Health Sector Response to Gender-Based Violence:

National Guidelines for Healthcare Providers on provision of care and prevention of GBV

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FOREWORD

Gender-based violence (GBV) is increasingly recognized around the world as a serious public health and development challenge and a violation of human rights. GBV is prevalent in both developed and developing countries, and the Maldives is no exception. Practices that are not aligned to address GBV by all sectors cause significant mortality and morbidity due to mental, physical, sexual, and reproductive health consequences and further leads to increased risk behavior. Even though gender-based and interpersonal violence are preventable, we have not been able to eradicate these atrocities from our communities. GBV targets both women and men, but the main risk factors, patterns and consequences of violence contribute to inequalities between men and women. GBV is a violation of the fundamental rights to life, liberty, security, dignity, non-discrimination and equality between men and women, including physical and mental integrity. Women's Health and Life Experiences Study conducted in the Maldives, found that one in three women aged 15-49 have experienced some form of physical or sexual violence at some point.

The first national guideline for health sector response to GBV, was developed by Ministry of Health with support of the United Nations Population Fund (UNFPA). This guideline was developed as a national health sector document published by the Ministry of Health in 2014, oriented and distributed to support implementation of health services and referral to survivors of gender-based violence.

One of the primary objectives of this guidance is to *"streamline and enhance the health sector response to survivors of GBV in order to enable the delivery of required interventions and conducting preventive activities by the healthcare professionals (HPs) within the health sector."* This updated guideline is intended to provide guidance to healthcare providers and healthcare professionals, towards further improving the health care response. In addition, this guideline will pave way to handle the medical, clinical and health service aspects of GBV care including referral to other services to help survivors of gender-based violence.

I would like to acknowledge the important role played by UNFPA in providing extensive technical and financial support, the lead Consultant team who diligently facilitated the development of this document. My appreciation goes to all organizations, institutions and individuals who have contributed during the development phase. I am also very appreciative of the contributions made by Indira Gandhi Memorial Hospital, Hulhumale' Hospital, ADK Hospital, Ministry of Gender Family and Social Services, Family Protection Authority, Maldives Police Services and relevant department, division of the Ministry of Health, especially to Health Protection Agency in initiating this revision and updating the first guidance document.

Given the multifaceted challenges that GBV presents, it is very important that the safety/protection, legal/justice, and health sector work together in well-coordinated mechanisms to prevent GBV, reduce harmful effects and respond to GBV to prevent further injury, trauma, and damage. I strongly encourage, and advocate that all healthcare professionals and providers use this guidance at all times.

Thasleema Usman
Commissioner of Quality Assurance
Ministry of Health
07 September 2023

Message from UNFPA Country Director

Elimination of Gender-Based Violence (GBV) and harmful practices against women and girls is one of the key results areas for UNFPA. It requires a multi-sectoral effort with the health sector often being the first point of contact for survivors of violence. Hence, it is critical that the health care system is ready to identify, refer and provide necessary care and services to survivors and as such, contribute to preventing and responding to GBV in the Maldives.

'Preventing and Responding to Gender-Based Violence, National Guidelines for Health Care Providers and Practitioners' provides guidance for the health sector to respond to survivors of violence. It draws from international standards and guidance tools to provide clear guidelines on clinical management of GBV, including working with children and adolescents experiencing violence. A comprehensive health sector response is not merely a professional obligation; it is a moral imperative. These guidelines equip us with the knowledge and tools to recognize, respond to, and prevent GBV within healthcare settings. They underscore the importance of a survivor-centered approach that respects autonomy, confidentiality, and the diverse needs of those seeking help.

UNFPA supports Maldives to build a society free from violence and harmful practices, to adhere to its international human rights commitments including *'The International Conference on Population and Development (ICPD) Programme of Action'*, *'The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)'* and '*The Sustainable Development Goals (SDG)'*. Primary prevention of GBV is the main aim of UNFPA to eliminate violence from happening in the first place. Life Skills Based Reproductive Health Education (LSBRHE) is a tool to bring awareness among children and adolescents to change harmful social norms that promotes violence. This document is part of the overall efforts to strengthen the national GBV prevention and response systems in the country. UNFPA is also supporting the government to harmonize standard operating procedures within the national GBV referral system. By working together, we can provide survivors with a holistic package of support, including health, protection, and psychosocial services.

I take this opportunity to sincerely thank the technical team and the policy leaders in the Ministry of Health, Health Protection Agency and the panel of experts who have been instrumental in developing this guideline. Thank you for your dedication and commitment in taking this significant step forward in addressing health sector response to GBV in the Maldives.

Together, let us rise to the challenge and create a world where gender-based violence has no place and where the right to health is truly universal.

Kunle Adeniyi

UNFPA Country Director, Maldives

Acknowledgement

Appreciation goes towards those organizations, institutions and individuals for bringing their expertise and experience around the table and continuous engagement and contribution in the development of these guidelines and standards.

Sincere appreciation to the Institute of Research and Innovation, Villa College for the consultancy to review, update and conduct the stakeholder discussions.

Recognize the significant contributions made by Indhira Gandhi Memorial Hospital (IGMH), Hulhumale Hospital (HMH), ADK Hospital and Treetop Hospital (TTH), Family Protection Authority (FPA), Maldives Police Service (MPS), Ministry of Gender, Family and Social Services (MoGFSS), including different departments, divisions of the Ministry of Health.

Further, acknowledge the significant role played by UNFPA in facilitating and assisting the development and updating of the “Health Sector Response to Gender-Based Violence: National Guidelines for Healthcare Providers on provision of care and prevention of GBV”.

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List of Acronyms and Abbreviations

A&E	Accidents and Emergency
AIDs	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CEDAW	Convention to Eliminate All Forms of Discrimination Against Women
DNA	Deoxyribo Nucleic Acid
DV	Domestic Violence
EC	Emergency Contraception
FCSC	Family and Children Service Centre
FGC/M	Female Genital Cutting/ Mutilation
FP	Family Planning
FPA	Family Protection Authority
FPU	Family Protection Unit
GBV	Gender Based Violence
HCP	Healthcare Provider
HIV	Human Immune Virus
HP	Healthcare Professional
ICU	Intensive Care Unit
IGMH	Indira Gandhi Memorial Hospital
IPV	Intimate Partner Violence
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
PCU	Post Care Unit
PEP	Post Exposure Prophylaxis
PNC	Postnatal Care
PTSD	Post-Traumatic Stress Disorder
RCH	Reproductive Child Health
SHE	Society for Health Education

STIs	Sexually Transmitted Infections
TT	Tetanus Toxoid
UK	United Kingdom
UN	United Nation
UNFPA	United Nation Population Fund
UNHCR	United Nations High Commission Refugees
USA	United States of America
WDC	Women's Development Committee
WHLE	Women's Health and Life Experience
WHO	World Health Organization

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PART 1

RATIONALE AND OBJECTIVES

RATIONALE AND OBJECTIVES

1.1. Why were the Guidelines developed?

Gender Based Violence (GBV) is a gender-neutral term by definition, but GBV affects primarily women and girls, and cuts across all strata of the society. Gender-based violence is widespread both in the developed and developing world and Maldives is no exception[1,2]. Preventing and responding to gender-based violence continues to be an ongoing priority area for the Maldivian government in policy and intervention programming.

The landmark study, the Maldives study on women's health and life experiences conducted in 2004[1] showed that 1 in 3 women aged 15-49 have experienced some form of physical or sexual violence during their lifetime. This includes intimate partner violence, sexual violence by family members and/or colleagues at work, as well as childhood sexual abuse. The high number of GBV cases reported to the Maldives Police Service and to the Ministry of Gender, Family and Social Services indicate that prevention of gender-based violence and responding to gender-based violence need to be prioritized by all relevant stakeholders. Maldives Demographic and Health Survey of 2016-17 reported that only 42% of women who have experienced physical and or sexual violence had sought help[2].

