.” Men may also be hesitant to reveal the sexual assault for fear that others will find out and question their manhood and sexuality.

- Reassure him that all his information will be kept completely confidential.
- Remind him that the assault was not his fault.

Modifying the physical exam for males

- Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus and anus.
- Note if the victim/survivor has been circumcised.
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
- Torsion of the testis is an emergency and requires immediate surgical referral.
- If the urine contains large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- Be aware that prostate infections caused by anal penetration can be difficult to treat and require antibiotics for an extended period.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

Special considerations for minors

- For minors, ensure that consent is obtained from both a caregiver and the child.
- If a child refuses, explore the reasons for refusal.
- Consider providing an examination on the lap of the caregiver or on an examination table with the mother close by.
- If the child still refuses, abandon the examination.

- Consider sedation only if the child denies permission, but conditions require medical attention.²⁸

Laboratory testing

- Only the samples mentioned in the chapter on forensic evidence need to be collected for laboratory testing. If indicated by the history or the findings on examination, further samples may be collected for medical purposes.
- If the victim/survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and for possible culture.
- Do a pregnancy test; if indicated and available. (Do as per results of assessment).
- Other diagnostic tests, such as X-ray and ultrasound examinations, may be useful in diagnosing fractures and abdominal trauma.

VICTIM/SURVIVOR PRESENTS MORE THAN 72 HOURS AFTER THE INCIDENT

Physical examination

It is rare to find any physical evidence more than one week after an assault. If the victim/survivor presents within a week of the sexual assault, or presents with complaints, do a full physical examination as above. In all cases:

- Note the size and colour of any bruises and scars.
- Note any evidence of complications of the sexual assault (deafness, fractures, abscesses, etc.).

- Check for signs of pregnancy.
- Note the victim/survivor's mental state (normal, withdrawn, depressed, suicidal).

Examination of the genital area

If the assault occurred more than **72 hours** but less than a week ago, note any healing injuries to genitalia and/or recent scars. If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g., of vaginal or anal discharge or ulcers), there is little indication to do a pelvic examination. Even when one might not expect to find injuries, the victim/survivor might feel that he/she has been injured. A careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the patient and might be the main reason he/she is seeking care.

Laboratory screening

Pregnancy test; if indicated and available. If laboratory facilities are available, samples may be taken from the vagina and anus for STI screening for treatment purposes.

Screening might cover:

- Rapid plasma reagin (RPR) test for syphilis or any point-of-care rapid test.
- Gram stain and culture for gonorrhoea.
- Culture or enzyme-linked immunosorbent assay (ELISA) for chlamydia or any point-of-care rapid test.
- Wet mount for trichomoniasis.
- HIV test (only on a voluntary basis and after counselling).

²⁸ Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

CHAPTER 9

Documentation and Recording²⁹

Health workers are professionally obliged to record in writing the details of any consultation with a patient. In the case of GBV, health-care providers need to explain to the victim/survivor what information will be recorded and why. If, on the other hand, the victim/survivor prefers not to have some information recorded, then this wish should be followed unless it is necessary for the provision of care.

A legible medical record must be prepared for each known or suspected client of GBV presenting at the facility. As medical records may be used in court as evidence, the recording of accurate and complete notes during the course of an examination is critical. For accuracy, make all notes during, rather than after, the course of the consultation.

This record should include the following:

- Complete the patient file for every patient.
- Documentation of confirmed or suspected domestic violence that is occurring presently or has occurred in the past.
- A description of domestic violence history, including present complaints or injuries, past experiences of physical, sexual and mental abuse and frequency of abuse. Include date, time and location of domestic violence incidents. Whenever appropriate, use the client's own words in quotation marks.
- Document all aspects of the consultation, including consents given; medical history; account of the abuse; outcome of the physical examination; samples taken; tests and their results; treatments and medications prescribed; and schedule of follow-up care and referrals.
- A description of the client's injuries, which includes the age, type, location, size and colour, if possible, should be captured.
- The mental state and status of the client should be assessed, described and recorded.
- Information about the alleged perpetrator, such as name, address, and relationship to client should be captured.
- A description of other health, physical or mental problems, which may be related to the violence should be noted and recorded.

²⁹ Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

- Document details of all interventions made, and all actions taken, including referrals.
- Ensure that any assessment is impartial and represents a balanced recording of the findings.
- N.B this documentation process may take place over more than one visit as further history is revealed. Different members of the health facility team may document different aspects of the violence.



IMPORTANT

No document (except the medical report) should include the victim/survivor's name. Use codes or anonymization or de-identification (a naming convention using district – facility – patient# should be adopted).

Data safety

- Patient records and other supporting information are strictly confidential.
- All health-care providers are professionally, legally, and ethically obliged to maintain and respect patient confidentiality and autonomy.
- Records and information should not be disclosed to anyone except those directly involved in the case or as required by law.
- All patient records (and any specimens) should be stored in a safe place. Biological evidence normally should be refrigerated or frozen; check with a laboratory regarding the specific storage requirements for biological specimens.
- No information or document may be disclosed without the victim/survivor's consent and without the authorization of the director of the health structure.
- It is recommended that statistical data concerning GBV cases are collected into a separate database system, only accessible to authorized staff members.

CHAPTER 10

Providing Care/Treatment

Clinical management of sexual assault

To prevent and manage possible health consequences, sexual assault victims/survivors must have access to clinical care as soon as possible after the incident, including supportive counselling. Clinical management of victims/survivors of sexual assault includes the availability of trained staff and compassionate and confidential treatment, including:

- Emergency contraception
- Treatment of STIs
- Post-exposure prophylaxis (PEP) to prevent HIV acquisition
- Care of wounds and prevention of tetanus
- Prevention of hepatitis B
- Referral for further services, e.g., health, psychological and social

TABLE 3
Management of sexual assault at a glance³⁰

	General remark	Women	Girls	Men/Boys
Pregnancy Test		Yes	Yes, if pubertal	N/A
Emergency Contraception	Pregnancy test is not pre-requisite	Within 120 hours (5 days)	For pubertal girls, give within 120 hours (5 days)	
HIV Test	Unknown Status	Offer HIV test at first visit and follow-up session		
	HIV Positive	Refer to ARV services for treatment and/or follow-up care		
HIV PEP	» HIV test is prerequisite » Risk assessment is advised	If < 72 hrs For adolescents and adults: -Initiate DTG/TRU or TDF/FTC/EFV (whichever is immediately available) -If side effects with EFV, switch to DTG as soon as possible		
STI Prophylaxis	Always give STI prophylaxis without delay	As per protocol (Refer to Table 4)		
Hepatitis B prophylaxis	Always if not fully immunized Better prophylaxis if within 14 days	Hep. B vaccine Schedule: d0-d7-d28 (1 booster dose, 1 year later)	< 5 years old Pentavalent Schedule: d0-d30-d60 > 5 years old same as for women	Men as per women Boys as per girls

³⁰ Botswana Primary Care Guidelines 2016 / [Sexually Transmitted Diseases Treatment Guidelines, 2015](#)

Table 3 (cont'd)

	General remark	Women	Girls	Men /Boys
Tetanus prophylaxis	Always if not fully immunized	TT Schedule: -M0-M1-M6	< 5yrs old Pentavalent Schedule: d0-d30-d60	Men as per women Boys as per girls
	If wound dirty and > 6 hours	250 IU IM	Same as for women	Same as for women
Wound management	Control bleeding, assess the wound, clean the wound (and remove debris), close by dressing or applying sutures if required, provide adequate pain relief, consider antibiotics and tetanus vaccination if required, screen for complications, and refer if needed			
Family Planning	Promote use of condoms for at least 6 months	Propose additional family planning methods	Propose additional family planning methods	

Source: Botswana Primary Care Guidelines 2016 / Sexually Transmitted Diseases Treatment Guidelines, 2015

Treatment will depend on how soon after the incident the victim/survivor presents to the health service. Follow the steps in Part A if he/she presents within **72 hours** of the incident; Part B is applicable to victims/survivors who present more than **72 hours** after the incident. Male victims/survivors require the same vaccinations and STI and HIV treatment as female victims/survivors.

VICTIM/SURVIVOR PRESENTS WITHIN 72 HOURS OF THE INCIDENT

Prevention of sexually transmitted infections

The Botswana Ministry of Health-recommended STI treatment protocols³¹ (also recommended for prophylaxis) are described below in Table 4. Health-care providers should note that in Botswana the treatment of STIs follows the Syndromic Case Management Approach. This means that treatment is based on identifying consistent groups of symptoms and easily

recognized signs (syndromes) and providing treatment which will deal with most organisms responsible for producing each syndrome. **Patients are thus given treatment on their first encounter with the health-care provider.** Below are some of the recognized STI syndromes to be aware of in follow-up care:

- i. Urethral discharge and/or dysuria (pain on passing urine)
- ii. Vaginal discharge and/ or dysuria
- iii. Genital sores or ulcers
- iv. Lower abdominal pain
- v. Scrotal swelling/pain
- vi. Genital growths
- vii. Inguinal bubo (groin swelling)

Be aware that women who are pregnant and children less than eight years old should not take certain antibiotics such as doxycycline, and tetracycline, and modify the treatment accordingly.

³¹ The National STI Guidelines are currently under review and may be updated by 2023. Please consider the most up-to-date guidelines at the time of applying this protocol

Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP), although the doses should be spread out to reduce side effects, such as nausea.

N.B: Assess for all syndromes, and order investigations as appropriate, including RPR. Remember to review results at follow up and provide treatment accordingly, including referral for further management for genital warts.

TABLE 4
STI prophylactic regimen

Adult prophylactic treatment of STIs						
	Product	Route of administration	Strength	Dosage	Duration	Pills
Adults	Ceftriaxone	Intramuscular injection	250 mg	250 mg	stat	
	Azithromycin	Oral tablet or capsule	1 g	1 g		1
	Metronidazole	Oral tablet or capsule	250 mg or 500 mg	2 g		8 or 4
Adult prophylactic treatment for trichomoniasis						
	Product	Route of administration	Strength	Dosage	Duration	Pills
Adults	Metronidazole	Oral tablet or capsule	250 mg or 500 mg	2 g	stat	8 or 4
*Children's prophylactic of treatment STIs						
Children	Product	Route of administration	Strength	Dosage	Duration	
< 45 kg	Erythromycin ^a	Oral suspension	125 mg/5 ml	50 mg/kg/day in four dosages	14 days	
	Ceftriaxone ^b	IM injection	250 mg	125 mg	Stat	
> 45 kg but < 8 years old	Azithromycin	Tablet or capsule	1 g	1 g	Stat	
> 8 years old	Use the adult regimen					
Children's prophylactic treatment for trichomoniasis						
Children	Product	Route of administration	Strength	Dosage	Duration	
< 45 kg	Metronidazole	Oral tablet / powder for suspension	250 mg or 500 mg or 125 mg/ml	15 mg/kg/day (maximum 250 mg per dose)	7 days	
> 45 kg	Metronidazole	Oral tablet or capsule	250 mg or 500 mg	2 g	stat	

*All children should be referred to a paediatrician.

^a Recommended for chlamydial infections

^b Recommended for gonococcal infections

Source: Handbook of the Botswana 2016 Integrated HIV Clinical Care Guidelines / Botswana STI Reference Manual

Post-exposure prophylaxis (PEP)³²

Introduction

Post-exposure prophylaxis (PEP) is a short course of antiretroviral medicines taken after exposure to HIV to reduce the likelihood of acquiring HIV infection.

A person can be accidentally exposed to HIV through health-care work (occupational exposure) or through exposures in a setting other than health care (non-occupational exposure), which includes sexual assault or any unprotected sex.

Ideally, PEP should be initiated within 4 hours of the exposure, and not later than 72 hours!

If started soon after exposure, PEP can significantly reduce the risk of HIV infection. Adherence to the full course of antiretroviral medication is critical to the effectiveness of the intervention.

Outline

- Determination of the HIV infectiousness of the body fluid to which the person was exposed
- Type and extent of exposure
- Immediate exposure management
- Estimation of the HIV risk of the specific exposure
- Counselling and determination of the HIV status of the exposed person
- Determination of the HIV status of the source patient/person
- Decision on whether to initiate PEP
- Initiation of PEP and monitoring of the exposed person on PEP

- Repeat HIV testing of the exposed person after completion of PEP
- Thorough documentation of the above steps.

Victims/survivors of rape, sodomy, and defilement—including infants and children—who present for care within 72 hours of the incident should be offered PEP.

Even if the perpetrator tests HIV-negative, the result must be interpreted with caution, as it is possible that the perpetrator is in the “window period.”

- Follow the PEP protocol for such victims/survivors, including infants and children, exactly as indicated above; this includes the need for baseline HIV testing.
- The practitioner must not wait for a police report before initiating PEP and is not bound by any police report in determining the need for PEP.
- It is essential that police understand that PEP must be started immediately for victims/survivors of sexual violence; therefore, the victims/survivors of sexual violence must first be brought to the hospital or clinic for PEP evaluation before a detailed police interrogation is initiated.
- A patient history of violent penetrative sex is sufficient for initiating PEP, per the above protocol. Although not a requirement for initiation of PEP, the victim/survivor should be encouraged to report the sexual abuse to the police once PEP has been initiated.
- Victims/survivors of sexual violence, especially children, require special medical and psychosocial care. Although appropriate referrals for this care may be necessary, the treating clinician must also provide such care, and not merely delegate it. Moreover,

³² The Botswana HIV Treatment Guidelines are currently under review. The above content is consistent with the draft new guidelines. Further edits may be made, so please refer to the final approved HIV Treatment Guidelines at the time of applying this protocol

this care should be given regardless of whether or not the victim/survivor receives PEP, as follows:

- Screening for other STIs which may have been transmitted during the sexual abuse should be done by obtaining cultures for chlamydia and gonorrhoea, if available, as well as baseline and follow-up RPR.
- After obtaining a screening pregnancy test, patients should also be offered emergency contraception in the form of the “morning-after pill” to prevent pregnancy.
- The patient/caregiver should receive education about signs and symptoms of STIs, including the importance of ongoing safe sex.
- If genital/rectal trauma has occurred, promptly refer the patient for appropriate surgical, urological, or gynaecological care, as indicated.
- Obtain baseline, 6 weeks, 3 months, and 6 months HIV rapid tests, and if positive, initiate appropriate support and referrals.
- Depression, shame, guilt, and suicide have followed rape or other forms of sexual abuse, so ongoing psychosocial interventions and counselling are required, including social worker referral for psychiatric evaluation.
- Since the psychological trauma of rape may not be evident at the initial visit, such interventions must be ongoing at follow-up visits, and should always be conducted within a safe, supportive, and confidential environment.

Body fluids and their HIV infectiousness

Body fluids which are **infectious** for HIV are generally those which are contained within enclosed, usually sterile body compartments, such as joints, the central nervous system, or the pleural space. Such fluids include:

- Blood
- Genital and anal secretions

- Pericardial fluid
- Pleural fluid
- Synovial fluid
- Amniotic fluid
- Cerebral spinal fluid
- Ascitic fluid
- Breast milk

Plus, any normally non-infectious fluid which is visibly contaminated with blood (or, in unusual cases, contaminated with any other infectious fluid).

• Fluids **not infectious** for HIV include:

- Urine
- Faeces
- Tears
- Saliva
- Perspiration
- Sputum
- Pus
- Nasal secretions

The above-mentioned fluids may, however, become infectious when contaminated with blood.

Type and extent of exposure

- **Percutaneous:** injury causing a break in skin and exposure to body fluid, usually via needle (needlestick injury) or scalpel injury.
- **Mucosal:** conjunctival and oral mucous membrane exposure to body fluid.
- **Cutaneous:** contact of HIV-infected material with a person’s skin.
- Exposure management
- Wash exposed wounds and skin sites with soap and water.
- Flush mucous membranes with water.

- **Avoid use of antiseptics, bleach, or other caustic agents**, including injection of the exposed site with these agents.

Estimation of the HIV risk of the specific exposure

Needlestick injuries: These are wounds caused by needles that accidentally puncture the skin; they commonly occur in the health-care setting. The risk of transmission from a needlestick involving HIV-containing blood has been estimated at 0.3 per cent, or just about three in a thousand. Transmission rate is greater if: there was a hollow-bore needle, the needle was in the source patient's artery or vein, there was visible source patient's blood or other infectious fluid on the needle, the injury was deep, and the source patient's viral load was high.

Mucous membrane exposure - estimated 0.09 per cent risk of HIV transmission. Factors that may affect this risk are the volume of HIV-infected fluid, the length of exposure, any exposure management undertaken (e.g., eye washing), and the underlying integrity of the conjunctival or oral mucous membranes (e.g., conjunctivitis, oral ulcers, and obvious breaks in the oral mucosa).