Fundamental Rights and Freedom is ensured under the Maldives Constitution where the Constitution guarantees to all persons, the rights and freedoms contained within Chapter Two (Maldives Constitution, 2008). National legal instruments include Law on Gender Equality 18/2016, the Law on Domestic Violence Prevention Act 3/2012, Penal code 9/2014, Social Protection Act 2/2014, the Sexual Harassment Act 16/2014, the Sexual Offences Act 17/2014, Family Act 4/2000 and supplementary guidelines, the Special Provisions Act to Deal with Child Sex Abuse Offenders 12/2009, the Anti-Human Trafficking Act 12/2013, Child Rights Protection Act 19/2019 and Local Governance Act 7/2010. These laws and their amendments and related fatwas further enable protection of survivors through provision of health and social protection services. However, both their implementation and awareness amongst the public and duty bearers are limited.

[1] Ministry of Gender and Family., & Fulu, E. (2007). *The Maldives study on women's health and life experiences: Initial results on prevalence, health outcomes and women's responses to violence*. Ministry of Gender and Family, UNFPA.
[2] Ministry of Health., & ICF. (2018). *Maldives Demographic and Health Survey 2016-17*. Ministry of Health, ICF.

In addition to the above legal protection, specific legal frameworks of the health sector including Public Health Protection Act 7/2012, Health Care Professional Act 13/2015, and the Health Services Act 29/2015 provide adequate legal frameworks to enable implementation of interventions within the health sector. Incorporation of addressing GBV in the health policies such as Health Master Plan (2016-2025), RMNACH strategy and action plan (2020-2025), HIV/AIDS, |Mental health policy and strategy are important components of the health sector response for prevention of GBV and protection of survivors.

One of the earliest responses from the Maldivian government was the setting up of a dedicated service point to provide health services to survivors of GBV. The Family Protection Unit (FPU) at the Indira Gandhi Memorial Hospital (IGMH) was set up with the collaboration of the Ministries of Health and Gender, IGMH and UNFPA in 2004. This has been the stepping stone for recognition of GBV as a public health concern in Maldives. Since then, interventions and service integration measures are ongoing. An assessment of the health sector response to GBV in the Asia Pacific Region conducted by UNFPA in 2010 recognized the health sector response made by Maldives as significant, among the countries in the Asia Pacific Region[3].

The first national guideline for health sector response to GBV, National guideline on providing care and prevention for healthcare providers was developed by Ministry of Health with support of the United Nations Population Fund (UNFPA). This guideline was developed as a national health sector document published by Ministry of Health in 2014 and distributed to the healthcare providers to support implementation of healthcare services and referral to survivors of gender-based violence. The guidelines provided direction to support healthcare providers in providing high-quality and comprehensive services to survivors of GBV, providing healthcare professionals with guidance for the medical management of GBV survivors and for prevention of GBV in the community.

Desk reviews were conducted in 2021 prior to updating the Health Sector Response to GBV (National Guideline for providing care and prevention for healthcare providers) document. The desk review showed existence of Domestic Violence Prevention Act 3/2012 and existing National Guideline for Health Sector Response to GBV which act as guiding tools and provide clear instructions. Positive steps continue with sustained service provision at the FPU at IGMH on a permanent basis and

[3] UNFPA Asia and the Pacific Regional Office. (2010). *Health Sector Response to Gender-based Violence an Assessment in the Asia Pacific region.* UNFPA.

localized operating procedures in Atoll and Regional Hospitals to implement the guidelines. Review further observed the need for ongoing capacity building and strengthening of procedures are required for healthcare providers and healthcare professionals. Additionally, strengthening of inter-sectoral collaboration is required for tackling gender-based violence through a holistic approach.

This update of the guideline draws on the best practices observed locally and internationally and operational lessons from the field.

1.2. Who are these guidelines intended for?

The guidelines are intended to provide guidance for healthcare providers and healthcare professionals, but primarily for doctors, nurses, and community health officers as they are directly involved in providing care to survivors of GBV as the first contact person in the health sector. With the guidance provided here, healthcare professionals will be better equipped to handle the medical aspects of GBV care and referral to other services such as counseling, police, or legal systems.

The guideline will be a valuable resource for guidance to any other category of health staff such as mental health professionals, social workers, therapists, and laboratory technicians who may have to provide supportive services to survivors of gender-based violence.

This guideline will also assist healthcare managers and planners to understand the needs of survivors, and to plan for the provision of services in health facilities and in the community for preventing and responding to gender-based violence.

1.3. What these guidelines set out to achieve?

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

In addition, the document acts as a guiding document for referral pathways and documentation. It also highlights the importance of basic psychological first aid and appropriate guidance to required mental health support to survivors of GBV.

Primary Objective

To streamline and enhance the health sector response to survivors of GBV in order to enable the delivery of required interventions and conducting preventive activities by the healthcare professionals within the health sector.

Specific Objectives

- To describe the roles and responsibilities delegated to healthcare providers under the Act on Prevention of Domestic Violence 3/2012 including Child Rights Protection Act 19/2019 and other relevant laws and regulations.
- To guide the healthcare professionals to respond and assist the survivors in a uniform and effective manner, across the health sector.
- To strengthen the medico- legal services by updating the knowledge of the healthcare professionals.
- To describe the referral pathways for providing services within the health sector, the instruments for documentation, and to identify relevant non health service providers who could assist the survivors.
- To provide guidance on screening for GBV among care seekers in the health sector.
- To provide guidance on medical management of the survivors while adhering to professional ethical principles.
- To provide guidance on documentation, data management and research on GBV related issues.
- To understand the importance of guiding principles for helping survivors of sexual violence.
- To provide a basic understanding of international human rights provisions relating to GBV and identify national legal and justice mechanisms and services for protection to survivors.

WHAT IS GENDER-BASED VIOLENCE (GBV)?

The term gender is not merely a concept based on biological sex, but a combination of biological and social constructs inclusive of roles, responsibilities and expectations from, male and female members of the society, affecting them throughout their life in many different ways. It is also seen that some members of the society, mostly males, use these gender "norms" as a basis to perpetrate and justify violence, often sexual in nature, mostly on women. Such acts based on gender are collectively known as gender-based violence. Gender-based violence is internationally recognized as a gross human rights violation, and an issue crosscutting all components of reproductive health. Gender-based violence is also a major public health problem with social, cultural, legal, economic, and psychological dimensions. It is not limited by any of the social, educational, cultural, religious, or racial stratifications. It is mostly perpetrated by men on women and affects the survivors throughout their life cycles leading to harmful, sometimes fatal, health and non-health consequences.

Gender based violence can be classified as physical, sexual, emotional, economic or social but there is a considerable overlap of the type of violence the survivor experiences within the relationship, often resulting in the same survivor suffering many types of violence concurrently. Past exposure to violence including witnessing or being a victim of violence as a child or as an adolescent can put the survivor at a higher risk for poly-victimization and complex trauma related ill health.

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

Root causes of GBV are gender discrimination and gender inequality, abuse of power by one group of the society, and the lack of respect for human rights. Along with root causes, there are contributing factors that perpetuate GBV or increase risk of GBV and influence the type and extent of GBV in any setting.

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

As the factors leading to GBV are complex and multiple, it is essential to have a multi- pronged

response to address GBV with all sectors of the community and the state government, participating and collaborating with each other.

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

2.1. Definitions

The definitions below are to be used for the purpose of this document.

Clinical enquiry or Case finding:

This refers to the identification of survivors of violence who present to health-care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from "screening" or "routine enquiry"[4].

Consent to treatment:

Consent to treatment means a person must give permission before they receive any type of medical treatment, test or examination[5].

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. The meaning of these terms are:

- voluntary – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- informed – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead
- capacity – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision

Domestic violence:

Domestic violence refers to commission of any act described as an act of violence under "Domestic Violence Act 3/2012 (4)" by the perpetrator against the victim provided such persons are bounded by a domestic relationship. It is acts by a perpetrator where such conduct harms or may cause imminent harm to, the safety, health, wellbeing of the victim(s), and provided the victim(s) and perpetrator are in a domestic relationship. It may be a single instance of violence or a series of acts that have been committed in a particular pattern over a given period of time which appear to have the characteristics of violence[6].

[4] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines*.
[5] National Health Service. (2022). *Consent to treatment.* NHS UK. https://www.nhs.uk/conditions/consent-to-treatment/
[6] *Domestic Violence Act 3/2012.* Unofficial translation. https://maldives.unfpa.org/sites/default/files/pub-pdf/the_domestic_violence_act_2012_maldives_english_translation_unofficial.pdf

Disclosure:

Release, transfer, provisions of, access to, or divulgence in any manner of information outside the entity holding the information[7]. In cases of GBV/DV, a survivor may choose to disclose information regarding history of GBV/DV to a healthcare professional/provider on their own. In other cases, a healthcare professional/provider may be able to identify suspected cases of GBV/DV through information gained from a survivor during specific examinations or treatment which may or may not be linked to the abuse.

Female genital mutilation (FGM):

Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons[8].

First line support:

First-line support provides practical care and responds to a survivor's emotional, physical, safety and support needs, without intruding on their privacy[9].

Forced marriage:

It is a marriage where at least one person is married without consent, against their will or is not able to exit the marriage. Within this dynamic, there is a continuum of coercion ranging from physical violence to psychosocial pressure[10].

GBV response:

Refers to immediate interventions that address survivors' physical safety, health concerns, psychosocial needs, and access to justice[11].

Gender–based violence:

An umbrella term for any act, omission, or conduct that is perpetuated against a person's will and that is based on socially ascribed differences between males and females. In this context, GBV includes, but is not limited to sexual violence, physical violence and harmful traditional practices,

[7] Department of Health and Human Services. (2017). *Glossary of HIPAA related terms.* USA.
[8] World Health Organization. (2023). *Female genital mutilation.* https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation
[9] World Health Organization. (2014). *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook.*
[10] United Nations. (2023). *Forced marriage: a violation of human rights.* https://www.ohchr.org/en/stories/2023/01/forced-marriage-violation-human-rights#:~:text=It's%20a%20marriage%20where%20at,to%20end%20this%20harmful%20practice
[11] United Nations High Commissioner for Refugees. (n.d.) *UNHCR GBV Toolkit.* Retrieved on August 22, 2023 from https://www.unhcr.org/gbvtoolkit/_test/#:~:text=(GBV)%20is%20'an%20umbrella,differences%20between%20males%20and%20females.

and economic and social violence. The term refers to violence that targets individuals or groups on the basis of their gender[12]; it refers to any harm that is done against a person's will be based on their gender and that has a negative impact on that person's physical and psychological health, development, and identity.

Healthcare providers and Healthcare professionals:

Healthcare providers are all people engaged in actions whose primary intent is to enhance health[13]. Healthcare professionals refers to professionals who are qualified by education and/or experience to provide health care and are practicing medical practitioners, dental practitioners, nurses, midwives, allied health professionals[14].

Intimate partner violence:

The term "intimate partner violence" describes physical, sexual, or psychological harm by a current or former partner or spouse. This refers to ongoing or past violence and abuse by an intimate partner or ex-partner – a husband, boyfriend or similar. Women may suffer several types of violence by a male partner, including physical violence, emotional/psychological abuse, controlling behaviors and sexual violence[15].

Mandatory reporting:

Refers to Maldivian legislation that requires healthcare providers through designated focal points, to formally report in writing, any incident of actual or suspected child/adult abuse and neglect; any incident of factual or suspected domestic violence or intimate partner violence to the Maldives Police Service and Family Protection Authority, and notification must be sent to Ministry of Gender, Family and Social Services.

Marital rape:

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

[12] United Nations High Commissioner for Refugees. (n.d.) *UNHCR GBV Toolkit.* Retrieved on August 22, 2023 from https://www.unhcr.org/gbvtoolkit/_test/#:~:text=(GBV)%20is%20'an%20umbrella,differences%20between%20males%20and%20females.

[13] World Health Organization. (2006). *World Health Report*.

[14] *Health care professional Act 13/2015.* (2015). http://mmc.gov.mv/ethicals-codes-and-guidelines/health-care-professional-act-132015/

[15] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian setting.*

other sexual activities that are considered by the survivor as degrading, humiliating, painful, and unwanted. Refer to Sexual Offences Act 17/2014 (20) for circumstances not deemed as consensual in the context of marriage.

Perpetrator:

A person, group, or institution that directly or indirectly inflicts, supports, and condones violence or other abuse against a person or a group of persons[16]. Perpetrators are often in a position of real or perceived power, decision making, and/or authority and can thus exert control over their victims.

Rape:

Rape is any non-consensual vaginal, anal or oral penetration of another person with any bodily part or object. This can be by any person known or unknown to the survivor, within marriage and relationships, and during armed conflict.[17]. Efforts to rape someone which do not result in penetration are considered attempted rape.

Shared decision making:

When clinicians and patients make decisions together in partnership, using the best available evidence. In shared decision making, patients are actively encouraged by clinicians, to consider available options and the likely benefits and harms of each, to communicate their preferences, and the patients are supported to select the course of action that best fits the patient as an individual.

Sexual abuse:

Actual or threatened physical intrusion of a sexual nature, including inappropriate touching by force or under unequal or coercive conditions[18].

Sexual exploitation:

Any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another[19]. Sexual exploitation is one of the purposes of human trafficking. The definition of sexual exploitation also includes a coercive, manipulative, or otherwise exploitative pattern, practice,

[16] United Nations. (2017). *Glossary on Sexual Exploitation and Abuse*.
[17] UN Women. (n.d.) *Frequently asked questions: Types of violence against women and girls*. Retrieved August 21, 2023, from https://www.unwomen.org/en/what-we-do/ending-violence-against-women/faqs/types-of-violence#:~:text=Rape%20is%20any%20non%2Dconsensual,relationships%2C%20and%20during%20armed%20conflict.
[18] United Nations. (2017). *Glossary on Sexual Exploitation and Abuse.*
[19] United Nations. (2017). *Glossary on Sexual Exploitation and Abuse.*

or scheme of conduct, which may include sexual contact that can be reasonably construed as being for the purposes of sexual arousal or gratification.

Sexual harassment:

Any unwelcome, usually repeated, and unreciprocated sexual advance; unsolicited sexual attention; demand for sexual access or favors; sexual innuendo or other verbal or physical conduct of a sexual nature; and any unwanted behavior of a sexual nature which makes a person feel humiliated, degraded, or intimidated or violates a person's dignity (e.g., sending pornographic material, sexual comments or jokes to a person's phone or via email) or creates an intimidating, hostile, or offensive environment (e.g. expectations of sexual favors for employment and promotion purposes). Further refer to Sexual Harassment Prevention Act 16/2014 (2).

Sexual Violence:

Acts of a sexual nature against one or more persons or that cause such person or persons to engage in an act of a sexual nature by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, or by taking advantage of a coercive environment or such person's or persons' incapacity to give genuine consent[20]. Sexual violence takes many forms, including rape, forced prostitution, forced pregnancy, forced abortion, sexual exploitation, and sexual abuse. It refers to any act, attempt, or threat of a sexual nature that results, or is likely to result, in physical, psychological, and emotional harm.

Survivor:

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

Routine enquiry:

Generally, referred to routinely asking regarding gender-based violence during a medical consultation. Consideration should be given with routine inquiry that it is appropriate to do so in the current situation and/or whether there are indicators or suspicions of abuse. Additionally, prior to asking about violence, survivors safety and factors such as privacy, confidentiality and maintaining sensitivity while inquiring to

[20] United Nations. (2017). *Glossary on Sexual Exploitation and Abuse.*

prevent further harm must be ensured[21].

Violence against women:

The term violence against women means any act of GBV 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[22].

[21] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*
[22] United Nations. (2017). *Glossary on Sexual Exploitation and Abuse.*

2.2. What Research Tells Us About Gender-Based Violence

GBV is a global pandemic and an estimated one in three women worldwide has been beaten, coerced into sex, or otherwise abused in their lifetime. The global report shows that violence against women is pervasive globally and are summarized in the box[23].

Finding from the global report (WHO, 2013).

- Overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. While there are many other forms of violence that women may be exposed to, this already represents a large proportion of the world's women.
- Most of this violence is intimate partner violence. Worldwide, almost one third (30%) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner. In some regions, 38% of women have experienced intimate partner violence.
- Globally, as many as 38% of all murders of women are committed by intimate partners.
- Globally, 7% of women have been sexually assaulted by someone other than a partner.
- Women who have been physically or sexually abused by their partners report higher rates of significant health problems. For example, they are 16% more likely to have a low-birth-weight baby. They are more than twice as likely to have an abortion, almost twice as likely to experience depression, and, in some regions, are 1.5 times more likely to acquire HIV, as compared to women who have not experienced partner violence.