Cutaneous exposure - the transmission risk from exposure of HIV-infected fluid to **intact** skin is believed to be negligible, unless there is underlying dermatitis or significant skin breakage.

Counselling and determination of HIV status of the exposed person

- If the exposed person is already known to be HIV-infected, PEP is not indicated; however, consider inoculation with HBV immune globulin (if available and the exposed person has not been vaccinated against hepatitis).
- To facilitate necessary evaluation and intervention, the rapid test should be used if available.

- If the exposed person refuses HIV testing, then PEP should not be given.
- If the exposed person tests HIV-positive, then PEP is not indicated, and necessary reassurance and emotional support must be provided with prompt referral for initiation of antiretroviral therapy.

Determination of the HIV status of the source patient

- If the exposed person is found to be HIV-negative, then the HIV status of the source person/patient must be determined, unless the source person/patient is already known to be HIV-infected.
- *If the source person's HIV status is unknown, and if he/she refuses HIV testing, then an HIV (rapid) test should be obtained; however, the results should not be shared with the source person/patient.* If the source patient physically hinders or obstructs performance of rapid testing, then it is necessary to initiate PEP for the exposed person.

Notwithstanding all the scenarios described above, remember the ideal time for initiating PEP is within 4 hours, and never later than **72 hours!**

Decision whether or not to initiate PEP

- Decisions regarding initiation of PEP must be based upon clinical evaluation of each exposure event, including the type of exposure, the amount of potentially infectious fluid to which the person was exposed, the potential infectiousness of the fluid, and the HIV status of the source patient.
- *Exposures to fluids not normally infectious for HIV, as listed above, do not merit PEP, even if the source patient is HIV-infected. Remember, exposure to potentially HIV-infected fluids may or may not merit PEP based on the exposure type and the clinician's assessment.*

- PEP is recommended for needle stick injuries when the body fluid is potentially infectious for HIV and the source patient is known to be HIV-infected.
- For a needle stick injury in which the body fluid is potentially infectious for HIV, and in which the source patient tests HIV negative, *the decision to initiate PEP must take into account the possibility that the source patient might be recently HIV-infected and is in the “window period” of infection. Whenever the practitioner believes there is a reasonable chance that the source patient who tests HIV negative may be in the “window period,” PEP should be given to the exposed person – “Err on the side of caution”.*
- For mucosal exposure, the amount of infectious fluid, the length of time of exposure, *the condition/integrity of the exposed mucous membrane*, whether or not there were any cleansing interventions, and the HIV status of the source patient should be taken into consideration.
- Many mucosal exposures do not merit PEP, especially when the exposure was minimal, there was no prior inflammation of the mucous membrane, and the source patient tests HIV-negative. An HIV Specialist should be consulted in difficult cases.
- Exposure of intact skin to HIV-infected fluid does *not* merit PEP.
- Human bites are not infectious for HIV, and do not merit PEP, unless visible blood from the biter was present in the biter’s mouth prior to the bite.
- The length of time HIV can survive outside the body is unknown. Nonetheless, needle stick injuries from devices left in the trash or elsewhere merit PEP.
- It is imperative that the medical practitioner be able to make decisions concerning PEP initiation without pressure from the exposed person.

Initiation of PEP and monitoring of the person taking PEP

ART regimens for PEP

Once the decision to initiate PEP has been made, *PEP should be started as soon as possible, ideally within 4 hours after exposure, but no later than 72 hours.*

PEP must be taken for a full period of 28 days.

The antiretroviral combination recommended for PEP is generally *the same as the first-line regimen used for ART, unless there is a contra-indication.*

In cases where the source patient/person has already failed the first -line regimen, discuss with an HIV specialist/expert to select the appropriate regimen for PEP.

- For adolescents and adults weighing ≥ 25 kg the recommended regimen is:
 - **TAF/FTC/DTG “TAF-ED”** or **TDF/3TC/DTG “TLD”** for those weighing ≥ 30 kg.
- Children weighing less than 25 kg must be given:
 - **ABC/3TC+DTG**
- Assure that the person taking PEP understands the importance of completing the **28 day**-course.
- Schedule clinical follow-up two weeks after PEP initiation, both to evaluate for side effects and to provide adherence counselling and emotional support.
- Monitor laboratory results of the person on PEP based on their medical history.

In some cases, baseline and follow-up laboratory testing are not necessary. However, obtaining any baseline laboratory tests, if clinically indicated, must not delay initiation of PEP beyond 4 hours after the incident.

- Pregnancy is not a contraindication to PEP. Discuss PEP treatment options with HIV specialists if necessary.

- Counsel the person taking PEP to practice safe sex during the period of PEP and until repeat HIV testing has been completed.
- Women who are breastfeeding must be counselled regarding the risks of breastfeeding following an HIV exposure and should be advised to abstain from breastfeeding until HIV status is fully known.
- Educate the person taking PEP about ARV side effects. Advise them to return immediately if such side effects appear.

Repeat HIV testing of victim/survivor after PEP

The victim/survivor should return for repeat HIV testing at 6 weeks, 3 months, and 6 months after the initial exposure.

For women who ceased breastfeeding while on PEP, confirm the negative 6-week HIV test to allow resumption of breastfeeding.

Thorough documentation of the above steps:

All of the above steps must be carefully documented in the medical record of the person taking PEP, and in relevant clinic/hospital records.

Special Situations

- When the source patient/person is a highly treatment-experienced patient, consultation with an HIV specialist is mandatory to determine appropriate PEP regimen.
- Clinicians prescribing PEP must watch out for drug-drug interactions between PEP medications and other medications that the person might be taking, e.g., contraceptives, anti-tuberculosis medications, etc.

Prevent pregnancy

Emergency Contraception

Taking emergency contraceptive pills (ECPs) within 120 hours (5 days) of unprotected intercourse will reduce the chance of a pregnancy

by between 56 per cent and 93 per cent, depending on the regimen and the timing of taking the medication. The provision of emergency contraception must be automatic for all women of childbearing age (from the onset of puberty, first period) if not already pregnant prior to the assault.

Emergency contraceptive pills work by interrupting a woman's reproductive cycle – by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. ECPs do not interrupt or damage an established pregnancy and thus WHO does not consider them a method of abortion.

The use of emergency contraception is a personal choice that can only be made by the woman herself. Women should be offered objective counselling on this method to reach an informed decision. A health-care provider should prescribe ECPs to victims/survivors of sexual assault who wish to use them.

If the victim/survivor is a child who has reached menarche, discuss emergency contraception with her and a parent or guardian, who can help her to understand and to take the regimen as required. Health-care providers should be aware that minors who have not reached menarche but have secondary sexual characteristics should be screened for pregnancy and given ECP as they are also at risk of pregnancy.

A pregnancy test is not required to start EC, but if a pregnancy test was provided and the result was positive, emergency contraception is neither necessary, nor effective.

If an early pregnancy is detected at this stage, either with a pregnancy test or from the history and examination, make clear to the woman that it cannot be the result of the sexual assault. There is no known contraindication to giving ECPs at the same time as antibiotics for STIs and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Refer to Table 5 below for various EC regimens available in Botswana.

Counsel the victim/survivor about:

- Side effects and the effect of the pills on her next menstrual period.
- Fact that EC's do not prevent pregnancy from sexual intercourse occurring after their use.

Adverse effects

Nausea: To reduce the risk of nausea, suggest that the victim/survivor eats something before taking EC pills.

Vomiting: If the woman vomits within two hours after taking EC, she should take another dose (and consider adding an anti-emetic). If vomiting occurs more than two hours after taking the EC, she does not need extra pills.

Precautions

- Inform the victim/survivor that her next menstrual period may start several days earlier or later than expected.
- If her next period is very different from normal, she should come back for consultation.
- Provide her with condoms for use in the immediate future and for dual protection.
- Discuss the options of a possible pregnancy if there is no menstruation within 21 days, or within 5 to 7 days after the expected date if the date is known. Instruct the *victim/survivor to return if effects such as headache, dizziness, or abdominal pain continue for longer than one week after taking the EC.*

TABLE 5

Types available, regimens and effectiveness of emergency contraception (EC)³³

Type	Content (in one pill)	Regimen/dosage	Effectiveness*
Low-dose COCs	30 mcg oestrogen + 150 mcg levonorgestrel	Take 4 tablets within 72 hours after unprotected sex, repeat in 12 hours after the first dose	Prevent 52%-94% of pregnancies
Special LNG-based ECP product	Levonorgestrel 1.5 mg	Take 1 pill within 72 hours after unprotected sex. No second dose.	
Special LNG-based ECP product	Levonorgestrel 0.75 mg	Take 2 pills within 72 hours after unprotected sex. No second dose.	
Progestin only oral contraceptives (POPs)	0.03 mcg levonorgestrel	Take 50 tablets (1.5 mg total) within 120 hours after unprotected sex. No second dose.	Prevent up to 95%-99% of pregnancies

³³ Botswana Family Planning Procedures Manual for Service Providers, 2021

Provide wound care

Clean any tears, cuts and abrasions and remove dirt, faeces, and dead or damaged tissue.

Decide if any wounds need suturing. Suture clean wounds within 24 hours. After this time, they will have to heal by secondary intention or delayed primary suture. Do not suture very dirty wounds. If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.

Prevent tetanus

Tetanus prophylaxis³⁴

The risk of tetanus infection depends on the nature and violence of the assault. However, within the specific framework of a sexual assault, maximum protection against tetanus infection must be ensured. Therefore, tetanus prophylaxis should always be given (even if the victim/survivor presents months or years after the incident), unless the victim/survivor has been previously fully vaccinated. Administer tetanus toxoid (TT), which gives active protection.

Indication:

Prevention of tetanus in wound management depends on risk and pre-exposure vaccination status:

- **Tetanus toxoid (TT) vaccine:** Any victim/survivor, who presents with breaks in skin or mucosa, based on immunization status.
- **Human tetanus immunoglobulin (TIG):** Dirty wounds are an increased risk for tetanus unless fully immunized. Provide HTIG in victims/survivors non-immunized or incompletely immunized or in victims/survivors whose immunization status is unknown, in combination with tetanus vaccine.

Tetanus toxoid vaccine: Dosages and schedule:³⁵

a. Adults, adolescents and children > 5 years

Tetanus toxoid vaccine: 0.5 ml/injection IM (adults and children¹⁰). The first two doses of TT are scheduled the same as the rapid hepatitis B vaccine schedule providing 80 per cent protection within 4 weeks. This is relevant to the management of the assault rather than providing extended protection. In most programmes, TT3, TT4, and TT5 will be given in the regular vaccination programme.

Advise victims/survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

b. Children < 5 years

For children less than 5 years old, pentavalent (DTP-Hib-HepB)³⁶ vaccine is preferred to tetanus toxoid alone. Schedule should be adapted according to the vaccination status of the child.

Pentavalent vaccine:

- Dose 1: given at the first visit to the clinic
- Dose 2: four weeks after the first dose
- Dose 3: four weeks after the second dose
- Booster: after 12 to 18 months

Tetanus toxoid alone: 0.5 ml per injection; same schedule as in adults.

Human tetanus immunoglobulin (TIG):

TIG: 250 international units (IU) in 1 ml by IM injection into the deltoid or gluteus region.

- If more than 24 hours have elapsed between being injured and seeking medical care, the dosage should be doubled (500 IU).

³⁴ Refer to The Botswana Primary Health Guidelines

³⁵ Refer to The Botswana Primary Health Guidelines

³⁶ Comprehensive Multi-Year Plan (cMYP) For National Immunization Program (NIP), 2011–2015, Ministry of Public Health DG of Preventive Medicine National Immunization Program (NIP), 2012

- If TT and HTIG are given at the same time, different needles, syringes and injection sites must be used.
- For children < 5 years: same dosage and indications as in adults.

Contra-indications, adverse effects, precautions:

- Known allergy to tetanus toxoid vaccine and TIG.
- Rare and mild local reaction: redness and pain at the injection site.
- No contra-indications for pregnant and breastfeeding women.
- No contra-indication in cases of symptomatic or asymptomatic HIV infection.

Storage

- Between 2 and 8 °C (never freeze)
- After opening, the 10-dose vial of vaccine may be kept for one month.

Tetanus toxoid (TT) is available in several different preparations. Tetanus immunoglobulin (antitoxin) is expensive and

needs to be refrigerated. The following are the various preparations. Prescribe whatever is available in your facility:

TT – Tetanus toxoid

- DPT – Triple antigen: Diphtheria and pertussis and tetanus toxoids vaccine
- DT – Double antigen: Diphtheria and tetanus toxoids; given to children up to 6 years of age
- Td – Double antigen: Tetanus toxoid and reduced diphtheria toxoid; given to individuals aged 7 years and over
- TIG – Tetanus immunoglobulin.

If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the victim/survivor has been fully vaccinated.

Use Table 6 to decide whether to administer tetanus toxoid (which gives active protection) and tetanus immunoglobulin, if available (which gives passive protection).

If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.

Advise victims/survivors to complete the vaccination schedule (second dose at four weeks, third dose at six months to one year).

TABLE 6

Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds

History of Tetanus immunization (Number of doses)	If wounds are clean and < 6 hours old or minor wounds		All other wounds	
	TT*	TIG	TT*	TIG
Uncertain or < 3	Yes	No	Yes	Yes
3 or more	No, unless last dose > 10 years ago	No	No, unless last dose > 5 years ago	No

*For children under 7 years of age, DPT or DT is preferred to tetanus toxoid alone. For persons 7 years and older, Td is preferred to tetanus toxoid alone.

Prevent hepatitis B

Approximately 30 per cent of the world's population, or about two billion people, have serologic evidence of current or past hepatitis B virus (HBV) infection. Of these, an estimated 361 million persons have chronic HBV infection. Persons with chronic HBV infection are at increased risk of cirrhosis of the liver and hepatocellular carcinoma. WHO estimates that around 600 000 persons die each year due to HBV-related chronic liver disease.³⁷ Although there are currently no systematic countrywide data available about the actual prevalence rate of HBV, it appears that Botswana remains at an early epidemic phase.

The risk of transmission of hepatitis B is significantly higher than that of HIV (100 times higher). A 2011 study of an adult HIV centre population in Botswana estimated a hepatitis B prevalence rate of 5.3 per cent. The study, which used a small non-probability sample, recommended further broader sampling to establish the true population prevalence of hepatitis B coinfection and the desirability of adding hepatitis B screening to HIV management.³⁸

A more recent study Investigating hepatitis B virus prevalence and vaccine antibody titers in children HIV-exposed but uninfected in Botswana found a prevalence of 1.74 per cent among HIV-positive mothers, no cases among their children. The study attributed the absence of hepatitis B positive cases among children to HBV vaccine responses and low maternal prevalence of hepatitis B in Botswana.³⁹

Every victim/survivor should be offered prophylaxis for hepatitis B as soon as possible after the incident. Victims/survivors of sexual assault should receive post-exposure immunization

with hepatitis B vaccine within the first 14 days, (or within the first three months of the incident), if possible. This gives maximum prophylactic protection after the assault. If a victim/survivor presents more than three months after the incident, hepatitis B vaccine should always be given, to ensure future protection against hepatitis B for the victim/survivor.

Hepatitis B has an incubation period of two to three months on average. If signs of an acute infection are apparent, the victim/survivor should be referred if possible or provided with counselling.

Hepatitis B vaccination should be offered without hepatitis B immune globulin.

To avoid unnecessary delays, presumptive treatment is preferable to testing for STIs.⁴⁰ If hepatitis B tests are available in the health facility, take blood for hepatitis B status prior to administering the first vaccine dose. If the victim/survivor is immune, no further course of vaccination is required.

The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It may be given at the same time as a tetanus vaccine.

The vaccine does not interfere with the immune response to any other vaccine and may be given simultaneously with other vaccines. It may be administered at the same time as the anti-tetanus vaccine, but the vaccines should not be combined in the same syringe.

Vaccine is administered by intramuscular injection in the anterolateral aspect of the thigh (children < 2 years) or in the deltoid muscle (adults and older children). Administration in the buttock is not recommended, as the immune reaction is insufficient. Several

³⁷ http://applications.emro.who.int/docs/EM_RC56_3_en.pdf

³⁸ Patel P; Davis, S. Tolle M., Mabikwa V. & Anabwani G. (2011) Prevalence of hepatitis B and hepatitis C coinfections in an adult HIV centre population in Gaborone, Botswana. *American Journal of Tropical Medicine & Hygiene*, 2011 Aug; 85 (2): 390-4. doi: 10.4269/ajtmh.2011.10-0510

³⁹ Baruti K., Lentz K., Motswedi A., Ajibola G., Phinius B.B., Choga., Mbangiwa T., Powis K.M., Sebunya T., Blackard J.T., Lockman S., Moyo S., Shapiro R. & Gaseitsiwe S (2020) Hepatitis B virus prevalence and vaccine antibody titers in children HIV exposed but uninfected in Botswana, *PLoS One*. 2020 Aug 7;15(8): e0237252. doi: 10.1371/journal.pone.0237252. eCollection 2020. PMID: 32764801

⁴⁰ Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013

hepatitis B vaccines are available, each with different recommended dosages and schedules. Check the dosage and vaccination schedule for the product that is available in your facility and prescribe accordingly.