Violence against women disproportionately affects low and lower-middle-income countries and regions[24]. In countries classified by the Sustainable Development Goals as "least developed", 37% of women aged 15 to 49 have been subject to physical and/or sexual intimate partner violence in their life, in "least developed countries", 22% of women living have been subjected to intimate partner violence in the past 12 months —substantially higher than the world average of 13 %. Although statistics on the prevalence of violence vary, the scale is tremendous, the scope is vast, and the consequences for individuals, families, communities, and countries are devastating.

[23] World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.*
[24] World Health Organization. (2018). *Violence Against Women Prevalence Estimates: Global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women.* Inter-Agency Working Group on Violence Against Women Executive Summary Estimation and Data (VAW-IAWGED).

2.3. GBV Situation in the Maldives

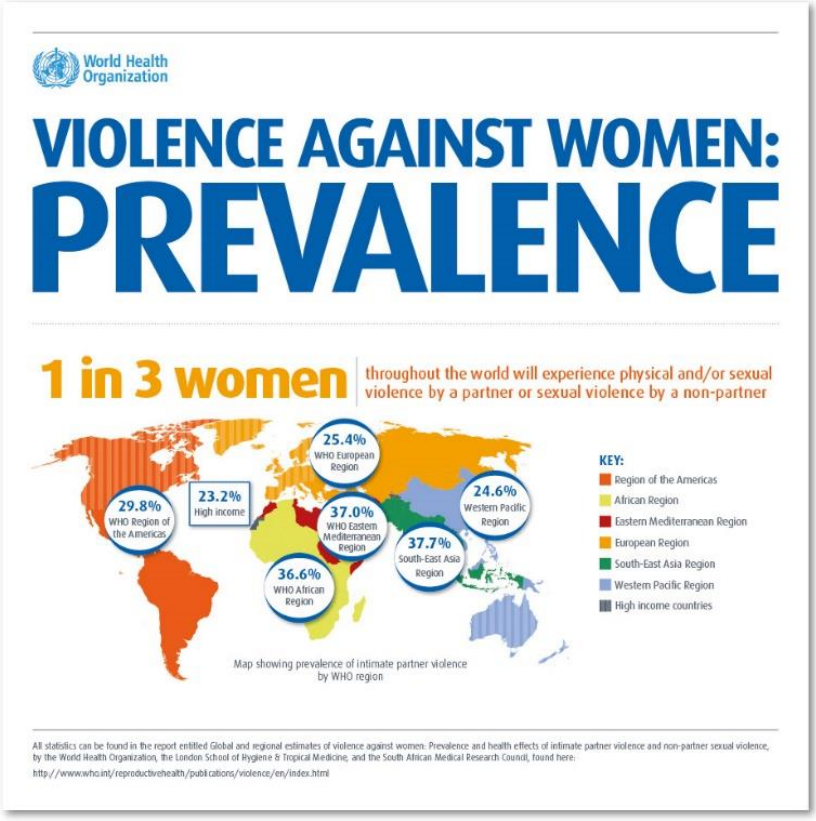


Figure 2. 1 Violence Against Women Prevalence Estimates, 2018 (Published in May 2021), WHO

The Women's Health and Life Experience (WHLE) Study conducted in 2007 provided much needed data on prevalence of GBV in the Maldives at a national level and was instrumental in highlighting the magnitude of the problem. WHLE survey findings served as a launching pad for a response from the state and other concerned organizations. Key findings of WHLE study were:

- Approximately 1 in 5 women aged 15-49 (19.5%), who had ever been in a relationship,reported experiencing physical and/or sexual violence by an intimate partner.
- More than 1 in 4 ever-partnered women aged 15-49 (29.2%) reported experiencing emotional abuse by an intimate partner.
- Reports of intimate partner violence were highest in the central and southern regions and lower in Male' and in the North.

The 2016-17 Maldives Demographic Health Survey (MDHS) data showed that in the decade between 2007 and 2017, the situation had not improved significantly. MDHS identified that 1 in 4 women (24%) aged 15-49 had experienced spousal violence in the 12 months preceding the survey. The key findings from the MDHS were:

- ***Experience of violence:*** Among women age 15-49, 17% have experienced physical violence and 11% have experienced sexual violence. Four percent of women have experienced physical violence during a pregnancy.
- ***Marital control:*** Six percent of ever-married women have experienced at least three types of marital control behaviours by their husbands or partners. Sixty-two percent have never experienced marital control behaviours by their husbands or partners.
- ***Spousal violence:*** Twenty-four percent of ever-married women age 15-49 have experienced physical, sexual, or emotional violence from their current or most recent husband/partner. Nineteen percent of women have experienced emotional violence, 12% have experienced physical violence and 2% have experienced sexual violence from a husband or partner.
- ***Injuries due to spousal violence:*** Forty-one percent of ever-married women who experienced spousal physical or sexual violence reported injuries.
- ***Help seeking:*** Forty-two percent of all women who have ever experienced physical or sexual violence have sought help.

Figure 2. 2 Gender based violence in the Maldives, MDHS 2016-17

Maldivian women experience more sexual violence and more severe physical violence, psychological violence, and more coercive controlling by their spouse or former spouse than by anyone else, as shown in figure 2.2.

As indicated by the statistics shown in figure 2.3., even though the number of cases of males who experience GBV are significantly lower in comparison to females, recognition of such violence, prevention and protection of survivors should not be neglected.

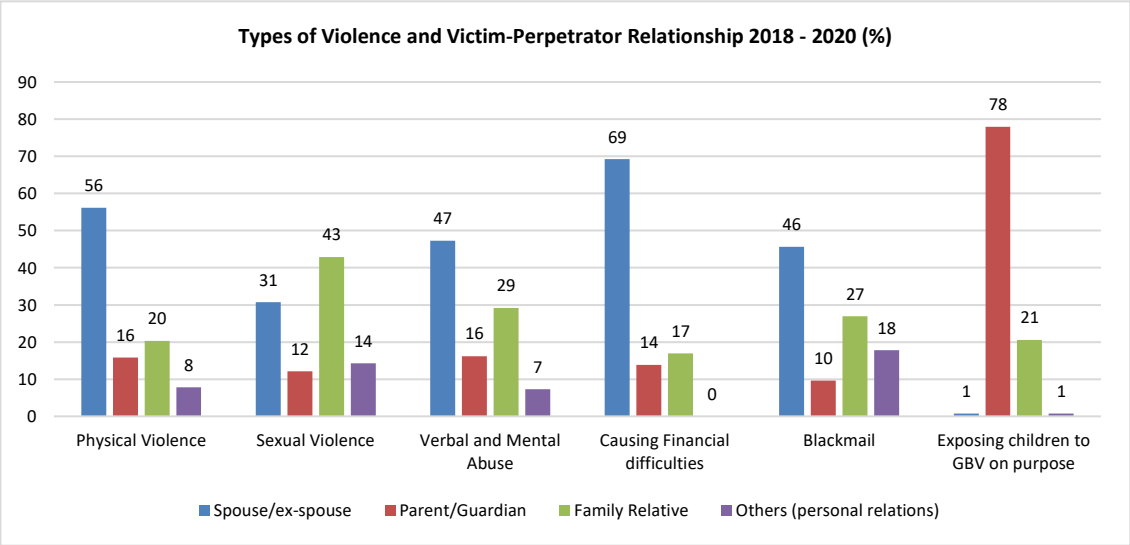


Figure 2. 3 Types of violence by victim-perpetrator relationship (Family Protection Authority-Statistics: 2018-2020)