There is no information on the incidence of hepatitis B virus infection following sexual assault. However, HBV is present in semen and vaginal fluid and is efficiently transmitted by sexual intercourse. If possible, victims/survivors of sexual assault should receive hepatitis B vaccine within 14 days of the incident.

If the vaccination record card of the victim/survivor confirms that hepatitis B vaccine has been given, no additional doses of hepatitis B vaccine need be given.

The usual vaccination schedule is at zero, one and six months. However, this may differ for different products and settings. Give the vaccine by intramuscular injection in the deltoid muscle (adults) or the anterolateral thigh (infants and children). Do not inject into the buttock, because this is less effective.

Bite marks

Special considerations should be given to the treatment of bite marks.

1. In general hand wounds, infected wounds or wounds presenting more than 12 hours are not closed.
2. Antibiotic prophylaxis is mandatory.
3. Closure, if done, is performed in a simple, interrupted fashion, avoiding layered closure with buried sutures.
4. Wound edges should not be watertight and should allow for drainage.

Provide mental health care

Social and psychological support, including counselling, are essential components of medical care for the sexual assault victim/survivor. Most victims/survivors of sexual

assault will regain their psychological health through the emotional support and understanding of people they trust, community counsellors, and support groups. At this stage, do not push the victim/survivor to share personal experiences beyond what they want to share. However, the victim/survivor may benefit from counselling later, and all victims/survivors should be offered a referral to the community focal point for sexual and GBV, if one exists.

If the victim/survivor has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e., without an organic cause), explain to him/her that these sensations are common in people who are very scared after having gone through a frightening experience, and that they are not due to disease or injury. The symptoms reflect the strong emotions the victim/survivor is experiencing and will disappear over time as the emotion decreases.

Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as not being able to talk to people, for at least 24 hours. In this case and only when the victim/survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, for no more than three days. Refer the person to a professional trained in mental health for reassessment of the symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose may be repeated for a few days with daily assessments.

Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma victims/survivors. Benzodiazepines should be avoided during pregnancy and breastfeeding. For concurrent medical conditions: before prescribing benzodiazepines, consider the potential for drug/disease or drug/drug interaction.

VICTIM/SURVIVOR PRESENTS BETWEEN 72 HOURS AND 120 HOURS AFTER THE INCIDENT

Prevention and treatment of sexually transmitted infections (STIs)⁴¹

For victims/survivors presenting beyond **72 hours**, manage STIs as per Ministry of Health STI treatment guidelines. Provide syndromic treatment with ceftriaxone, azithromycin and metronidazole as per Table 4.

Collect bloods for RPR, and assess for other STIs e.g., genital warts, and refer for further treatment as appropriate depending on findings.

HIV transmission

In some settings, testing for HIV can be done as early as six weeks after a sexual assault. However, it is recommended that the victim/survivor is referred for voluntary counselling and testing (VCT) after three months, to avoid the need for repeated testing.

Pregnancy

Most female victims/survivors of sexual assault are concerned about the possibility of becoming pregnant because of the assault. Intimate partner violence and sexual assault are significantly associated with unwanted pregnancy, which can lead to unsafe abortions practice (Pallitto et al., 2013). Deaths due to unsafe abortion remain close to 13 per cent of all maternal death.⁴²

If the victim/survivor is pregnant, try to ascertain if she could have become pregnant at the time of the sexual assault. If she is, or may be, pregnant because of the sexual assault, counsel her on the options available to her.

Emergency contraception

If a woman seeks health care within a few hours and up to five days post-sexual assault, emergency contraception should be offered. Taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within **72 hours**, but it is still moderately effective within 120 hours after unprotected intercourse. *Please follow the same Emergency Contraception as per the Ministry of Health Family Planning Manual.*

If the victim/survivor presents more than five days after the assault, she should be advised to return for pregnancy testing if she misses her next menstrual period.

Determining pregnancy⁴³

Whether the victim/survivor has become pregnant because of the sexual assault or was already pregnant prior to the sexual assault can be important for her to determine. Determining whether a victim/survivor was pregnant prior to the sexual assault is not a prerequisite for using emergency contraceptives, as these will not harm a pre-existing pregnancy.

⁴¹ Refer to Botswana Primary Health Care Guidelines

⁴² http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/

⁴³ Adapted from Medical Protocol for Sexual Violence, MSF Sexual & Reproductive health working group, 2011

1. Determining pregnancy by pregnancy test

TABLE 7

Determining pregnancy by pregnancy test

Determining pregnancy by testing		
Result	Timing of test	Conclusion
Test +	< 2 weeks after the sexual assault	The victim/survivor is pregnant The pregnancy is probably <i>NOT the result of the sexual assault</i>
Test +	> 2 weeks after the sexual assault	The victim/survivor is pregnant If victim/survivor is NOT sexually active, it is probably <i>the result of the sexual assault</i> If victim/survivor is sexually active, it is <i>impossible to determine</i> whether or not the pregnancy is the result of the sexual assault
Test -	< 2 weeks after the sexual assault	Probably NO pre-existing pregnancy. Repeat the test 2 weeks later
Test -	> 2 weeks after the sexual assault	The victim/survivor is not pregnant and will not become pregnant because of the sexual assault

N.B: a pregnancy can only be detected a minimum of 2 weeks after insemination

2. Determining pregnancy by history

When a pregnancy test is not available, assessment of the victim/survivor to establish if she was pregnant prior to the sexual assault can be made by applying the following checklist:⁴⁴

Determining pre-existing pregnancy by history

Questions (YES/NO)

1. Have you given birth in the last four weeks?
2. Are you less than six months post-partum AND exclusively breastfeeding AND free from menstrual bleeding since the birth of your last child?
3. Did your last menstrual period start within the past seven days?
4. Have you had an abortion or miscarriage in the past seven days?
5. Have you gone without sexual intercourse (other than the incident) since your last menstrual period?

6. Have you been using a reliable contraceptive method consistently and correctly? (ask further with specific questions about the form of contraception used).

If the victim/survivor answers YES to at least one question, and signs and symptoms of pregnancy are absent, she is unlikely to be pregnant prior to the sexual assault. She may however have become pregnant because of the sexual assault. Inform the victim/survivor of the possibilities of emergency contraception (see below).

If a victim/survivor says NO to all the questions, a pregnancy prior to the sexual assault cannot be out ruled or determined, unless of course she has signs and symptoms of pregnancy.

Termination of Pregnancy

Abortion is covered by Sections 160–162 of the Botswana Penal Code (Amendment) Act, 1991.⁴⁵

⁴⁴ This checklist can assist to determine approximately 88 per cent of pregnancies, according to Medical Protocol for Sexual Violence, MSF Sexual & Reproductive health working group, 2011

⁴⁵ Government of Botswana. Penal Code (Amendment) Act, 1991 of 11 October 1991. (Government Gazette, Suppl. A, 1991, pp. A55- 6., 1991)

Abortion is permitted in Botswana if it is undertaken within the first 16 weeks of pregnancy in the following cases:

- a) rape, defilement or incest, according to evidence accepted by the medical practitioner carrying out the abortion, and if requested by the victim/survivor or next of kin or guardian acting in *loco parentis* if the victim lacks the capacity to make such a request;
- b) risk to the life of the pregnant woman or injury to her physical or mental health, again if requested by the pregnant woman or next of kin; or
- c) risk of such serious physical or mental abnormality that a child, if born, would suffer serious disability or disabling disease.

In the above conditions, an abortion may only be carried out by a registered medical practitioner in a “Government hospital or a registered private hospital, or a clinic approved for the purpose by the Director of Health Services”. In points (b) and (c), abortion is permissible only when “two medical practitioners have given their opinions formed in good faith, in writing” that these conditions apply.

The Botswana Comprehensive Post-Abortion Care Reference Manual⁴⁶ covers the legal framework on abortion, abortion itself, clinical assessment, uterine evacuation methods, MVA procedure, processing IPAS instruments, post-procedure care, management of complications, infection prevention, counselling, post-abortion contraception, community linkages, and monitoring of PAC services. Comprehensive post-abortion care (CPAC) is defined as follows in the reference manual: **“...a series of medical and related interventions designed to manage the complications of spontaneous and induced abortions, both safe and unsafe and addresses women’s related health care needs” (p. 1).**

It has the following five essential elements (pp. 1–2): community and service provider partnerships, counselling, treatment, contraceptive and family planning services, and reproductive and other health services. Barriers to CPAC include stigma around abortion and negative attitudes of the service providers and the community, community attitude, service provider attitude, and lack of knowledge and skills among primary health-care service providers (p. 2).

Women seek abortions for a range of reasons (pp. 2–3), and often “a woman’s felt need for abortion stems from her lack of power to negotiate sex and/or the use of contraception”. The document also acknowledges the contextual factors that not only affect how women with unintended or unwanted pregnancies approach those pregnancies, but also the kinds of services they receive and their likely health outcomes.

With regards to the legal framework on abortion, the Reference Manual states that (p. 6):

- The provision of post-abortion care need not be affected by whether abortion is legal or not.
- The medical profession has the responsibility to provide comprehensive post-abortion services including family planning to all women who need them, to the full extent of the legal limits.
- Emergency care for the complications of abortion (post-abortion care), both spontaneous and induced, is legal and not punishable by any part of the law. Emergency abortion care (post-abortion care) is a requirement of the ethical practice of medicine in every country, as this care is often essential to save the woman’s life and preserve health (Kleinman, 1998).
- The laws and regulations regarding post-abortion are not often understood, either by women needing care or by the health-care providers, therefore PAC services are not adequately put in place.

⁴⁶ Botswana Ministry of Health. Comprehensive Post Abortion Care Trainer’s Manual. (2016)



Abortion is defined as the “**termination of pregnancy or expulsion of non-viable fetus [sic] weighing 500 g or less before 24 weeks of gestation**” (p. 8)*.

Abortion can be either spontaneous or induced, with the latter being the deliberate termination of pregnancy, and spontaneous abortion caused by either maternal or foetal factors. The following types of abortion are listed, together with information on the clinical presentation and management of each (pp. 9–10*): threatened abortion, inevitable abortion, incomplete abortion, complete abortion, septic abortion and missed abortion.

*The Botswana Comprehensive Post-Abortion Care Reference Manual

Victim/survivor presents 120 hours after the assault

Emergency contraception is no longer effective after 120 hours.

If a woman presents after the expiration of the time-limit for emergency contraception (5 days or 120 hours), if the emergency contraception provided is ineffective, or if the woman is already pregnant because of the sexual assault, she should be offered counselling.

Family Planning

Apart from emergency contraception, a family planning method should be suggested to all female sexual assault victims/survivors.

Following an act of sexual aggression, the victim/survivor needs time to recover psychologically.

An unplanned pregnancy in the months following the attack may destabilize the victim/survivor and delay her return to physical, sexual and psychological well-being.

The victim/survivor should be advised to use a condom consistently and appropriately with her partner(s) for a period of six months (or until STI/HIV status has been determined).

Tetanus prophylaxis⁴⁷

The risk of tetanus infection depends on the nature and violence of the assault. However, within the specific framework of a sexual assault, maximum protection against tetanus infection must be ensured. Therefore, tetanus prophylaxis should always be given (even if the victim/survivor presents months or years after the incident), unless the victim/survivor has been previously fully vaccinated. Administer tetanus toxoid (TT), which gives active protection.

Indication:

Prevention of tetanus in wound management depends on risk and pre-exposure vaccination status:

- **Tetanus toxoid (TT) vaccine:** Any victim/survivor, who presents with breaks in skin or mucosa, based on immunization status.
- **Human tetanus immunoglobulin (TIG):** Dirty wounds are an increased risk for tetanus unless fully immunized. Provide

⁴⁷ Refer to The Botswana Primary Health Guidelines

HTIG in non-immunized victims/survivors or incompletely immunized or in victims/survivors whose immunization status is unknown, in combination with tetanus vaccine.

Tetanus toxoid vaccine: Dosages and schedule⁴⁸

a. Adults, adolescents and children > 5 years

Tetanus toxoid vaccine: 0.5 ml/injection IM (adults and children > 10). The first two doses of TT are scheduled the same as the rapid hepatitis B vaccine schedule providing 80 per cent protection within four weeks. This is relevant to the management of the assault rather than providing extended protection. In most programmes TT3, TT4, and TT5 will be given in the regular vaccination programme.

Advise victims/survivors to complete the vaccination schedule (second dose at four weeks, third dose at six months to one year).

b. Children < 5 years

For children less than 5 years old, pentavalent (DTP-Hib-HepB)⁴⁹ vaccine is preferred to tetanus toxoid alone. Schedule should be adapted according to the vaccination status of the child.

Pentavalent vaccine:

- Dose 1: given at the first visit to the clinic
- Dose 2: four weeks after the first dose
- Dose 3: four weeks after the second dose
- Booster: after 12 to 18 months

Tetanus toxoid alone: 0.5 ml per injection; same schedule as in adults.

Human tetanus immunoglobulin (TIG):

TIG: 250 international units (IU) in 1ml by IM injection into the deltoid or gluteus region.

- If more than 24 hours have elapsed between being injured and seeking medical care, the dosage should be doubled (500 IU).
- If TT and HTIG are given at the same time, different needles, syringes and injection sites must be used.
- For children < 5 years: same dosage and indications as in adults.

Contra-indications, adverse effects, precautions

- Known allergy to tetanus toxoid vaccine and TIG.
- Rare and mild local reaction: redness and pain at the injection site.
- No contra-indications for pregnant and breastfeeding women.
- No contra-indication in cases of symptomatic or asymptomatic HIV infection.

Storage

- Between 2 and 8°C (never freeze)
- After opening, the 10-dose vial of vaccine may be kept for 1 month.

Special care for child victims/survivors

As it is obligatory to report cases of child abuse in Botswana, obtain information on police and court procedures. Evaluate each case individually – in some situations, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible, therefore, always report in a manner that will ensure protection to the child victim/survivor. Be aware of specific laws that determine who can give consent for minors and who can go

⁴⁸ Refer to The Botswana Primary Health Guidelines

⁴⁹ Comprehensive Multi-Year Plan (cMYP) For National Immunization Program (NIP), 2011–2015, Ministry of Public Health DG of Preventive Medicine National Immunization Program (NIP), 2012

to court as an expert witness. Health-care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that health-care providers receive special training in examining children who may have been abused.

General

A parent or legal guardian should sign the consent form for examination of the child and collection of forensic evidence. In the absence of a parent / legal guardian, a representative from the police, the community support services, or the court may sign the form.

The child should never be examined against his or her will, whatever the age, unless the examination is necessary for medical care. The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications include convulsions; persistent vomiting; stridor in a calm child; lethargy or unconsciousness; inability to drink or breastfeed.

In children younger than 3 months, look also for fever, low body temperature, bulging fontanelle, grunting, chest in drawing, and a breathing rate of more than 60 breaths/minute. The treatment of these complications is not covered in detail here.

Create a safe environment

Take special care in determining who is present during the interview and examination (remember that it is possible that a family member is the perpetrator of the abuse). It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who he or she would like to be present and respect his or her wishes. Introduce yourself to the child. Sit at eye level and maintain eye contact. Assure the child that he or she is

not in any trouble. Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favourite activities.

Take the history

Begin the interview by asking open-ended questions, such as *“What can I do for you here today?”* or *“What were you told about coming here?”* Avoid asking leading or suggestive questions. Assure the child it is alright to respond to any questions with *“I don’t know”*. Be patient; go at the child’s pace; do not interrupt his or her train of thought. Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details. For girls, depending on age, ask about menstrual and obstetric history.

The pattern of sexual abuse of children is different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation (has the child a secure place to go to?)
- How the sexual assault/abuse was discovered.
- Who did it, and whether he or she is still a threat?
- If this has happened before, how many times, and the date of the last incident?
- Whether there have been any physical complaints (e.g., bleeding, dysuria, discharge, difficulty walking, etc.).
- Whether any siblings are at risk.

Prepare the child for examination

- As for adult examinations, there should be a support person or trained health-care provider whom the child trusts in the examination room with you.
- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.

- Explain what will happen during the examination, using terms the child can understand.
- With adequate preparation, most children will be able to relax and participate in the examination.
- It is possible that the child cannot relax because he or she has pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions.
- Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.
- Do not carry out a digital examination (i.e., inserting fingers into the vaginal orifice to assess its size). Look for vaginal discharge.
- In prepubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine prepubertal girls; it is extremely painful and may cause serious injury.
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a prepubertal child is usually done under general anaesthesia.
- Depending on the setting, the child may need to be referred to a higher level of health care.
- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- All children, boys and girls, should have an anal examination as well as the genital examination.

Conduct the examination

Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:

- Note the child's weight, height, and pubertal stage.
- Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.
- Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it. Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation. Do not carry out a digital examination to assess anal sphincter tone.

Laboratory testing

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations: the child presents with signs or symptoms of STI; the suspected offender is known to have an STI or is at high risk of STI; the child or parent requests testing.

Screening for gonorrhoea and chlamydia, syphilis and HIV should be done for all children who may have been sexually assaulted. The

presence of any one of these infections may be diagnostic of sexual assault (if the infection is not likely to have been acquired perinatally or through blood transfusion).

In rare cases, a child cannot be examined because he or she is highly agitated. Only if the child cannot be calmed down, and physical treatment is vital, the examination may be performed with the child under sedation, using one of the following drugs:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg; or
- promethazine hydrochloride, syrup, by mouth
 - 2–5 years: 15–20 mg
 - 5–10 years: 20–25 mg

These drugs do not provide pain relief. If you think the child is in pain, **give simple pain relief first**, such as paracetamol (1–5 years: 120–250 mg; 6–12 years: 250–500 mg). Wait for this to take effect. Oral sedation will take 1–2 hours for full effect.

In the meantime, allow the child to rest in a quiet environment.

Treatment

Regarding STIs, HIV, hepatitis B, and tetanus, children have the same prevention and treatment needs as adults but may require different doses. Special protocols for children should be followed for all vaccinations and drug regimens. Recommended dosages for post-exposure prophylaxis to prevent HIV transmission in children are given in Tables 4 and 6.

Follow-up

Follow-up care is the same as for adults. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse.

Management of burns

Health-care workers are often called to provide specialist, multidisciplinary care in the management of burn injuries. Such a call can be a challenge for health-care workers in remote outlying areas where there might not be specialist burn units or facilities.

Burn care involves high expenses for wound management materials, staffing, equipment and long-term scar management products. Burns can also result in long-term issues arising from the initial trauma and resultant scars, all of which can have ongoing effects on the patient and their family.

It is acknowledged that primary care or follow up management of burn injuries may occur outside of specialist units, particularly for patients with minor burns. This chapter provides a practical guide to complement relevant clinical knowledge and the care and management techniques required for effective patient management. Clinicians working outside a specialist burn unit are encouraged to liaise closely with their colleagues within the specialist units for advice and support in burn patient management.

The aims of burn management are to avoid infection, reduce pain, promote effective wound healing, minimize scarring and psychological trauma and restore or replace damaged skin and normal movement.



As with any wound or trauma, the management of burns follows a series of standard measures:

1. First aid
2. Resuscitation
3. Tetanus prophylaxis
4. Analgesia
5. Prophylactic antibiotics
6. Nutrition
7. Avoid hypothermia
8. Wound management

Although no specific data exists, it is commonly known that burning is a type of violence used against women and girls and that sometimes females may choose self-immolation as a suicide option; or suffer burns at the hands of an often-male perpetrator intent on deforming her.

Pathology

Type of burn

Flame and scald burns are the most common. Flame burns are usually deep and appear so at presentation, whereas scald burns may appear much less severe at first. Contact flame burns are typically deep at the centre.

Electrical burns fall into two categories: flash burns and high-voltage burns. Flash burns occur when a person causes a short circuit resulting in an electrical flash, but no current travels through the body. These may be treated as regular thermal injuries. High voltage (> 1,000 volts) electrical conduction injuries – the current travels through the body and is characterized by the “can’t let go” phenomenon – are “iceberg injuries”, as they usually present with small cutaneous wounds and severe deep-tissue damage.

Friction burns (also described as ‘gravel rash’) occur when the skin comes into contact with a rapidly moving object such as a car or a road.

Chemical burns are caused by agents: acids, alkalis, and specific compounds (napalm, phosphorus, vesicants, etc.), with their individual characteristics.

Burn depth

Burns involve varying amounts of injury to the skin, partial or full thickness, and classically correspond to 3 degrees of burn depth of

increasing severity. It is important to estimate the depth of the burn to assess its severity and to plan future wound care.

It is common to find all three types within the same burn wound and the depth may change with time, especially if infection occurs.⁵⁰ Any full-thickness burn is considered serious.

Extent of burns

Measuring burn surface area is important during the initial management of victims/survivors with burns, particularly regarding estimating fluid requirements and determining the need to transfer to a burns service

Although it is difficult to grade the severity of burn wounds, the following provides a rule of thumb:⁵¹

Minor:

- Second degree less than 15% TBSA
- Third degree less than 3% TBSA

Moderate:

- Second degree 15–25% TBSA
- Third degree less than 10% TBSA

Major:

- Second degree more than 25% TBSA
- Third degree more than 10% TBSA

Adults

The ‘Rule of 9s’ is commonly used to estimate the burned surface area in adults.

The body is divided into anatomical regions that represent 9 per cent (or multiples of 9 per cent) of the total body surface (Figure below). The outstretched palm and fingers approximate to 1 per cent of the body surface area. If the burned area is small, assess how many times your hand covers the area.

⁵⁰ Management of burns, WHO Surgical Care at the district Hospital, reformatted 2007

⁵¹ Burn Injuries, War Surgery, ICRC

Morbidity and mortality rise with increasing burned surface area. It also rises with increasing age so that even small burns may be fatal in elderly people.

Children

- The 'Rule of 9s' method is too imprecise for estimating the burned surface area in children because the infant or young child's head and lower extremities represent different proportions of surface area than in an adult (see Figure below).
- Burns greater than 15 per cent in an adult, greater than 10 per cent in a child, or any burn occurring in the very young or elderly are serious.

Estimating the burned surface area in children:⁵²

TABLE 8
Burn area by age in years

Area by age in years				
	0	1	5	10
Head (A/D)	10%	9%	7%	6%
Thigh (B/E)	3%	3%	4%	5%
Leg (C/F)	2%	3%	3%	3%

Non-accidental burns

To provide comprehensive care for a patient, it is important to distinguish intentional burns from accidental burns.

Indicators of possible non-accidental burns or scalds include the following:

- Delay in seeking help.
- Historical accounts of injury differ over time.

- History inconsistent with the injury presented or with the developmental capacity of a victim/survivor.
- History of abuse or family violence.
- Inappropriate behaviour/interaction between victim/survivor and husband/family members.
- Glove and sock pattern scalds.
- Scalds with clear-cut immersion lines.
- Symmetrical burns of uniform depth.
- Restraint injuries on upper or lower limbs.
- Other signs of physical abuse or neglect.

Burn management:

Follow Botswana Primary Care Guidelines and other guidelines as needed.

Management of wounds^{53,54}

Introduction

Victims/survivors of GBV often present with wounds of different types and sizes resulting from violence. Thus, wound management is an important part of care for victims/survivors of violence. This makes collaboration between the nursing team and treating medical team essential to ensure appropriate wound management and facilitate optimal wound healing. Referrals to stomal therapy (via an EMR referral order) may also be necessary to ensure appropriate management and dressing selection for more complex wounds.

⁵² Surgical Care at the district Hospital, WHO 2003

⁵³ Medical Care and Management of Rape Survivors, MSF-Suisse, 2011

⁵⁴ Refer to Botswana Primary Health Care guidelines

The primary goals for wound care are to attain a functional closure, decrease potential risk for infection, and minimize scar formation.

Recommended steps

- Control the bleeding
- Assess the wound
- Cleanse the wound (and remove debris)
- Closure of wound
- Provide appropriate dressing
- Consider antibiotics
- Consider tetanus prophylaxis (TT and TIG)
- Consider pain relief
- Offer follow-up.

GBV victims/survivors may sustain acute wounds because of the violence. Most of these wounds are classified as '**Traumatic wounds**' (like abrasions, lacerations, punctures, incisions), as they are the result of tissue damage caused by trauma, including blunt force, projectiles, heat, electricity, chemicals or friction. Acute wounds also include by definition surgical wounds.

An acute wound is expected to progress through the phases of normal healing, resulting in the closure of the wound. Depending on its level, all acute wounds may have serious short and long-term consequences. Therefore, all GBV victims/survivors with wounds should

have their wounds appropriately assessed by a trained health worker as soon as possible after their arrival at the medical facility.

All aspects of wound care, including assessment, treatment and evaluation, should be documented clearly and comprehensively by progress notes and treatment plans.



Refer to Botswana Primary Health Care Guidelines for clinical management

CHAPTER 11

Counselling the Victim/Survivor

Victims/survivors seen at a health facility immediately after the sexual assault are likely to be extremely distressed and may not remember advice given at this time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and information in writing (in the local language/s), or as illustrations/animated and give the victim/survivor a copy before he/she leaves the health facility as deemed appropriate (even if the victim/survivor is illiterate, he/she can ask someone they trust to read it to them later). Give the victim/survivor and/ or next of kin the opportunity to ask questions and to voice their concerns.

Psychological and emotional problems

Medical care for victims/survivors of sexual assault includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all victims/survivors should be offered a referral to the community focal point for sexual and GBV if one exists. A coordinated integrated referral system should be put in place.

Most sexual assault victims/survivors never tell anyone about the incident. If the victim/survivor has told you what happened, it is a sign that they trust you. Your compassionate response to their disclosure can have a positive impact on their recovery.

Provide basic, non-intrusive practical care. Listen but do not force him/her to talk about the event and ensure that the patient's basic needs are met. Because it may cause greater psychological problems, do not push victims/survivors to share their personal experiences beyond what they would naturally share.

Ask the victim/survivor if they have a **safe place** to go to and if someone they trust will accompany them when they leave the health facility. That safe place can be within the family, relatives, or a shelter. If they have no safe place to go to immediately, efforts should be made to find one for him/her. Enlist the assistance of the counselling services, community services provider, and law enforcement authorities, including police or security officers as appropriate. If the victim/survivor has dependents to take care of; and is unable to carry out day-to-day activities because of their trauma, provisions must also be made for their dependents and their safety.

Victims/survivors are at increased risk of a range of symptoms, including:

- feelings of guilt and shame
- uncontrollable emotions, such as fear, anger, anxiety
- nightmares
- suicidal thoughts or attempts
- numbness
- substance abuse
- sexual dysfunction
- medically unexplained somatic complaints
- social withdrawal

Tell the victim/survivor that they have experienced a serious physical and emotional event. Advise him/her about the psychological, emotional, social and physical problems that he/she may experience. Explain that it is common to experience strong negative emotions or numbness after sexual assault.

Advise the victim/survivor that they need emotional support. Encourage them (without forcing them) to confide in someone they trust

and to ask for this emotional support, from a trusted family member, friend or significant other. Encourage active participation in family and community activities.

Involuntary orgasm can occur during sexual assault, which often leaves the victim/survivor feeling guilty. Reassure the victim/survivor that, if this has occurred, it was a physiological reaction and was beyond their control.

In many cultures, there is a tendency to blame the victim/survivor in cases of sexual assault. If the survivor expresses guilt or shame, explain gently that sexual assault is always the fault of the perpetrator and never the fault of the victim/survivor. Assure him/her that he/she did **not** deserve to be sexually assaulted that the incident was not their fault, and that it was **not** caused by their behaviour or manner of dressing. Do not make moral judgments of the victim/survivor.

Special considerations for men

Male victims/survivors of sexual assault are even less likely than women to report the incident, because of the extreme embarrassment or social norms that they typically experience. While the physical effects differ, the psychological trauma and emotional after-effects for men are like those experienced by women.

When a man is anally sexual assaulted, pressure on the prostate can cause an erection and even orgasm. Reassure the victim/survivor that, if this has occurred during the sexual assault, it was a physiological reaction and was beyond his control (as mentioned above).

Pregnancy

Emergency contraceptive pills do not prevent pregnancy resulting from sexual acts that take place after the treatment. If the victim/survivor wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her and prescribe this to start on the first day after completing EC treatment or refer her to the family planning services.

Female victims/survivors of sexual assault are likely to be very concerned about the possibility of becoming pregnant because of the sexual assault. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:

- There may be adoption or foster care services in your area. Find out what services are available and give this information to the victim/survivor.
- Abortion laws in relation to the mental and physical health of the woman allow termination of the pregnancy if it is the result of sexual assault.
- Determine where safe abortion services are available so that you can refer victims/survivors to this service **within the law if they so choose**.
- Advise victims/survivors to seek support from someone they trust - e.g., a religious leader, family member, friend or community worker.

Women who are pregnant at the time of a sexual assault are especially vulnerable, physically and psychologically. They are susceptible to miscarriage, hypertension in pregnancy and premature delivery and post-partum psychosis or depression. Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the

pregnancy. Their infants may be at higher risk for abandonment, so follow-up care is also important.

HIV and STIs counselling

Both men and women may be concerned about the possibility of becoming infected with HIV following sexual assault. Compassionate and careful counselling around this issue is essential. The health-care provider may also discuss the risk of transmission of HIV or STI to partners following a sexual assault.

The victim/survivor should be referred to an HIV testing service. Counsel the survivor on the importance of consistent condom use.

Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation.

Other

Give advice on proper care for any injuries following the incident, infection prevention (including perineal hygiene, perineal baths), signs of infection, antibiotic treatment, when to return for further consultation, etc.

Give advice on how to take the prescribed treatments and on side effects of treatments.

Follow-up care at the health facility

Tell the survivor that he/she can return to the health service at any time if they have questions or other health problems. Encourage them to return in two weeks for follow-up evaluation of STI and, in the case of women and girls, pregnancy.

Give clear advice on any follow-up needed for wound care or vaccinations.

If the woman is pregnant because of the sexual assault

- A pregnancy may be the result of the sexual assault. All the options available, e.g., keeping the child, adoption and, where legal, abortion, should be discussed with the woman, regardless of the individual beliefs of the counsellors, medical staff or other persons involved, to enable her to make an informed decision.
- Where safe abortion services are not available, women with an unwanted pregnancy will often undergo an unsafe abortion. These women should have access to comprehensive post-abortion care (CPAC), including emergency treatment of abortion complications, counselling on family planning, and links to reproductive health services as guided by the Botswana CPAC Manual.

- Children born because of sexual assault may be mistreated or even abandoned by their mothers and families. They should be monitored closely, and support should be offered to the mother. It is important to ensure that the family and the community do not stigmatize either the child or the mother. Foster placement and, later, adoption should be considered if the child is rejected, neglected or otherwise mistreated.



CHAPTER 12

Follow-up Care of Victims/Survivors

At each follow-up contact with the client:

- Enquire about history of violence since last contact including other family members.
- Enquire on coping strategies employed.
 - Have they accessed any one of the suggested service providers?
- Ask about any abuse of children or any member of the household since the last visit.
- Enquire on availability of social support systems.
- Provide reassurance and positive reinforcement.
- Reiterate options to client (friend's/relative's home, shelter, support groups, legal help).

It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit and plan for community reintegration, as this may be the only visit.

The follow-up visits for victims/survivors who receive post-exposure prophylaxis (PEP) for HIV and those who do not receive PEP differ slightly.

Note: Follow-up care of victims/survivors for counsellors need not follow the clinical follow-up schedule.

Follow-up visits for victims/survivors who do not receive post-exposure prophylaxis

Two-week follow-up visit

- Evaluate pregnancy and provide counselling.
- Check that the survivor has taken the full course of any medication given for STIs.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; arrange for cognitive behaviour therapy or eye movement desensitisation or reprocessing if the person is incapacitated by the post-rape symptoms. If the person has mental health problems, provide care in accordance with WHO MAGAP intervention guide 2010. Refer or treat as needed.

Three-month follow-up visit

- Evaluate for STIs and treat as appropriate.
- Assess pregnancy status, if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on voluntary counselling and testing for HIV.

- Evaluate mental and emotional status and arrange for post-traumatic stress disorder (PTSD), treatment with cognitive behaviour therapy (CBT) or eye movement desensitization and processing (EMDR). Refer or treat as needed.

Follow-up visits of victims/survivors who receive post-exposure prophylaxis

One-week follow-up visit

- Evaluate post-exposure prophylaxis (side-effects and adherence).
 - If not supplied at the first visit, provide the additional three-week supply of post-exposure prophylactic medication.
- Check that the survivor has taken the full course of any medication given for STIs.
- Evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed.