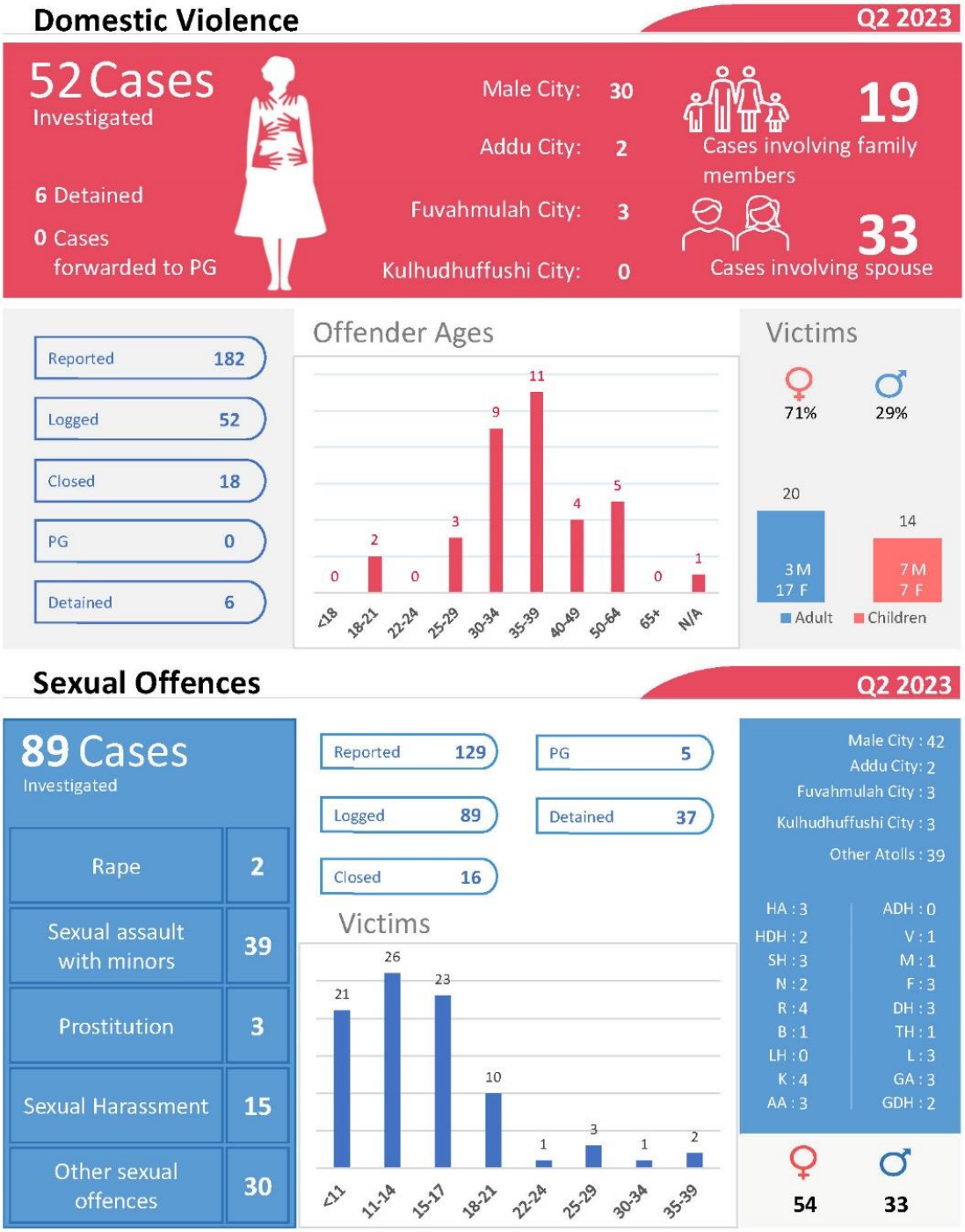


Figure 2. 4 Snapshot of domestic violence and sexual violence analyzed by region, age and gender (Maldives Police Services, second quarter, 2023)

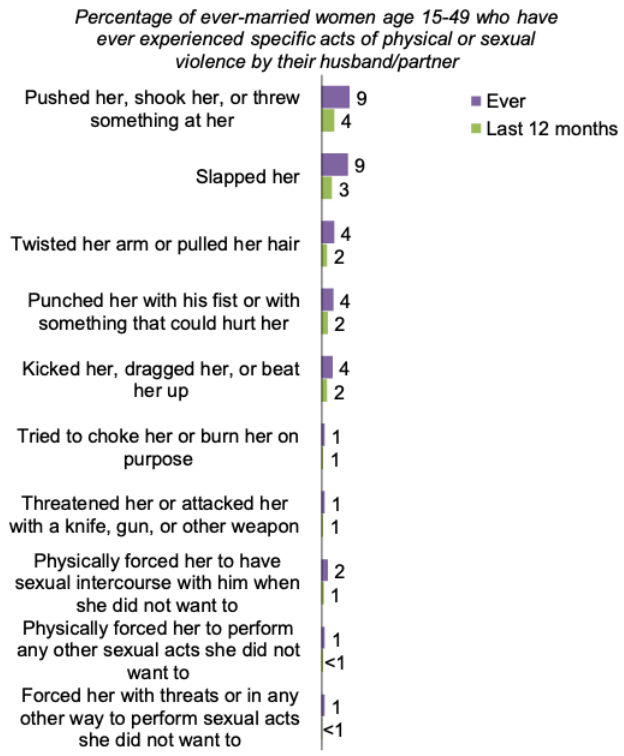


Figure 2. 5 Most common forms of spousal violence, MDHS 2016-17

The MDHS survey showed that women who are divorced, separated, or widowed (45%) and those in the central region (26%) are the most likely to report having ever experienced physical violence. Women in the northern region, and never married women are less likely to have ever experienced violence since age 15 than most other women. These point to geographical differences in attitudes towards women and towards gender-based violence highlighting regions where efforts towards GBV prevention and care need to be enhanced.

Attitudes towards gender equality

The study conducted by HRCM (2020), "*The 'rights' side of life*" presented significant findings regarding attitudes towards equal rights for women where most of the questions regarding attitudes towards equal rights for women yielded a high rate of non-response (more than 80%) in comparison to all the other questions of this survey. This high rate of non-response and inability to provide a definite point of view on gender equality is an extremely significant drawback for women's rights over the years. This indicates that healthcare professionals need to be sensitized to gender equality, gender biases and gender norms since their lives and expectations can replicate societal norms and biases which can have an impact on use of technical guidelines for prevention and response to gender based violence.

Female Circumcision or FGM

The findings of MDHS 2016-17 showed that approximately 1 in 10 women/girls in the Maldives are circumcised. The prevalence of female circumcision increases steeply with age, from 1% among women aged 15-19 to 38% among women aged 45-49[25].

[25] Ministry of Health., & ICF. (2018). *Maldives Demographic and Health Survey 2016-17*. Ministry of Health, ICF.

2.4. GBV and providing Health Care

GBV is a major, but preventable problem affecting the health of individuals, mostly that of women, but also men, children and elderly. The public health approach is a science driven, population based, inter-sectoral approach which is recognized effective and successful in prevention of GBV and support for survivors. The WHO recognizes GBV as an important public health issue. As well as being a direct cause of injury, ill health, and even death; it affects women's long term physical and mental health. The 2013 WHO report on intimate partner and non-partner violence against women identified causal pathways for health effects of intimate partner violence as complex and occurring at multiple layers of ill health[26].

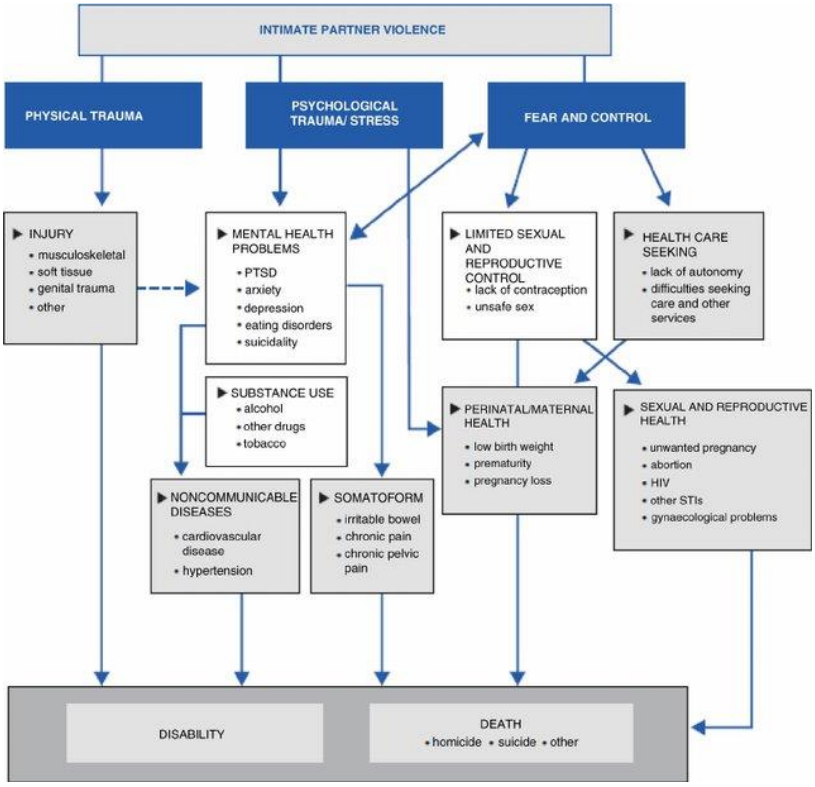


Figure 2. 6 Causal pathways for health effects of intimate partner violence, WHO, 2013