Six-week follow-up visit

- Evaluate pregnancy and provide counselling.
- If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate, and provide advice on voluntary counselling and testing for HIV.

- Evaluate mental and emotional status; refer or treat as needed.

Three-month follow-up visit

- Evaluate for STIs and treat as appropriate.
- Assess pregnancy status, if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on follow-up voluntary counselling and testing for HIV for those who had a negative test during the first week.
- Offer voluntary counselling and testing for HIV to victims/survivors that were not tested before.
- Evaluate mental and emotional status; refer or treat as needed and facilitate community re-integration.
- Harmonize appointments (review dates) to facilitate comprehensive integrated services where possible.

Helping with more severe mental health problems

- Assessment of mental status. Assess mental status while you do the general health examination. Assessing mental status begins with observing and listening closely. Monitoring and evaluation (M&E) are an important part of an accountable and effective GBV response.



The WHO-UNFPA-UN Women Clinical Handbook provides tools to assess for risk of mental issues, self-harm and depressive disorder, pages 72–85.

CHAPTER 13

Reporting Medical Findings in Court

If the survivor wishes to pursue legal redress and the case comes to trial, the health-care providers who examined him/her after the incident may be asked to report on the findings in a court of law.

Many health-care providers may be anxious about appearing in court or feel that they have not enough time to do this. Nevertheless, providing such evidence is an extension of their role in caring for the survivor.

1. In cases of sexual assault, the prosecution (not the health-care provider) must prove three things:
 - a. Some penetration of the vagina or anus by a penis or other object, or penetration of the mouth by a penis or other object(s).
 - b. That penetration occurred without the consent of the person. However, in children below 18 years and the mentally challenged the issue of consent does not apply.
 - c. The identity of the perpetrator.

In most settings the health-care provider is expected to give evidence as a factual witness (that means reiterating the findings as he or she recorded them), not as an expert witness.

All cadres of health-care providers (doctors, clinical officers and nurses) can and should serve as factual witnesses. Nurses and other health-care providers often spend more time with the survivor than the doctors and have a more in-depth understanding of the survivor's mental and physical condition at the time of examination.

2. Meet with the prosecutor prior to the court session to prepare your testimony and obtain information about the significant issues involved in the case.

3. Conduct yourself professionally and confidently in the courtroom by:

- Dressing appropriately
- Speaking clearly and slowly, and make eye contact with whomever you are speaking to
- Avoid using medical terms
- Answer questions as thoroughly and as professionally as possible
- If you do not know the answer to a question, say so. Do not make up answers, 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 questions.

4. The notes written during the initial interview and examination are the mainstay of the findings to be reported. It is difficult to remember things that are not written down. **This underscores the need to record all statements, procedures and actions in sufficient detail, accurately, completely and legibly.** This is the best preparation for an appearance in court.



CHAPTER 14

Caring for the Health-Care Provider, including Self-Care

Responding to victims/survivors of GBV can be stressful and overwhelming. Health-care providers may be negatively affected by the stories of victims/survivors or may be affected by violence in their own family situation.

As a health-care provider, it is important to pay extra attention to your own well-being and to be sure that you are physically and emotionally equipped to help others:

- Take care of yourself so that you can best care for others.
- If working in a team, be aware also of the well-being of your colleagues.
- Consider how stress may be best managed, to support and be supported by your colleagues or supervisor.

The following suggestions may be helpful in managing your stress:

- Think about what has helped you cope in the past and what you can do to stay strong.
- Try to take time to eat, rest and relax, even for short periods.
- Practice brief relaxation techniques during the workday.
- Try to keep reasonable working hours so you do not become too exhausted.

- GBV victims/survivors may have many problems. You may feel inadequate or frustrated when you cannot help people with all their problems. Remember that you are not responsible for solving everyone's problems. Do what you can to help victims/survivors help themselves.
- Check in with colleagues to see how they are doing and have them check in with you. Find ways to support each other.
- Talk with friends, loved ones or other people you trust for support.
- Try to do some form of regular exercise.
- Try to increase doing things you enjoy.
- Minimize your intake of alcohol, and caffeine and avoid non-prescription drugs.

Health-care providers may experience several stress responses, which are considered common when working with GBV victims/survivors. These include:

- Increase or decrease in activity level
- Difficulties sleeping

- Feeling sad, nervous
- Numbing
- Irritability, anger, and frustration
- Upsetting thoughts or memories about the traumatic events disclosed by victims/survivors
- Confusion, lack of attention and difficulty making decisions
- Physical reactions (headaches, stomach aches, being easily startled)
- Symptoms of depression or anxiety
- Decrease in social activities
- Substance abuse

It is important to recognize these symptoms, increase self-care activities and get support from someone you trust.

If these difficulties continue for more than one month, try to speak to a counsellor or a mental health specialist if available.



CHAPTER 15

Monitoring, Evaluation & Learning (MEL)

Monitoring and evaluation (M&E) are an important part of an accountable and effective GBV response.

Proposed theory of change

If the Ministry of Health staff and each stakeholder provides the required inputs (resources, staff training/capacity building, programming/activities, and monitoring framework) on GBV prevention and response.

AND



Make progress toward the sector-specific special intermediate results proposed for inclusion in the mission's performance management plan.

AND



Integrate the GBV Prevention and Response Roadmap Guiding Principles, (including a survivor-centred approach, trauma-informed healing, and social norm change) into programming in attributable ways.

AND



Monitor, evaluate and adapt based on learning.

THEN



Implementation of the Botswana Protocols and Service Standards of Prevention and Management of Gender-Based Violence/ Ministry of Health will make a measurable and trackable contribution to GBV prevention, mitigation, and response at the individual, family, community and institutional level.

Data collected using the standardized tools lead to indicators to enable the programme to answer the following questions, even at the health facility level:

- Are people accessing health facilities for gender-based violence (GBV) services?
- Does service uptake match what is known about GBV in the community from other data sources (anecdotal evidence, police data, NGO/CBO data working in GBV)?
- What are the types and frequency of GBV being reported to the health facility (Domestic violence? Physical assault? Sexual Assault/rape? Psychological Abuse)?
- Are the same patients presenting again and again for reasons related to GBV?
- What are the demographics of those reporting GBV to the health facility (age group, sex)?
- Are those reporting sexual assault being provided with a complete package of prevention services, including HIV testing, post-exposure prophylaxis (PEP) for HIV, post-exposure prophylaxis (PEP) for STI, emergency contraception pill (ECP), hepatitis B vaccination, tetanus toxoid vaccination?
- Are the health services preventing new HIV infection and unintended pregnancy due to sexual assault?

TABLE 9

List of GBV data elements to be collected at health facilities

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
1	# cases of GBV registered (new) at health facility, disaggregated by sex and age group	Number of patients presenting at the health facility for a gender-based violence (GBV) related reason and registered in the GBV register as a new case of GBV	To describe the types of GBV presenting in health facilities and their concurrences	All new clients presenting at the health facility reporting GBV including any of the following types: sexual assault, physical assault, psychological abuse, domestic violence, etc. It also includes GBV clients re-presenting at the health facility to report a new and separate incident of GBV	All clients presenting at the facility for a follow up visit related to an earlier GBV visit, e.g., follow up counselling, HIV testing, etc. Sexual assault clients are reported under follow up visits for sexual assault at 1 week, 6 week and/or 3 months. Other related GBV follow-up visits are not recorded in this register	GBV register
2	# cases of sexual assault/rape reported (new) to health facility, disaggregated by sex	Number of patients presenting at the health facility for reasons of sexual assault/rape	To describe the frequency of sexual assault presented at health facilities relative to other forms of GBV, including their concurrences	All new clients presenting at the health facility reporting sexual assault/rape, including sexual assault linked to domestic violence Includes sexual assault victims/survivors who also report other forms of GBV (e.g., psychological abuse, physical assault, domestic violence)	All clients presenting at the health facility for follow-up services linked to an earlier sexual assault (e.g., 1 week, 6 weeks and/or 3-month follow-up)	GBV register
3	# cases of GBV psychological abuse reported (new) to health facility	Number of patients presenting at the health facility for reasons of psychological abuse that are linked to gender-based violence	To describe the frequency of GBV psychological abuse presented at health facilities relative to other forms of GBV, including their concurrences	All new clients presenting at the health facility reporting psychological abuse linked to gender-based violence, including domestic violence Includes victims of psychological abuse who also report other forms of GBV (e.g., sexual assault, physical assault, domestic violence)	All clients presenting at the health facility reporting psychological abuse NOT linked to gender-based violence	GBV register

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
4	# cases of GBV physical assault reported (new) to health facility	Number of patients presenting at the health facility for reasons of physical assault that are linked to gender-based violence	To describe the frequency of physical assault presented at health facilities relative to other forms of GBV, including their concurrences	All new clients presented at the health facility reporting physical assault linked to gender-based violence, including domestic violence Includes physical assault who also report other forms of GBV (e.g., sexual assault, psychological abuse, domestic violence)	All clients presented at the health facility reporting physical assault NOT linked to gender-based violence All clients presented at the health facility reporting physical assault whereby the assault was limited to genitalia (report these as part of sexual assault)	GBV register
5	# cases of domestic violence (DV) reported (new) to health facility	Number of patients presenting at the health facility for reasons of domestic violence	To describe the frequency of domestic violence presented at health facilities, including their concurrences	All new clients presented at the health facility reporting any form of GBV linked to domestic abuse, including sexual assault/rape, physical assault, psychological abuse	All new clients presented at the health facility reporting any form of GBV NOT linked to domestic abuse, including sexual assault/rape, physical assault, psychological abuse	GBV register
6	# cases of GBV (all) repeat registered at health facility	Number of patients presenting at the health facility for a gender-based violence (GBV) related reason and registered in the GBV register as a new case, but who have already presented at the health facility for another, separate GBV reason in the past	To describe the burden of GBV at health facilities due to repeated GBV incidents	All new clients presented at the health facility reporting any form of GBV but who are known to have presented at the health facility on an earlier case of GBV, e.g., women presenting on a case of domestic violence and physical assault who had presented for similar reasons six months previously	All new clients presented at the health facility reporting any form of GBV with no known history of reporting GBV	GBV register
7	# GBV (new) referred to place of safety	Number of cases of GBV (new) who were referred to a place of safety	To monitor referral rates to places of safety for GBV	All GBV who were referred to places of safety	All GBV who were not referred to places of safety	GBV register
8	# GBV (new) referred for social support	Number of cases of GBV (new) who were referred for social support	To monitor referral rates for social support	All GBV who were referred for social support include support groups and counselling	All GBV who were not referred for social support	GBV register

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
9	# GBV (new) referred for psychological support	Number of cases of GBV (new) who were referred for psychological support	To monitor referral rates for psychological support	All GBV who were referred for psychological support	All GBV who were not referred for psychological support	GBV register
10	# cases of GBV reported to police	Number of cases of GBV (new) known reported to police	To monitor known police reporting rates for GBV	All GBV victims/survivors who are known to have reported the case to the police, including those referred to the health facility from the police, those for whom the health-care provider called the police to the health facility and patients presenting evidence of having reported the GBV to the police	All GBV where there is no evidence that the patient has reported the GBV to the police or the patient has refused to report	GBV register; to correlate with the BP reported sexual assaults
11	# cases of GBV opened with court	Number of GBV (new) known opened case with the courts	To monitor court case opening rates for GBV	All GBV patients who are known to have opened a case regarding the sexual assault with the courts	All GBV where there is no evidence that the patient has opened a case	GBV register; to correlate with the courts' registered number of cases relating to sexual assaults
12	# GBV (new) immunized anti-tetanus toxoid (ATT)	Number of sexual assaults and/or physical assaults presenting at the health facility for reasons of GBV who were immunized with anti-tetanus toxoid (ATT) (either at visit or had proof of immunization that was still current)	To monitor ATT coverage among GBV patients	All GBV (new) who presented at the health facility and were immunized (and/or showed proof of immunization) with anti-tetanus toxoid	All GBV (new) who presented at the health facility and were not immunized or had no proof of immunization of anti-tetanus toxoid	GBV register
13	# forensic examinations done to standard	Number of sexual assaults for whom a comprehensive forensic examination was done (may or may not include completion of form BP73)	To determine the proportion of sexual assaults which were followed by a comprehensive forensic examination	All GBV patients for whom a forensic exam was done	All sexual assaults which did not receive a forensic examination\	GBV register

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
14	# sexual assault (new) initiated on PEP for STI	Number of patients presenting at the health facility for reasons of sexual assault/rape who were initiated on post-exposure prophylaxis (PEP) for STI at 1st visit	To monitor PEP for STI uptake among sexual assaults	All sexual assaults (new) who presented at the health facility and were initiated on PEP for STI	All sexual assaults (new) who presented at the health facility and were NOT initiated on PEP for STI	GBV register
15	# sexual assault (new) tested for pregnancy	Number of patients who had been sexually assaulted who were tested for pregnancy	To monitor pregnancy screening coverage among sexual assaults	All sexual assaults (new) who presented at the health facility and took a pregnancy test		GBV register
16	# sexual assault (new) provided emergency contraception pill (ECP)	Number of female sexual assaults presenting at the health facility for reasons of sexual assault/rape who were provided with emergency contraception pill	To monitor ECP uptake among female sexual assaults	All female sexual assaults (new) who presented at the health facility and were provided with emergency contraception pill	All male sexual assaults (new) and/or female sexual assaults who were not provided with emergency contraception pill	GBV register
17	# sexual assault (new) immunized hepatitis B	Number of sexual assaults presenting at the health facility for reasons of sexual assault/rape who were immunized (had proof of valid immunization of) hepatitis B	To monitor hepatitis B uptake rate among sexual assaults	All sexual assaults (new) who presented at the health facility and were immunized for hepatitis B and/or showed proof of immunization for hepatitis B	All sexual assaults (new) who presented at the health facility and were not immunized for hepatitis B	GBV register
18	# sexual assault Known Positive (KP) for HIV before 1st visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who were already known HIV positive from a previous HIV test and therefore ineligible for HIV testing and/or PEP for HIV	To supporting monitoring of HIV testing uptake and PEP for HIV uptake at facilities by excluding those known HIV positive	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment)	All sexual assault (new) who tested positive for HIV at 1st visit All sexual assaults (new) who presented at the health facility without a known HIV positive status (e.g., unknown status or HIV negative at an earlier test). These clients should be tested for HIV at 1st visit	GBV register

◀ Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
19	# sexual assault (new) tested positive for HIV at 1st visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV positive at 1st visit	To monitor HIV positivity rate of sexual assaults at 1st visit	All sexual assaults (new) who presented at the health facility who were tested for HIV at 1st visit and whose test confirmed the patient as HIV positive and ineligible for PEP	All sexual assaults (new) who presented at the health facility with a known HIV positive status (e.g., already tested HIV positive and/or is currently in HIV care and treatment) – These patients should be recorded under indicator # sexual assault Known Positive (KP) for HIV before 1st visit	GBV register
20	# sexual assault (new) tested negative for HIV at 1st visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV negative at 1st visit and may be eligible for PEP for HIV	To monitor HIV negativity rate of sexual assaults at 1st visit and to determine those who may be eligible for PEP for HIV	All sexual assaults (new) who presented at the health facility who were tested for HIV at 1st visit and whose test confirmed the patient as HIV negative and who if arrived within 72 hours may be eligible for PEP for HIV	All sexual assaults (new) who presented at the health facility with a document HIV positive status (e.g., already tested HIV positive) and/or those who tested HIV positive at 1st visit	GBV register
21	# sexual assault (new) presented within 72 hours of assault	Number of patients presenting at the health facility for reasons of sexual assault/rape who presented at the health facility within 72 hours of the sexual assault	To monitor if sexual assault survivors arrive at health facilities early enough to benefit from PEP for HIV	All sexual assaults (new) who presented at the health facility within 72 hours of the sexual assault	All sexual assaults (new) who presented at the health facility after 72 hours of the sexual assault	GBV register
22	# sexual assault (new) initiated on PEP for HIV	Number of patients presenting at the health facility for reasons of sexual assault/rape who were confirmed HIV negative at 1st visit arrived within 72 hours of the sexual assault and were initiated on post-exposure prophylaxis for HIV at 1st visit	To monitor PEP for HIV uptake among sexual assaults	All sexual assaults (new) who presented at the health facility within 72 hours of the sexual assault and were tested for HIV at 1st visit and whose test confirmed the patient as HIV negative and were initiated on PEP for HIV	All sexual assaults (new) who presented at the health facility who were not initiated on PEP for HIV either because of a documented HIV positive status (e.g., already tested HIV positive), an HIV positive test at 1st visit and/or presentation after 72 hours after the sexual assault	GBV register

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
23	# follow-up visits for sexual assault at 1 week	Number of sexual assaults who attended the health facility for a 1 week follow-up visit	To monitor week 1 follow-up visits for sexual assault	All sexual assaults who returned to the health facility for a follow-up visit around one week	Any other GBV (non-sexual assault) who returned to the health facility for a follow-up visit around one week	GBV register (Reporting month: 1; collate only after one month)
24	# sexual assault completed PEP	Number of sexual assaults who received the full regimen of post-exposure prophylaxis for HIV and reported completing the entire dose	To monitor PEP completion rate linked to sexual assault	All sexual assaults who completed a full course (28 days) of post-exposure prophylaxis for HIV	Sexual assaults who either did not start PEP for HIV and/or did not receive or take the full regimen	GBV register (Reporting month: 2; collate only after two months)
25	# follow-up visits for sexual assault at 6 weeks	Number of sexual assaults who attended the health facility for a 6-week follow-up visit	To monitor week 6 follow-up visits for sexual assault	All sexual assaults who returned to the health facility for a follow-up visit around six weeks	Any other GBV (non-sexual assault) who returned to the health facility for a follow-up visit around six weeks	GBV register (Reporting month: 2; collate only after two months)
26	# sexual assault Known Positive (KP) for HIV before 6-week visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who were already known HIV positive from a previous HIV test and therefore ineligible for HIV testing	To monitor HIV positivity rate of sexual assaults at 6-week visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment) including those who tested HIV positive at 1st visit	All sexual assault (new) who tested positive for HIV at 6-week visit (see indicator 27) All sexual assaults (new) who presented at the health facility without a known HIV positive status (e.g., unknown status or HIV negative at an earlier test). These clients should be tested for HIV at 6-week follow-up visit	GBV register (Reporting month: 2; collate only after two months)

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
27	# sexual assault (new) tested positive for HIV at 6-week visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV positive at 6-week follow-up visit	To monitor HIV positivity rate of sexual assaults at 6-week visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 6-week follow-up visit and whose test confirmed the patient as HIV positive Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment and/or tested HIV positive at 1st visit) –These patients should be recorded under indicator # sexual assault Known Positive (KP) for HIV before 6-week visit	GBV register (Reporting month: 2; collate only after two months)
28	# sexual assault (new) tested negative for HIV at 6-week follow-up visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV negative at 6-week follow-up visit	To monitor HIV negativity rate of sexual assaults at 6-week visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 6-week follow-up visit and whose test confirmed the patient as HIV negative Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a document HIV positive status (e.g., already tested HIV positive) and/or those who tested HIV positive at 6 weeks and clients with an unknown HIV status at 6-week follow-up	GBV register (Reporting month: 2; collate only after two months)
29	# sexual assault (new) referred for medical termination of pregnancy (MTP)	Number of sexual assaults confirmed pregnant and referred for medical termination of pregnancy	To monitor efficiency of ECP to prevent unintended pregnancy due to sexual assault	All sexual assaults who are confirmed pregnant at c. 6 weeks after sexual assault and requesting referred for MTP	Exclude MTP referral not linked to sexual assault/rape	GBV register (Reporting month: 2; collate only after two months)
30	# follow-up visits for sexual assault at 3-months	Number of sexual assaults who attended the health facility for a 3-month follow-up visit	To monitor 3-month follow-up visits for sexual assault	All sexual assaults who returned to the health facility for a follow-up visit around 3 months	Any other GBV (non-sexual assault) who returned to the health facility for a follow-up visit around 3 months	GBV register (Reporting month: 3; collate only after three months)

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
31	# sexual assault Known Positive (KP) for HIV before 3-month visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who were already known HIV positive from a previous HIV test and therefore ineligible for HIV testing	To monitor HIV positivity rate of sexual assaults at 3-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment) including those who tested HIV positive at 1st visit	All sexual assault (new) who tested positive for HIV at 3-month visit (see indicator 32) All sexual assaults (new) who presented at the health facility without a known HIV positive status (e.g., unknown status or HIV negative at an earlier test). These clients should be tested for HIV at 3-month follow-up visit	GBV register (Reporting month: 3; collate only after three months)
32	# sexual assault (new) tested positive for HIV at 3-month visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV positive at 3-month follow-up visit	To monitor HIV positivity rate of sexual assaults at 3-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 3-month follow-up visit and whose test confirmed the patient as HIV positive Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment and/or tested HIV positive at 1st visit or 6-week follow-up visit)—These patients should be recorded under indicator # sexual assault Known Positive (KP) for HIV before 3-month visit	GBV register (Reporting month: 3; collate only after three months)
33	# sexual assault (new) tested negative for HIV at 3-month follow-up visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV negative at 3-month follow-up visit	To monitor HIV negativity rate of sexual assaults at 3-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 3-month follow-up visit and whose test confirmed the patient as HIV negative Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a documented HIV positive status (e.g., already tested HIV positive) and/or those who tested HIV positive at 3 months and clients with an unknown HIV status at 3-month follow-up	GBV register (Reporting month: 3; collate only after three months)

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
34	# follow-up visits for sexual assault at 6 months	Number of sexual assaults who attended the health facility for a 6-month follow-up visit	To monitor 6-month follow-up visits for sexual assault	All sexual assaults who returned to the health facility for a follow-up visit around 6 months	Any other GBV (non-sexual assault) who returned to the health facility for a follow-up visit around 6 months	GBV register (Reporting month: 6; collate only after six months)
35	# sexual assault Known Positive (KP) for HIV before 6-month visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who were already known HIV positive from a previous HIV test and therefore ineligible for HIV testing	To monitor HIV positivity rate of sexual assaults at 6-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment) including those who tested HIV positive at 1st visit	All sexual assault (new) who tested positive for HIV at 6-month visit (see indicator 36) All sexual assaults (new) who presented at the health facility without a known HIV positive status (e.g., unknown status or HIV negative at an earlier test). These clients should be tested for HIV at 6-month follow-up visit	GBV register (Reporting month: 6; collate only after three months)
36	# sexual assault (new) tested positive for HIV at 6-month visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV positive at 6-month follow-up visit	To monitor HIV positivity rate of sexual assaults at 6-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 6-month follow-up visit and whose test confirmed the patient as HIV positive Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a known HIV positive status already (e.g., already tested HIV positive and/or is currently in HIV care and treatment and/or tested HIV positive at 1st visit or 6-week follow-up visit)— These patients should be recorded under indicator # sexual assault Known Positive (KP) for HIV before 6-month visit	GBV register (Reporting month: 6; collate only after six months)

Table 9 (cont'd)

	Data Element Name	Definition	Use and context	Inclusions	Exclusions	Source
37	# sexual assault (new) tested negative for HIV at 6-month follow-up visit	Number of patients presenting at the health facility for reasons of sexual assault/rape who tested HIV negative at 6-month follow-up visit	To monitor HIV negativity rate of sexual assaults at 6-month visit as a way to monitor the effectiveness of PEP for HIV to prevent new HIV infections	All sexual assaults (new) who presented at the health facility who were tested for HIV at 6-month follow-up visit and whose test confirmed the patient as HIV negative Includes clients who completed and/or did not complete PEP for HIV	All sexual assaults (new) who presented at the health facility with a documented HIV positive status (e.g., already tested HIV positive) and/or those who tested HIV positive at 6 months and clients with an unknown HIV status at 6-month follow-up	GBV register (Reporting month: 6; collate only after six months)

ANNEXES

Annex 1: Checklist of needs for clinical management of sexual assault victims/survivors

ITEM (Tick)	Note/Comments
Protocols	
Written clinical protocol*	
Personnel	
Trained health-care professionals (available 24 hours/day) *	
The examination should preferably be performed by a same-sex health-care provider in a language understood by the survivor If this is not possible, any same sex health worker (or companion), acceptable to the survivor should be in the room during examination*	
Furniture/Setting	
Private room (well-ventilated and adequate light, quiet, accessible, with access to a toilet or latrine) *	
Adequate seating arrangements for all, and desk for the provider	
Examination couch*	
Examination light, preferably fixed (a torch may be threatening for children) *	
Magnifying glass (or colposcope where possible)	
Access to an autoclave to sterilise equipment*	
Access to laboratory facilities/microscope/trained technician	
Weighing scales and height chart for children	
Supplies	
"Sexual assault kit" for collection of forensic evidence, could include:	
Speculum* (preferably plastic, disposable)	
Comb for collecting foreign matter in pubic hair	
Syringes/needles /specimen containers for collecting blood	
Glass slides for preparing wet and/or dry mounts (for sperm)	
Cotton-tipped swabs/applicators/gauze compresses for collecting samples	
Laboratory containers for transporting swabs	
Large paper sheet for collecting debris as the survivor undresses	
Tape measure for measuring the size of bruises, lacerations, etc*	
Paper bags for collection of evidence*	
Paper tape for sealing and labelling containers/bags*	

ITEM (Tick)	Note/Comments
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap) *	
Resuscitation equipment*	
Sterile medical instruments (kit) for repair of tears, and suture materials*	
Needles, syringes*	
Cover (gown, cloth, sheet) to cover the survivor during the examination*	
Spare items of clothing to replace those that are torn or taken for evidence	
Sanitary supplies (pads)	
Pregnancy tests	
Pregnancy calculator disk to determine the age of a pregnancy	
Drugs	
For treatment of STIs as per Botswana treatment guide /protocols*	
For post-exposure prophylaxis (PEP) of HIV transmission	
Emergency contraceptive pills	
Tetanus toxoid, tetanus immunoglobulin	
Hepatitis B vaccine	
For pain relief* (e.g., paracetamol)	
Anxiolytic (e.g., diazepam)	
Sedative for children (e.g., diazepam) <i>caution against prescribing</i>	
Local anaesthetic for suturing*	
Antibiotics and cleaning materials for wound care*	
Administrative Supplies	
Medical chart with pictograms*	
Forms for recording post-sexual assault care	
Consent Forms*	
Information pamphlets for post-sexual assault care (for survivor) *	
Safe, locked filing space to keep records confidential* / computer, electronic device with adequate protection and access control	

To be updated for TESTS, and Directory of Services and Referral (as indicated in MS Excel Sheet)

*Items marked with an asterisk are the minimum requirements for examination and treatment of a sexual assault survivor.

Annex 2: Survivor-centred approach



Survivor-centred care is commonly understood as an approach whereby the focus rests on the survivor seeking care. It is a standard of care that ensures that the patient/survivor is at the centre of care. Although there are various definitions of survivor-centred care, a respectful attitude, effective listening and support for personal autonomy are ingredients and requirements to ensure that that care offered is tailored to the individual needs of each survivor (i.e., survivor-centred).

Attitude

A respectful attitude, whereby the value of a survivor as a unique individual is appreciated, comprises the first component of survivor-centred care. When working with GBV victims/survivors, adopting a respectful attitude is fundamental to the development of a relationship of trust.

Show respect

- The survivor has suffered a traumatic experience. His/her ability to survive the violence and his/her courage in seeking medical help merit the staff member's full respect.
- The survivor might also feel shame, a lack of self-worth, isolation, and rejection by his/her partner or family circle at the time when he/she arrives at the health structure. The respect shown will help in his/her recovery.

Do not judge

- Believe the survivor without judging: the role of the health-care provider is not to prove/disprove any allegations, nor whether sexual assault has occurred.
- Neither should health staff judge the survivor based on the reaction experienced during the assault (e.g., no resistance) or after the assault (e.g., not seeking help). Listening with

an open-minded and an accepting attitude will enable the survivor to express himself/herself more freely.

- Victims/survivors often harbour feelings of guilt as to their behaviour, believing that they failed to act properly to avoid the violence. It is important to stress that GBV is a violation of a survivor's human rights and that it is the perpetrator who is the guilty party. When people are paralysed by fear or are unable to escape from the attack, they are often in shock and reacting in the only way possible for them at the time; any lack of resistance may result in a non-fatal outcome.

Guarantee confidentiality

- Assure the survivor that confidentiality is guaranteed by all persons involved in their care (doctor, midwife, nurse) and that no information will be released without their consent.
- Confidentiality is crucial to protect the safety of the survivor and to respect their dignity and privacy.

Be empathic

- Put yourself in the survivor's place and try to understand what he/she is feeling. N.B: ask the survivor how they are and what they are feeling – they may not necessarily

feel the same as you would in the same situation; each survivor reacts differently to similar incidents.

Show patience

- Do not pressure the survivor but let them express themselves at their own pace and show that you are listening.
- Do not interrupt him/her but try to keep the interview to the subject, if necessary.
- Allow for silences (but not so long that it becomes uncomfortable for the survivor), hesitation, repetition.
- Adjust your attitude according to the characteristics of the survivor.

Effective listening

- Effective listening is considered key to the survivor-centred approach to explore the survivor's complaints, to understand the individual, to ensure shared decision-making and to enhance the patient-health-care provider relationship.
- Effective listening skills should be applied throughout the entire process of care delivery for victims/survivors of GBV, starting from the moment of identification, through the provision of first-line support, history-taking, examination, treatment and during any follow-up stage.

Attending to body language (physical presence)

- Eye contact: always turn your head towards the survivor and look at him/her.
- Body position: sit facing the survivor, close enough for eye contact but far enough away for them not to feel threatened.

- Make sure your non-verbal behaviour corresponds to your verbal behaviour; avoid uncontrolled expressions of e.g., disgust, disapproval.
- Avoid sudden movements.
- Use a soft tone of voice without being monotonous and avoid sudden changes in volume that could disturb the survivor.
- In case of sexual assault, do not touch the survivor (e.g., a comforting hand on the shoulder), as victims/survivors of sexual assault often fear physical contact, at least in the early stages following the assault.

Listen attentively and actively

- Give the survivor your full attention and show him/her you are listening through non-verbal behaviour and encouraging responses (e.g., "mmm", "I see", "Yes").
- To encourage the survivor to carry on talking and to show you are following their train of thought, apply "re-formulation" which means expressing back to the survivor the content of what he/she has said (in other words, summarizing what they said).
- Listen carefully to what the survivor is saying by trying to capture the meaning of their words and phrases, of what they mean (if necessary, check with them that you have understood what they meant).
- Observe their body language, the sound of their voice, their movements, expressions, silences.
- Do not concentrate solely on understanding the facts but try to understand how he/she is feeling.

Ask questions

There are several types of question, each with a different purpose:

- Closed questions (to which the only response is yes or no or responding with facts (e.g., how old are you?) limit self-expression. It is easy to answer these questions and they may therefore be useful in beginning the interview (to get going) or when raising emotionally charged subjects. However, these questions should not be used to any great extent, or the survivor will feel he/she is being submitted to an interrogation.
- Open questions (e.g., how are you feeling?) encourage free expression. Specifically, they allow the survivor to express their feelings. This type of question should be used whenever possible. However, if the survivor is not relaxed (at the beginning of the interview when emotionally charged subjects are raised, they will find it difficult to respond to this type of question.

Avoid asking questions that:

- begin with the word “Why” (e.g., why did you do that at that moment?) as they will often seem like an implied accusation rather than an actual question
- might be seen as leading questions that suggest the “right” answer should also be avoided
- require a yes or no answer. Don’t say “Are you feeling alright?”, which will lead the survivor to respond “Yes, I am alright” - Rather say “How are you feeling?”, which leaves the survivor free to choose their response.

Accept physical and emotional reactions

- The reactions of a GBV survivor may vary from agitation to depression. They may feel fear, anger, helplessness, shame, and sadness, and

may express their feelings in tears, shouting, silence, and aggression. This can make you feel uncomfortable. However, you must:

- Allow the survivor to express their feelings. (If, for example, he/she cries, don’t say “you should not cry” but remain calm and show you are with them; offer them a tissue. If the survivor is suspicious or aggressive, don’t take it personally).
- Reassure the survivor by explaining that their physical and emotional reactions are normal in reaction to the violence they have suffered.

Specific considerations for children:

- Introduce yourself to the child and tell him/her your role using developmentally appropriate language.
- Avoid making assumptions about the non-verbal behaviour of children at all developmental levels.
- Avoid making assumptions about the way the child feels about the perpetrator or the acts of GBV violence and exploitation (i.e., that the acts were painful, that the child hates the perpetrator).
- If possible, speak at eye level or below.
- Establish rapport with the child by discussing things other than the reason for their visit (e.g., school, siblings, etc.).

Empowerment

Survivor-centred care is also associated with patient choice, involving the patient in or giving them more control over decisions on the interventions or forms of care that they may receive, to empower and enable the patient to participate more fully in their health care.

During a GBV assault, the survivor may have been forced to endure a painful and humiliating experience over which they had no control.