The health sector has a major and undisputable role in responding to survivors of GBV by providing medical, medico-legal, and emotional support in collaboration with law enforcement and social services. Overlooking the physical and mental health implications of GBV is a violation of medical ethics. Health care workers may fail to provide necessary—even life-saving—care, such as post-exposure prophylaxis (PEP) for HIV; emergency contraception; treatment for sexually transmitted infections (STIs); physical, mental health and psychosocial support; unless they act

[26] World Health Organization. (2013). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence.*

proactively to identify risk factors for violence in their patients and enquire for GBV as part of their general interaction and examination of patients[27].

Health care system is unique in that it provides multiple opportunities for women to interact with a healthcare professional at some point in their lives, as when seeking antenatal care, labor and delivery, bringing her child for check-up, or immunization and for personal health issues. Healthcare providers providing maternity care, outpatients' departments, Emergency departments, family planning services, mental health services) have a critical role to play in organizing service delivery that enable a conducive environment for detecting gender-based violence, empathetically listening, caring and referring for relevant services. Appropriate interventions by the Healthcare professionals can mitigate the potential long term and short term negative health and non-health impacts of GBV indirectly too, through prevention of unwanted pregnancies and their associated risks, prevention of unsafe abortions, mental health and suicidal ideation and sexually transmitted diseases including HIV/AIDS[28].

2.5. Who experiences gender-based violence?

Survivors of GBV, mostly women and girls, and a fewer number of men and boys, come from all strata of society. Although association with some risk factors has been recorded, it must not be erroneously considered as GBV being limited to "at risk" groups such as women with learning disabilities, substance abusers, the elderly, and domestic workers.

2.6. Who is a perpetrator?

Perpetrators of GBV are mostly indicated as men, and a much lesser number as women, and they come from all strata of society and often are known to the survivor. Especially in child abuse cases, perpetrators often have a "protective" role assumed of them such as with children's school teachers, home tutors, stepfathers, and relatives who are looked upon as

Perpetrators of GBV comes from every age group, religion, ethnic/racial group, socioeconomic level, educational background and sexual orientation.

[27] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*
[28] Terry, G. (Ed.). (2007). *Gender-Based Violence*. Oxfam.

custodians of children.

- Sometimes healthcare providers can be misled because the perpetrator does not "look like" a vicious or a cruel person (For example, the perpetrator may be elderly, upper class, charming, in a position of authority, or a professional).
- The one defining similarity among all perpetrators is their use of tactics of control, but not their demographic or other characteristics.
- Both men and women may perpetrate violence. In heterosexual relationships it is often the male, although the women can also be the perpetrator. In same sex relationships it could be either gender.
- Irrespective of who is doing it to whom, healthcare professionals need to address gender-based violence as a serious health issue.
- If the perpetrator accompanies the survivor, or the perpetrator is someone working in the health system, or a member of the immediate family, the HP may hear denying, minimizing, lying or self-blaming by the survivor.
- There is strong evidence that crime levels and conflict in society more generally are not only correlated, but causally linked with higher levels of violence against women.

2.7. What are the Health Impacts of GBV?

WHO research suggests that health consequences are spread over a wide a range and of a greater magnitude than commonly perceived by the healthcare providers, healthcare professionals, or the public. Figure 2.7. illustrates this.

Figure 2. 7 Violence against women: Health impact, WHO, 2013

Although we recognize health consequences as different entities it should be noted that a survivor often suffers multiple negative health consequence from a single act of violence or from multiple acts of the same type of violence within a single relationship. Identification of complex trauma experienced by poly-victimization (experience of seven or more types of violence) may need expert training, guidance, and trauma specific referrals. Health consequences of GBV could cover a wide range and is given in Table 2.1.

Table 2. 1 Health consequences of gender-based violence, UNFPA 2010

Physical Consequences	Psychological/behavioral consequences	Sexual and reproductive consequences	Fatal Health Consequences
Abdominal/thoracic injuries	Alcohol and drug abuse	Gynecological disorders	AIDS-related mortality
Bruises and welts	Depression and anxiety	Pregnancy complications	Maternal mortality
Lacerations and abrasions	Eating and sleep disorders	Miscarriage/low birth weight	Homicide
Fractures and breaks	Feelings of shame and guilt	Pelvic inflammatory disease	Suicide
Eye injuries	Phobias and panic disorders	Sexual dysfunction	
Rupture of the eardrum	Physical inactivity	STIs, including HIV/AIDS	
Burns	Poor self-esteem	Unsafe abortion	
Chronic pain syndromes	Post-traumatic stress disorder (PTSD)	Unwanted pregnancy	
Disability	Psychosomatic disorders		
Gastrointestinal disorders	Smoking		
Fibromyalgia	Suicidal behavior and self-harm		
Reduced physical functioning	Unsafe sexual behavior		

GBV can have long-lasting and negative health, social and economic consequences that span generations, often leading to cycles of violence and abuse within families and sometimes within communities. At an individual level, violence occurring in childhood and younger years, impacts particularly on the mental health that may affect that individual and their family for the rest of their

lives. This can lead to negative consequences in many spheres of life such as unsafe sexual practices, increased uptake of health –risk behaviors such as use of alcohol and illicit drugs, and perpetration of intimate and sexual violence.

2.7.1. Health risk behaviors associated with child abuse

Childhood abuse and witnessing domestic violence in both females and males is known to be associated with increased health risks and health risk behaviors. Some of the known effects include[29].

Table 2. 2 Effects of childhood sexual abuse and witnessing DV (males and females)

Stuttering	Sleep disruption	School problems, school dropout
Being terrified	Aggressive behavior toward others	Delinquency
Running away from home episodes	Suicidal ideation, self-harm	Alcohol/drug experimentation
Continuation of violence in adult relationships	Expansion of violence in the community	

2.7.2. Health risk behaviors associated with adults

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

Table 2. 3 Health problems associated with adult survivors of GBV

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

[29] World Health Organization. (2002). *World report on violence and health.*

2.8. GBV during pregnancy

The proportion of women in the WHO Multi country Study[30] reporting physical violence during at least one pregnancy varied markedly among countries and fell between 4% and 12%. These rates were not parallel to the overall rates of GBV indicating that the cultural values towards pregnancy within a particular community has an influence on the prevalence of GBV in pregnancy and in some communities, violence during pregnancy may be less accepted than in others.

The WHLE study in Maldives showed that among women who had ever been pregnant, 6.3% reported being beaten during pregnancy. Of those who reported being beaten, 39% had been punched or kicked in the abdomen. In most cases, women who were physically abused during pregnancy had been beaten prior to getting pregnant; however, a significant number (38.3%) reported that the beating had started during pregnancy[31].