Following such a disempowering experience, it is essential to ensure that the survivor benefits from control of the medical process. Otherwise, the provision of medical care may be perceived by the survivor as yet another experience of abuse. Therefore, it is important to inform the survivor fully about the care and various services to be provided, in order that they may be able to make fully informed choices and that any treatment decision is a shared one.

- Inform the survivor fully about the offer of care and continue to do so during the various stages of the consultation.
- Explain to the survivor that he/she may choose at any stage to accept or refuse an examination, a test, a treatment, a referral, etc.
- Respect their wishes, rights and dignity.
- Respect and always support their choices.
- Advise self-control whenever possible.
- Always act in the best interests of the survivor.
- Always be guided by safety considerations for the survivor.

Specific considerations for children:

Involve the child in the decision-making:

- Children have a right to participate in decisions that have implications in their lives.
- The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age, and local laws.
- Although service providers may not always be able to follow the child's wishes (based on best-interest considerations), they should always empower and support children and deal with them in a transparent, open manner with respect.
- If a child's wishes are not able to be followed, then the reasons behind not being able to follow them should be explained.

Strengthen children's resiliencies:

- Each child has unique capacities and strengths and possesses the capacity to heal.
- Identify and build upon the child's and family's natural strengths as a part of the recovery and healing process.
- Factors that promote the child's resilience should be identified and built upon during the episode of care.
- In case of sexual violence, research has shown that children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong are more likely to recover and heal from sexual violence.

Annex 3: Job Aid - Helping victims/survivors cope with negative feelings

Job aid

Helping victims/survivors cope with negative feelings	
The feeling	Some ways to respond
Hopelessness	"Many people do manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on their strengths and how they have been able to handle a past dangerous or difficult situation.
Powerlessness, loss of control	"You have some choices and options today in how to proceed."
Flashbacks	Explain that these are common and often become less common or disappear over time.
Denial	"I'm taking what you have told me seriously. I will be here if you need help in the future."
Guilt and self-blame	"You are not to blame for what happened to you. You are not responsible for their behaviour."
Shame	"There is no loss of honour in what happened. You are of value."
Unrealistic fear	Emphasize, "You are in a safe place now. We can talk about how to keep you safe."
Numbness	"This is a common reaction to difficult events. You will feel again—all in good time."
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with perpetrator	Acknowledge that this is a valid feeling.
Anxiety	"This is common, but we can discuss ways to help you feel less anxious."
Helplessness	"We are here to help you."

Annex 4: Additional guidance on preparing the victim/survivor for exam & obtaining informed consent⁵⁶

Communicate

- Ask the survivor's permission to do a physical exam and obtain informed consent for each step.
- Ask if he/she wants a specific person to be present for support, such as a family member or friend.
- If you are a male provider, ask if he/she is comfortable with you examining them. If not, find a female provider to do the exam.

Have an observer there

See that another person is present during the exam – preferably a trained support person, preferably of the same sex as the survivor. It is especially important to have a woman present if the provider is male.

- Introduce this person and explain that she is there to give the survivor help and support.
- Otherwise, keep the number of people in the exam room to a minimum.

Obtain informed consent

Informed consent is required for examination and treatment, and for the release of information to third parties, such as the police and the courts.

- Explain to the survivor that he/she will be examined and treated only if he/she wants. Explain that he/she can refuse any aspect of the examination (or all).
- Describe the four aspects of the exam:
 - medical exam
 - pelvic exam
 - evidence collection

- turn-over of medical information and evidence to the police if he/she wants legal redress.

- For each aspect of the exam, invite questions and answer fully. Make sure that he/she understands. Then, ask him/her to decide yes or no. Tick the box on the form.
- Once you are sure that he/she has understood the exam and the form completely, ask him/her to sign (ascertain if they can read or write, and account for the situation) or use a thumbprint.
- Ask another person to sign the form as a witness, if required. (See Chapter 11 for issues of consent for minors).

Talking about reporting to the police

- If the law requires you to report to the police, tell the survivor/victim that.
- If he/she wants to go to the police, tell him/her that he/she will need to have forensic evidence collected. Tell him/her whether a health-care provider trained to do this is available.
- Tell him/her what evidence collection would involve.
- If he/she hasn't decided whether to go to the police, the evidence can be collected and held.
- If he/she wants evidence collected, call in or refer to a specifically trained provider who can do this.
- Even if the forensic evidence is not collected, the full physical exam should be done and well documented.
 - The exam can be useful if a survivor decides to pursue a legal case.

⁵⁶ For further details on forensic examinations, see the following guidelines, see Clinical management of rape survivors, 2004 at <http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/> & Guidelines for medico-legal care for victims of sexual violence, 2003 at http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

Annex 5: General tips for history-taking

- First, review any medical records belonging to the survivor.
- Develop a good rapport by showing empathy, even if validating information gathered and documented by other people involved in the case.
- Keep a respectful attitude and a calm voice.
- Maintain eye contact as culturally appropriate.
- Avoid distraction and interruption.
- Take time to collect all needed information.



Ask about general medical information

General medical information should cover any current or past health problems, allergies, and any medications that the survivor is taking.

See the history and exam form for what questions to ask.

This information may help with understanding examination findings.



Talk about the assault

The reason to obtain an account of the violence is to:

- Guide the exam so that all injuries can be found and treated.
- Assess risk of pregnancy, STIs and HIV.
- Guide specimen collection and documentation.



Communicate

- Politely ask the survivor to briefly describe the events.



Do not force the survivor to talk about the assault if they do not want to.

In all cases, limit questions to just what is required for medical care. However, if a survivor wants to talk about what happened, it is very important to listen empathetically and allow them to talk.

- Explain that learning what happened will help you give them the best care.
- Assure them that you will keep what they say private unless they want the police to take up their case or the law requires you to report.

- Explain that they do not have to tell you anything that they do not want to talk about.
- Let them tell their story in their own way and at their own pace.
- Do not interrupt. If it is essential to clarify any details, ask after they have finished.
- Question gently. Use open-ended questions that cannot be answered with yes or no.
- Avoid questions that might suggest blame, such as “*What were you doing there alone?*” or “*Why did you...?*”.
- The survivor may omit or avoid describing painful, frightening or horrific details.
- Do not force them to describe them. If you need specific information to treat them properly, explain why you need to know.



Take a gynaecological history

The examination form suggests the questions to ask.

The purpose of taking a gynaecological history is to check the risk of pregnancy and STIs and help determine whether any exam findings could result from previous traumatic events, pregnancy or delivery.



Assess mental health

Ask general questions about how he/she is feeling and what their emotions are while taking their history. If you see signs of severe emotional distress, ask specific questions.

Annex 6: Additional care for mental health: Psychological first aid & support



Many victims/survivors of intimate partner violence or sexual violence will have emotional or mental health problems. Once the violent assault or situation passes, these emotional problems will get better. Most people recover. There are specific ways you can offer help and techniques you can teach to reduce their stress and help them heal.

Some victims/survivors, however, will suffer more severely than others. It is important to be able to recognize these individuals and to help them obtain care. If such help is not available, there are things that first-line health-care providers can do to reduce their suffering.



Basic psychosocial support

After a sexual assault basic psychosocial support may be sufficient for the first 1–3 months, at the same time monitoring the survivor for more severe mental health problems.

- Offer first-line support at each meeting.
- Explain that he/she is likely to feel better with time.
- Help strengthen their positive coping methods.
- Explore the availability of social support.
- Teach and demonstrate stress reduction exercises.
- Make regular follow-up appointments for further support.



Strengthening positive coping methods

After a violent event a survivor may find it difficult to return to their normal routine. Encourage them to take small and simple steps. Talk to

them about their life and activities. Discuss and plan together. Let them know that things will get better over time.



Encourage the survivor to:

- Build on their strengths and abilities. Ask what is going well currently and how they have coped with difficult situations in the past.
- Continue normal activities, especially ones that used to be interesting or pleasurable.
- Engage in relaxing activities to reduce anxiety and tension.
- Keep a regular sleep schedule and avoid sleeping too much.
- Engage in regular physical activity.
- Avoid using self-prescribed medications, alcohol or illegal drugs to try to feel better.
- Recognize thoughts of self-harm or suicide and come back as soon as possible for help if they occur.
- Encourage them to return if these suggestions are not helping.

Explore the availability of social support

Good social support is one of the most important protections for any survivor suffering from stress-related problems. When victims/survivors experience abuse or violence, they often feel cut off from normal social circles or are unable to connect with them. This may be because they lack energy or feel ashamed.

You can ask:

- “When you are not feeling well, who do you like to be with?”
- “Who do you turn to for advice?”
- “Who do you feel most comfortable sharing your problems with?”



Note: Explain to the client that, even if there is no one with whom they wish to share what has happened, they still can connect with family and friends. Spending time with people they enjoy can distract them from their distress.

Help the client to identify past social activities or resources that may provide direct or indirect psychosocial support (for example, family gatherings, visits with neighbours, sports, community and religious activities). Encourage them to participate.

Collaborate with social workers, case managers or other trusted people in the community to connect them with resources for social support such as:

- community centres
- self-help and support groups
- income-generating activities and other vocational activities
- formal/informal education.



See additional resources to help reduce stress (Chapter 10)

Annex 7: Additional resources: Exercises to help reduce stress

Below is some guidance on breathing and relaxation exercises and techniques that you can use or share with the survivor to empower them to manage their stress and anxiety.

Slow breathing technique

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
 - First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
 - Put your hands on your belly. Think about your breath.
 - Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
 - Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
 - Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.
- Breathe deeply and count to three while holding your toe muscles tight. Then, relax your toes and let out your breath.
 - Breathe normally and feel the relaxation in your toes.
 - Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to three, and then relax and breathe out slowly.
 - Hold your leg and thigh muscles tight...
 - Hold your belly tight...
 - Make fists with your hands...
 - Bend your arms at the elbows and hold your arms tight...
 - Squeeze your shoulder blades together... Shrug your shoulders as high as you can...
 - Tighten all the muscles in your face....
 - Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest.

Progressive muscle relaxation technique

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
 - Curl your toes and hold the muscles tightly. This may hurt a little.
- Do this three times.
 - Now, go the other way...inhale to the left and back, exhale to the right and down. Do this three times.
 - Now bring your head up to the centre. Notice how calm you feel.



Annex 8: Script: Adherence counselling

I want to explain to you how to take the medicine you have been prescribed.

Post-exposure prophylaxis medicine works best when the level in your blood stays roughly the

same throughout the day. To make this happen, it is important that you take your medicine at regular intervals. In other words, you need to take the dose that you have been prescribed at certain times. For instance, if the medicine needs to be taken twice a day, you should take one dose in the morning, at regular times when you have breakfast or get up, and one in the evening, for example, when you eat dinner or go to bed. For some medicine, there are other instructions: for example, they must be taken with or without food.

These instructions must also be followed.

It is also important that you remember to take each dose. We should think about what you do every day to see if there is anything that might make you miss taking the medicine or if there is anything that might remind you to take it at set times. The full course of medicine is four weeks, so we need to think about what you might be doing over the next four weeks.

I have some tips that might help you take your medicine correctly.

- Use daily life events as cues to take your medicine, such as brushing your teeth or eating meals.
- Establish a set place to take your medicine.
- Try taking medicine with food as this can help to reduce nausea, a common side effect of this medicine. Is food available when you need to take your medicine?

- Consider your work or school patterns and whether taking medicine will mean telling colleagues or family members about post-exposure prophylaxis.
- Think about the days when your routine is different. For example, on weekends, a change in your routine could make you more likely to forget a dose. If you are planning to be out in the evening, it's okay to take a dose a bit early or to take a dose with you.
- Some people find that, when they lie down, although they do not intend to fall asleep, occasionally they do. If you think there is a chance that you might fall asleep if you lie down, you should consider taking the medicine before lying down, even if you do not expect to sleep.
- Set a mobile phone, or some other form of alarm, as a reminder for taking your pills.
- If you feel you can, you could ask family or friends to help you remember to take your medicine.

If you do forget to take your medicine at the right time, you should still take it if it is less than halfway to the time for your next dose. For example, if you usually take your medicine at around 10 in the morning and again at 10 in the evening, but forget the dose at 10 in the morning, you can still take it if you remember to do so before, say 3 in the afternoon. However, if you don't remember until after 4 in the afternoon, then don't take it, but take the next dose at 10 in the evening as usual. Never take a double dose of your medicine.

➤ **Speak to your health-care worker or doctor if you have any problems or questions.**

Annex 9: Minimum care for victims/survivors of sexual assault

Protocol	Available?
Written Medical Protocol	
Personnel	Available?
Trained health-care professionals (available 24 hours/day)	
Where possible a same-sex health-care provider or companion available in the room during examination	
Furniture/Setting	Available?
Private room (well-ventilated and adequate light, quiet, accessible, with access to a toilet or latrine)	
Examination couch	
Examination light, preferably fixed (a torch may be threatening for children)	
Access to an autoclave to sterilize equipment	
Supplies	Available?
“Sexual Assault Kit” for collection of forensic evidence, including	
Speculum (various sizes)	
Set of replacement clothes where possible	
Tape measure for measuring the size of bruises, lacerations, etc	
Supplies for universal precautions	
Resuscitation equipment for anaphylactic reactions	
Sterile medical instruments (kit) for repair of tears, and suture material	
Needles, Syringes (various sizes)	
Gown, cloth, or sheet to cover the survivor during the examination	
Sanitary supplies (pads or local clothes)	
Drugs	Available?
For treatment of STIs and PEP for HIV as per country protocol	
Emergency contraceptive pills and /or IUD	
For pain relief (e.g., paracetamol)	
Local anaesthetic for suturing	
Antibiotics for wound care	
Administrative supplies	Available?
Medical chart with pictograms	
Consent, assessment and police forms	
Information pamphlets for post-sexual assault care (for victims/survivors)	
Safe, locked filing space to keep confidential records	

Annex 10: Sample consent form

Notes on completing the consent form

Consent for an examination is a central issue in medico-legal practice. Consent is often called “informed consent” because it is expected that the patient (or his/her parent(s) or guardian) will receive information on all the relevant issues, to help the patient decide about what is best for them at the time.

It is important to make sure that the patient understands that their consent or lack of consent to any aspect of the exam will not affect their access to treatment and care.

The health-care provider must provide information in a language that is readily understood by the patient or his/her parent/guardian to ensure that he/she understands:

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.
- What the physical examination will involve.
- What the pelvic examination will involve.
- That the physical examination, including pelvic examination, will be conducted in privacy and in a dignified manner.
- That during part of the physical exam, the patient will lie on an examination couch.
- That the health-care provider will need to touch them for the physical and pelvic examinations.
- That a genito-anal examination will require the patient to lie in a position where the patient’s genitals can be seen with the correct lighting.
- That 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.
- That clothing may be collected. And that not all the results of the forensic analysis may be made available to the patient and why.
- That they can refuse any aspect of the examination they do not wish to undergo.
- That they will be asked to sign a form which indicates that they have been provided with the information and which documents what procedures they have agreed to.

Inform the patient that if, and only if, he/she decides to pursue legal action, the information told to the health worker during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice with their consent.

Sample consent form (victims/survivors)

Name of facility _____

I _____ (Name of Survivor)
authorize the above-named health facility to perform the following (tick the appropriate):

Conduct a medical examination

Conduct pelvic examination

- **Collect as much forensic evidence as possible such as body fluid samples, collection of clothing, hair combings, scraps or cuttings of fingernails, blood samples, and photographs.**
- **Provide evidence and medical information to the police and/or courts concerning my case;** this information will be limited to the results of this examination and any relevant follow-up care provided.

I understand that I can refuse any aspect of the examination I don't wish to undergo.