Adverse outcomes of pregnancy are related to:

- Direct effect of battering
- Late entry to antenatal care
- Frequently repeated pregnancies,
- Lack of social support
- Tendency to follow risky behaviors and substance abuse
- Depressive symptoms influencing the mother's perceptions, tolerance and the responses to onset of symptoms which in turn may potentially affect her health seeking behavior

Recorded complications attributable to domestic violence during pregnancy include:

- Abortions, both spontaneous and unsafely induced
- Higher incidence of preterm labor, increased rates for severely abused women
- Abruption of the placenta and ante partum haemorrhage
- Pregnancy psychosis and depression. A prospective cohort study on post-partum depression found that, of the 16% of women who had depressive

[30] World Health Organization. (2005). *WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses*.
[31] Ministry of Gender and Family., & Fulu, E. (2007). *The Maldives study on women's health and life experiences: Initial results on prevalence, health outcomes and women's responses to violence*. Ministry of Gender and Family, UNFPA.

symptoms, 40% had experienced domestic violence[32]

- Low birth weight babies
- Intra uterine deaths
- Failure of breast feeding

2.9. What are the barriers to seeking help?

To provide health care for survivors of gender-based violence, it is important to understand the reasons why people stay in abusive relationships, why they may not seek help or respond to offers of help. Some of the barriers are practical while others are psychological, emotional, and cultural barriers. Some of the survivors may not realize they are in a violent relationship. Some behaviors survivors of violence may exhibit are given in table 2.4.

Table 2. 4 Behaviors of GBV survivors

Often fearful of the partner
Often not allowed to gain access to family, friends or get assistance
Often experience reduced freedom and/or when they exercise autonomy, there are abusive consequences
Often feel guilty or think that they are to blame for their partner's violence
Can often articulate what precipitated specific incidents or the progression of violence if the survivor is given time and the health professional is patient and demonstrates empathetic listening and care

It is a fact that most survivors want the violence to end, but not the relationship. Unfortunately, this does not materialize most of the time and the violence continues. The commonly mentioned reasons for not leaving an abusive relationship are given in table 2.5.

Table 2. 5 Reasons for not leaving an abusive relationship

Fear of further violence for self or the children, and fear of being judged and of not being believed
Lack of safe housing options including shelters for short term stay, and long-term family housing

[32] Woolhouse, H., Gartland, D., Hegarty, K., Donath, S., & Brown, S. J. (2011). Depressive symptoms and intimate partner violence in the 12 months after childbirth: A prospective pregnancy cohort study. *British Journal of Obstetrics and Gynaecology*. *119*(13), doi:10.1111/j.1471-528.2011.03219.x.

Lack of continuous and sustained family or community social, emotional, and financial support
Concern about the future welfare of the children and fear of losing contact with the children, relatives, and friends
Social stigma attached to a single parent or separated woman
Lack of economic empowerment andbeing dependent on the perpetrator
Continued love, loyalty or emotional attachment towards the perpetrator and the hope that the abuser will change
Perceived cultural and religious beliefs and expectations
Perceiving violence to being resolved with time, without any external interventions
Lack of experience or knowledge of positive action from statutory agencies

Organizational and institutional barriers for prevention of gender-based violence are often entrenched in social and cultural beliefs and expectations that promote women's subservience and obedience to men, hence, are difficult to be overcome. Despite comprehensive legal protection and policy initiatives, gender-based violence continues to be a destructive force, that damages, families, communities, and the society across generations.

PART 2

LEGAL FRAMEWORK AND HEALTH POLICIES

WHAT ARE THE LEGAL OBLIGATIONS AND POLICY EXPECTATIONS?

3.1 Legislation addressing GBV

Health Care Practitioners in the Maldives are in a position of privilege, to understand legislation for protection of their clients against GBV, to inform and empower the clients and the community of their legal rights to access services, to attract resources for primary prevention and to bring about societal change to end violence against women and girls. Following section highlights significant progress in Maldivian legislation which health practitioners can use to identify potential abuse, to enable and encourage disclosure, make assessments, and plan for interventions for their clients.

Constitution of the Republic of Maldives 2008: Article 21, under Right to Life, states that: "Everyone has the right to life, liberty and security of the person, and the right not be deprived thereof to any extent except pursuant to a law made in accordance with Article 16 of this Constitution". Article 35, under the 'Provision; Special protection to children, young, elderly and disadvantaged people', the Constitution of Maldives states that, "(a) Children and young people are entitled to special protection and special assistance from the family, the community and the State. Children and young people shall not be harmed, sexually abused, or discriminated against in any manner and shall be free from unsuited social and economic exploitation. No person shall obtain undue benefit from their labor. (b) Elderly and disadvantaged persons are entitled to protection and special assistance from the family, the community and the State".

Domestic Violence Act 3/2012: Identifies responsibilities of health services on reporting of violence. Section 8. on reporting mentions that "Cases of alleged domestic violence pursuant to Section 8 a) may be reported by any of the following persons: Employee of a health or social service provider ..." Section 9. on health care mentions that "A duty of care is hereby established on health professionals and social workers to report suspected cases of domestic violence to the Police or the Authority in order to protect the victim(s). Health professionals and social workers shall further provide full support during the investigative and court stages of such cases of domestic violence, in such a manner that it does not compromise the welfare of the victim but ensures protection of the interests

of the victim.[33]"

Under this Act "domestic violence refers to commission of any act described as an act of violence under this Act, by the perpetrator against the survivor, provided such persons are bound by a domestic relationship". Part 3 (Definitions) – Section 4a of Domestic Violence Act identifies 17 actions that can be considered as acts of domestic violence.

Table 3. 1 Types of abuse listed in the Domestic Violence Prevention Act (3/2012)

Physical abuse	Harassment
Sexual abuse	Stalking
Verbal and psychological abuse	Damage to property
Economic or financial abuse	Intimidation
Impregnating the spouse, without concern to her health condition and against any medical advice to refrain from impregnation for a specified period of time	Coercing, intimidating, or forcing the victim to commit an act which such person would not have consented to or committed by their own volition
Impregnating a woman, who is trying to remove herself from a harmful marriage, against her will	Confining the victim to a place or restricting their movement against their will
Deliberately withholding the property of a person	Attempting to commit any of the foregoing acts or causing apprehension of such acts; or
Any other act which may be described as controlling or abusive behavior towards the victim	Causing a minor to witness or hear an act of domestic violence or presenting or placing a minor in such situation where such minor may witness or hear an act of domestic violence

Section 12 of the Domestic Violence Act states that "A health professional that that has been notified by the Police that an act of domestic violence may have been committed on a victim or who for any other reason otherwise suspects the same must carry-out the following;

(a) Examine the suspected victim to the highest possible degree.

(b) Advise the victim of support options available.

(c) Assist the victim in seeking psychiatric or counseling support.

(d) In situations where the health professional suspects, during examination, that an act of domestic violence involving physical abuse or sexual abuse is likely to be committed on a

[33] *Domestic Violence Act 3/2012.* Unofficial translation. https://maldives.unfpa.org/sites/default/files/pub-pdf/the_domestic_violence_act_2012_maldives_english_translation_unofficial.pdf

victim, then the health professional must carry out the following.

1. Examine the suspected victim to the highest possible degree.
2. Prepare a written report based on the examination of the victim.
3. Submit the report prepared under Section 12(d)(2) to the Police and Authority

Gender Equality Act 18/2016: Article 18 stipulates the health sector to evaluate the degree of participation of each gender in health services and take appropriate steps to balance such participation, to eliminate weakness or difficulty caused by inequality between men and women and to take appropriate steps to facilitate the special needs of a particular gender to achieve ease of attainment of services.