Signature of survivor _____

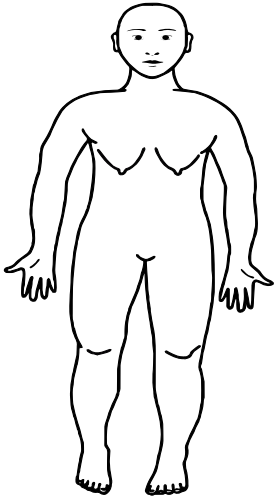
Date: _____

Witness: _____

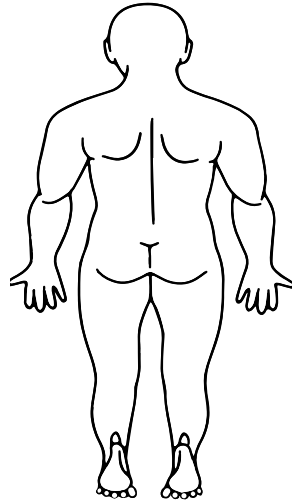
Annex 11: Pictograms

Sketch of person

Anterior view

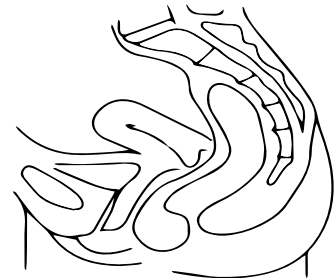
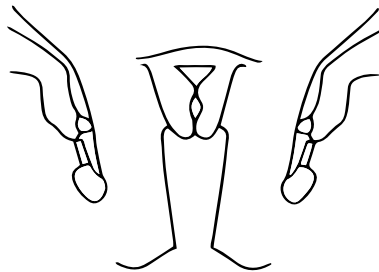
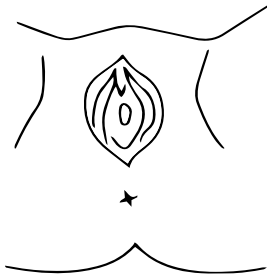


Posterior view

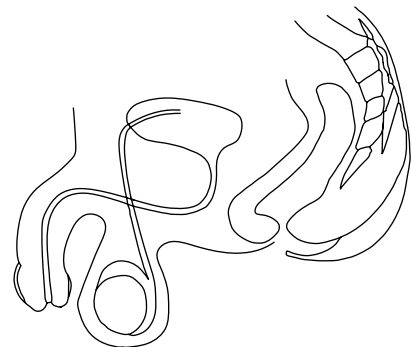
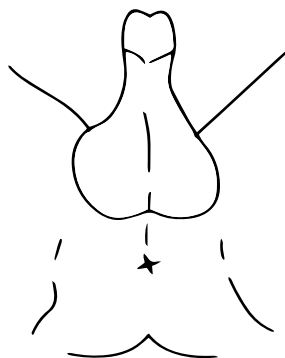
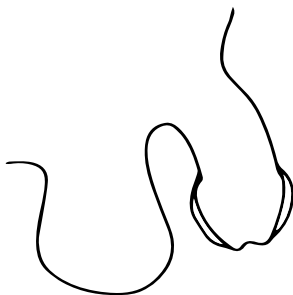


Comments

Female genitalia



Male genitalia



Annex 12: Forensic evidence collection

As stated in Chapter 6–7, the capacity of laboratories to analyse forensic evidence differs considerably. This annex describes the different types of forensic evidence that can be collected and outlines procedures for doing so. Health workers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about sexual assault and different guidelines on what is accepted as evidence. Do not collect evidence that cannot be processed.

Inspection of the body

- Examine the survivor's clothing under a good light before he/she undresses.
- Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, foreign hairs).
- Ask the person to undress while standing on a sheet of paper to collect any debris that falls. Do not ask them to uncover fully.
- Examine the upper half of the body first, then the lower half, or provide a gown for the patient to cover themselves. Collect torn and stained items of clothing only if you can provide replacement clothes.
- Document all injuries in as much detail as possible.
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit the victim/survivor) or semen on the skin, with the aid of a sterile cotton tipped swab, lightly moistened with sterile water if the skin is dry.
- The survivor's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity for direct examination for sperm and for DNA and acid

phosphatase analysis. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.

- Take blood and/or urine for toxicology testing if indicated (e.g., if the survivor was drugged).

Inspection of the anus, perineum and vulva

Inspect and collect samples for DNA analysis from the skin around the anus, perineum and vulva using separate cotton-tipped swabs moistened with sterile water. For children, always examine both the anus and the vulva.

Examination of the vagina and rectum

Depending on the site of penetration or attempted penetration, examine the vagina and/or the rectum.

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis).
- Using a cotton-tipped swab, collect fluid from the posterior fornix for examination for sperm. Put a drop of the fluid collected on a slide, if necessary, with a drop of normal saline (wet-mount) and examine it for sperm under a microscope. Note the mobility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.
- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina for acid phosphatase analysis.
- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

Maintaining the chain of evidence

It is important to always maintain the chain of evidence, to ensure that the evidence will be admissible in court. This means that the evidence is collected, labelled, stored and transported properly.

Documentation must include a signature of everyone who has possession of the evidence at any time, from the individual who collects it to the one who takes it to the courtroom, to keep track of the location of the evidence.

If it is not possible to take the samples immediately to a laboratory, precautions must be taken:

- All clothing, cloths, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper (not plastic) bags. Samples can be tested for DNA many years after the incident, provided the material has been well dried.
- Blood and urine samples can be stored in the refrigerator for five days. To keep the samples longer they need to be stored in a freezer. Follow the instructions of the local laboratory (specimen or results).
- All samples should be clearly labelled with a confidential identifying code (not the name or initials of the survivor), date, time and type of sample (what it is, from where it was taken), and put in a container.
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your initials across the tape.

Evidence should be released to the authorities only if the survivor decides to proceed with a legal case.

The survivor may consent to have evidence collected but not to have it released to the authorities at the time of the examination. In this case, advise them that the evidence will be kept in a secure locked space in the health centre for one month and then destroyed. If he/she changes their mind during this period, he/she can advise the authorities where to collect the evidence.

Report on Examination in a case of Alleged Assault or Other Crime

THIS FORM IS TO BE USED BY MEDICAL OFFICERS AND MEDICAL PRACTITIONERS
MAKING AN EXAMINATION FOR THE GOVERNMENT

Form "A" should be completed in all cases including rape and post-mortem examinations where injuries are found and form "B and C" should be completed in cases where a person has been examined in connection with a sexual offence.

This is to certify that at the request of ⁽¹⁾.....

I have this ⁽²⁾..... day of....., 20..... at the hour of.....m

examined at ⁽³⁾.....

⁽⁴⁾.....

Sex..... Apparent Age..... Race.....

State of the person as regards physical, mental and general state of health.....

.....

.....

Condition of Clothing.....

.....

Bruises and Abrasions (if any) ⁽⁵⁾.....

.....

Wounds (if any) ⁽⁶⁾.....

.....

.....

Any other Injuries ⁽⁶⁾.....

State of Organs of Generation (of examined) ⁽⁶⁾.....

.....

Microscopical or other Special Examination of States, etc. ⁽⁷⁾.....

.....

.....

.....

Remarks.....

.....

.....

Name of Officer in full.....

Medical Officer, or Medical Practitioner

⁽¹⁾ Name of official or person at whose instance the examination was carried out.

⁽²⁾ Date and hour of conducting the examination.

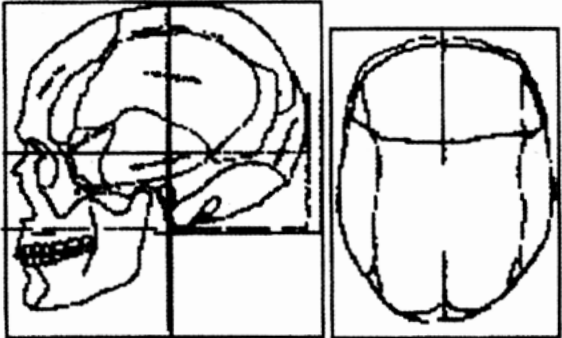
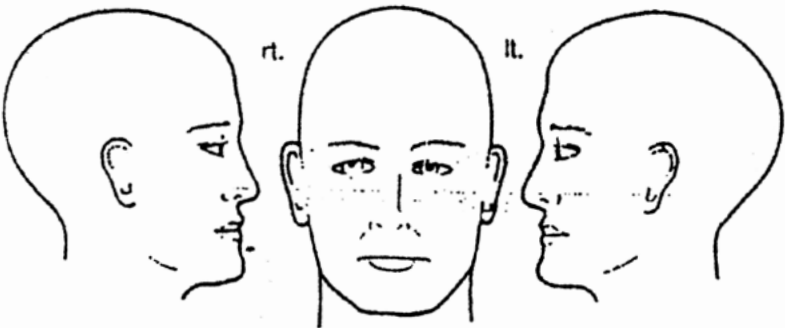
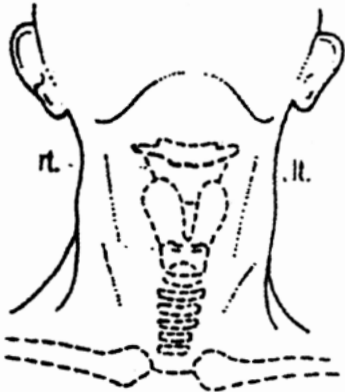
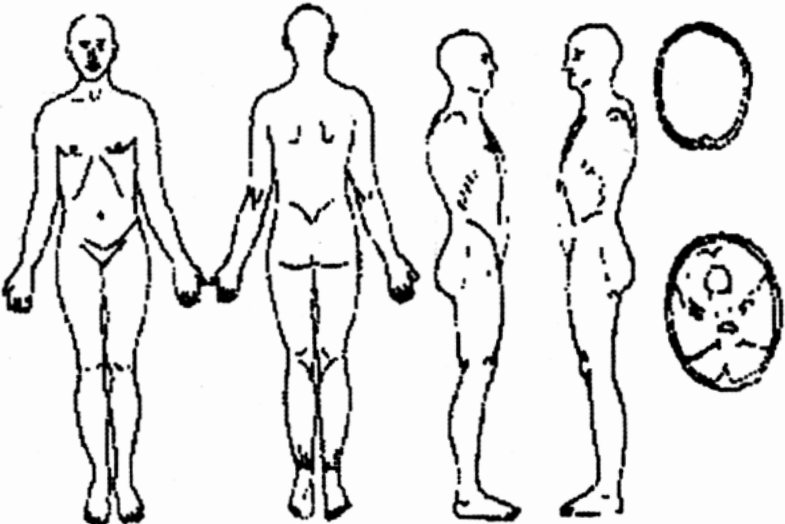
⁽³⁾ Place where examination was carried out.

⁽⁴⁾ Name of person examined.

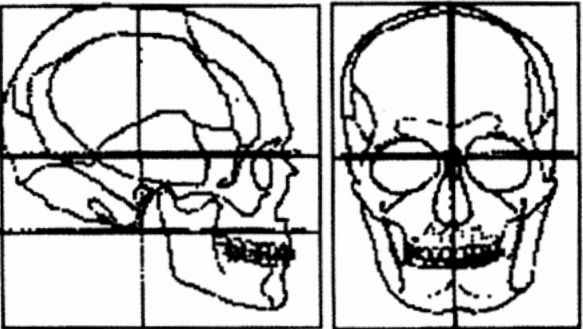
⁽⁵⁾ In every case the nature, position and extent of the abrasion, wound, or other injury must be exactly described, together with its probable date and manner of causation, any apparent discrepancy between any statement made by the person and the conditions actually found on examination being noted.

⁽⁶⁾ In the case of a female her consent, or, if a minor, the consent of her lawful guardian, should be first obtained especially if the examination is undertaken in connection with a charge of infanticide or concealment of birth.

⁽⁷⁾ If any vomit or excreta or portion of clothing or other article is taken for special examination, its nature should be noted here and the manner of its preservation and disposal.



Detailed Sketch of Affected Area
(If required)



Signature _____

REPORT ON EXAMINATION IN A CASE OF ALLEDGED RAPE OR OTHER SEXUAL OFFENCE

FEMALE

.....

 Sexual History.....
 Menstruation.....Pregnancies.....

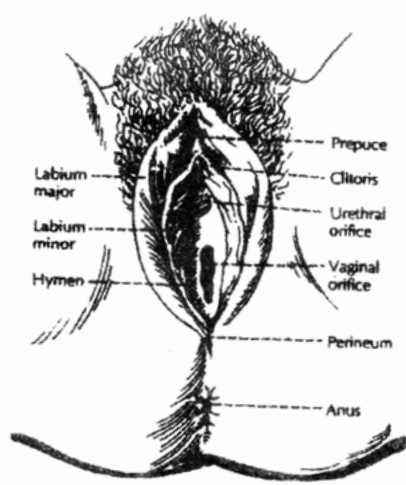
 Assault as described by patient.....

 Injuries: (Extragenital).....

 Breasts.....
 Labia Majora.....
 Labia Minora.....
 Vestibule.....
 Hymen.....
 Vagina: (1,2,3 Fingers).....
 Fourchette.....
 Perineum.....
 Anus.....
 Discharge.....
 Haemorrhage.....
 Internal Examination (Easy—Painful).....
 Uterus.....
 Vaginal Smears.....

Anus

Cervix



Opinion: _____
 Signature _____

REPORT ON EXAMINATION IN A CASE OF ALLEDGED RAPE OR OTHER SEXUAL OFFENCE

MALE

Sexual History
.....
.....

Injuries: (Extra Genital)
.....
.....

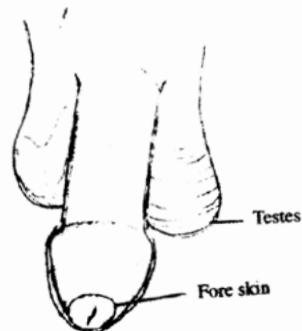
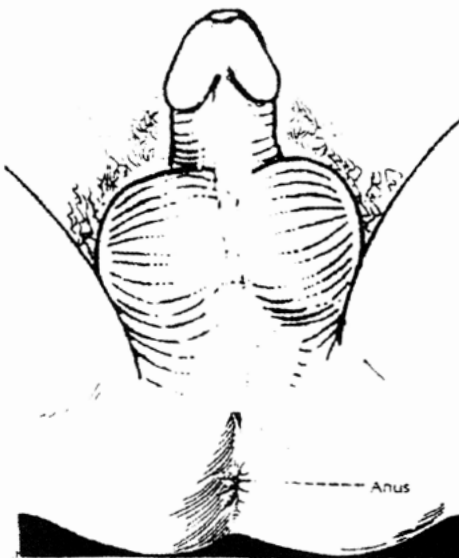
Pubis
.....

Penis

Anus
.....

Rectal Examination:
.....
.....

Ancillary Investigations:
.....
.....



Opinion:	Signature _____
-----------------	------------------------

Annex 15: Reference Group members

Stakeholder	Name & Surname	Agency/ Organization/ Department	Designation	
Government of Botswana Ministries and Agencies	Ministry of Health	Ms. Sifelani Malima	MoH - SRHD	Principal Health Officer
		Ms. Tduetso Nkutilwisang	MoH - Princess Marina Hospital	Nurse/Midwife & GBV/MI ToT
		Ms. Naledi Segokgo	MoH - SRHD	Health Officer
		Ms. Galaletsang Mudongo	MoH - SRHD	Chief Registered Nurse, SRH/HIV Integration
		Dr. Lisani Ntoni	MoH/UB	Senior Medical Officer/ Public Health Medicine Resident
		Ms. Tlhomamo Pheto	MoH -SRHD	Principal Health Officer, Cervical Cancer
	Ministry of Local Government and Rural Development	Ms. Ilanah Maloto-Moyo	MoLRD- Department of Social Protection	Hospital Social Worker, Goodhope Primary Hospital
	Ministry of Nationality Immigration and Gender Affairs (Ministry of Youth, Gender, Sports and Culture)	Budani Madandume	MNIG (MYGSC) Gender Affairs Department	Gender Officer
	Attorney General's Chambers	Tjeludo Bianca Gaborekwe	Attorney General's Chambers	Legislative Drafter
	Botswana Police Service	Ms. Thokozile Patricia Fanie	Botswana Police Service	Forensic Scientist
Dr. Kaone Panzirah-Mabaka		Botswana Police Service	Medical Specialist	
CSOs	Men and Boys for Gender Equality	Ms. Chaha R Charumbira	Men and Boys for Gender Equality	Business Development Officer
	Botswana Gender-Based Violence and Prevention and Support Centre	Ms. Pearl Shamukuni	Botswana Gender-Based Violence and Prevention and Support Centre	Outreach Coordinator
	Men for Health and Gender Justice	Mr. Onkokame Mosweu	Men for Health and Gender Justice	Programme Manager
	Botswana Network on Ethics, Law & HIV/AIDS	-		
	BOFWA	-		

Table 15 (cont'd)

Academia	University of Botswana	Dr. Vincent Setlhare	UB, Faculty of Medicine	HoD, Family Medicine
United Nations and T/A	UNAIDS	Ms. Mpho Mmelesi	UNAIDS	Strategic Information Adviser
	UNICEF	Ms. Gomolemo Rasesigo	UNICEF	Child Protection Specialist
	UNFPA	Ms. Kesaobaka Dikgole	UNFPA	SRH/HIV Linkages Coordinator
	WHO	Dr. Juliet Evelyn Bataringaya	WHO	Health Systems Advisor
	UN Gender Theme Group	Ms. Vanilde Furtado	RCO	Gender Advisor
	UNFPA- ESARO	Dr. Muna Abdulla	UNFPA ESARO	Health System Specialist



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