Penal code (Chapter 130 Sexual Assault Offenses) **Section 134** - General Provisions Relating to Sexual Assault Offenses makes exemption for Health professionals; (c) Exception for Medical Treatment. A physician or other licensed medical professional or a parent, stepmother or stepfather or legal guardian does not commit an offense under this Chapter if his conduct constitutes only a medical examination or procedure: (1) for the purpose of providing medical care, (2) in a manner consistent with accepted medical standards, and (3) for which he has the level of training and expertise required to perform such medical examination or procedure. **Section 416 – Abortion** (b) Exception for Mother at Risk. A person does not commit the offense in Subsection (a) if (1) such person (A) the mother, or (B) a licensed medical professional; and (2) a licensed medical professional has determined that the pregnancy is putting the mother's life at risk. (c) Exception for attempting to prevent pregnancy. Prevention of pregnancy by medically obstructing means of pregnancy or prescribing an oral contraception or any other substance that works prior to being pregnant or at the time or afterwards, is not an offence under subsection (a) of this Section. (d) Exception for Pregnancy Resulting from Sexual Assault or Incest. It is not an offense under Subsection (a) to terminate a pregnancy if the pregnancy is the result of (a) sexual assault, as defined by Section 130, or (2) incest, as defined by Section 413.[34]

Disability Act 8/2010: Protection of the Rights of Persons with Disabilities and Provision of Financial Assistance, Section 21, states the responsibilities of Health sector in providing easy and non-discriminatory services and section 22(a) states that inclusive of health care service providers and professionals to be cautious and recognize the possibility of discrimination, harassment and harm

[34] *Penal Code 6/2014.* Chapter 130. Sexual Assault offenses. https://www.law.upenn.edu/live/files/4203-maldives-penal-code-2014

PWD's maybe subjected from family, caretakers, institutions etc.[35]

Sexual Harassment Prevention Act 16/2014: Under this Act, (a) Health sector, inclusive of practitioners and healthcare providers to address and prevent the sexual abuse and harassment within the employees and in service provisions, where every place of employment shall openly display their policy on sexual harassment where the employees and others who obtain their services can see and indicate that sexual harassment is prohibited by law and that measures will be taken against persons who commit such acts. (b) Workplaces shall make arrangements to make publicly available and accessible; complaints of sexual harassment, forms for submission of complaints, the procedure to be followed, and the Prevention of Sexual Abuse and Harassment Act 5 measures that will be taken against such acts. (c) All places of employment shall brief their employees, clearly, on their respective Sexual Harassment Policy. Similarly, institutions shall openly display their policy on sexual harassment where those who obtain their services, and if the institution is a shelter for children and other persons, where the children and other persons can see and indicate that sexual harassment is prohibited by law and that measures will be taken against persons who commit such acts[36].

Social Protection Act 2/2014: Mandates relevant state institutions to provide assistance on mental health support and any other emergency support required by the vulnerable groups[37]

The Child Right Protection Act 19/2019: Gives power to authorities to undertake rapid assessments of reported cases where the child may be in imminent danger and mandates all the concerned institutions in the investigation process to coordinate and support each other to protect the best interest of the child. Chapter 22, clause 124-126, clearly describes that non-reporting of violence against children is a crime punishable by three years in prison. Institutional failure for a rapid response in GBV cases where children may witness or experience abuse or neglect, can be reported to the Children's Ombudsperson (Chapter 21, clause 115).

Sexual Offences Act 17/2014: Provides for the protection of children and adults from all forms of sexual violence and includes an aspect to prevent rape within marriage.

[35] *Disability Act 8/2010*. https://www.mvlaw.gov.mv/pdf/ganoon/chapterII/8-2010.pdf
[36] *Sexual Harassment Prevention Act 16/2014.* http://gender.gov.mv/en/wp-content/uploads/sites/1/2018/08/17-2014-jinsee-kushuge-qaanoonu.pdf
[37] *Social Protection Act 2/2014.* http://gender.gov.mv/en/wp-content/uploads/sites/1/2018/08/2-2014-ijthimaaee-rakkaatherikamuge-qaanoonu.pdf

Health Service Act 29/2015: Clearly states not to discriminate in service provision based on sex, birth country, birth island, family, political affiliation, ethnicity, disability or income level (Article 48), maintain confidentiality of patient information (Article 40), obtaining consent of patient (Article 30) and informing the patient of services available to them (Article 29) and recording of detailed medical information of patients and maintaining confidentiality of medical records (Article 39). Article 31, allows for provision of medical services without consent, when the patient's health state is unfit for provision of a consent and the legal guardian is not assigned, or non-provision of medical care will result in loss of life or irreversible damage, provided the standards and procedures for provision of services and record keeping for such instances are laid down and pre-published (Article 31(a) and (b)).

Healthcare Professional Act 13/2015: Article 27 General standards at workplaces for Healthcare professionals as states that persons working in the health care profession, both in their work environment, and in providing care to the citizens, shall adopt the following.

(a) Provide care with honesty, faithfulness, and care.
(b) Provide care in a manner that does not cause intentional or negligent harm.
(c) Provide care without discrimination towards race, nationality, ethnicity, sex, age, mental or physical disability, political or other personal opinions, financial condition, social origin, or other status of the recipient.
(d) Maintain the confidentiality of information received during the course of work.
(e) Respect the religious, political, social, and cultural beliefs and actions of the recipient, and act in a reasonable manner not contradicting such beliefs and activities.
(f) Make professional decisions in a manner that portrays the profession as reliable and trustworthy.
(g) Provide care and service that focus on the needs of the person.
(h) Ensure that the work environment is safe for recipient of the service and to sustain such safe working environment.
(i) Conduct self in a way that upholds professional and ethical standards and the rights of the recipient.
(j) Provide information and spread awareness of the recipient and their family in order for them to lead a content, healthy lifestyle.

(k) Participate in activities that promote the standards of the health care profession.

(l) During the provision of healthcare, be transparent and proactive in providing information about regulations and guidelines of which the service user should be aware.

In addition to these general guidelines, Maldives Medical and Dental Council, Maldives Nursing Council and Maldives Allied Health Council lay out specific codes of conduct and good practice for the respective health professionals that reinforce accountability, privacy and confidentiality by informing patients of available services, maintenance of privacy and confidentially and obtaining informed consent prior to patient examination and procedures.

In the 6th State report to CEDAW Committee in 2019, the Government of Maldives expressed its commitment for enhancing emergency and support care service and protocols to survivors of domestic violence (both adult and children) within health and other related environments; in partnership with Ministry of Health and significantly strengthen partnerships with a diverse range of stakeholders, including Island Councils who are an important first line of defense across the islands[38].

Health care practitioners can play an advocacy role to inform the public of existing laws and to bring about systemic changes, such as creation of new laws, and amendment of existing laws. They can proactively contribute to and influence the way governments and decision makers develop policies and programs, to ensure a gender perspective is incorporated in all phases of service provision. High-level policy commitment to GBV as a public health issue is necessary to ensure an institutional and sustainable response.

Health Master Plan (2016-2025) specifies strategic actions to develop health service capacity and mechanisms to support national efforts to address gender-based violence.[39]

The Maldives National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan (2020-2025)[40], aims to increase awareness, detection and reporting of GBV and DV in the health sector (objective 6.1) and increase awareness that female circumcision/FGM is a harmful practice and a human rights violation (objective 6.2).

[38] Convention on the Elimination of All Forms of Discrimination against Women. (2019). *Sixth periodic report submitted by Maldives under article 18 of the Convention, due in 2019**. United Nations.
[39] Ministry of Health. (n.d.). *Health Master Plan 2016-2025.*
[40] Ministry of Health. (n.d.). *Maldives National Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy and Action Plan (2020-2025).*

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

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

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

3.2.1. Minimum services

Minimum services that need to be available are described according to these levels of care as given in Table 3.2.

Table 3. 2 Minimum services that should be available at different levels of health institutions

	Primary care and only Outpatient centers (e.g. Health centers/ private medical clinics)	Secondary care hospitals/ Specialized centers (e.g. Atoll level and private general hospitals)	Secondary and limited Tertiary care (e.g. Regional level)	Tertiary hospitals (Public and private)
1. Programming and Training of Service Providers				
Institution/health facilities to plan and schedule orientation and training for all staff at the facility on health sector response to GBV including safeguarding, reporting and referral and related patient care and patient health rights	**x**	**x**	**x**	**x**
Provide coordinated support, training, and guidance to other health facilities		**x**	**x**	**x**
Work collaboratively with other health facilities to ensure quality practice across the whole health system	**x**	**x**	**x**	**x**
Ensure the health facility has a hard/soft copy of health sector response to GBV guideline accessible to all staff room with highlighted web link to the guideline.	**x**	**x**	**x**	**x**

Ensure regular sharing of good practice within the institution, in staff meetings, in in-house training courses and through specialist training elsewhere, thus providing motivation	**x**	**x**	**x**	**x**
Plan for and conduct annual reviews/evaluations on implementation of health sector response to GBV and effectiveness at facility level	**x**	**x**	**x**	**x**
2. Enabling environment				
Provide within the health facility, if possible, a disability accessible, comfortable space, with external access, a toilet with shower	**x**	**x**	**x**	**x**
Ensure a warm, non-judgmental, respectful, sympathetic welcome is provided to survivors and those accompanying them (encourage to bring a supportive family member or friend whenever possible)	**x**	**x**	**x**	**x**
3. Medical services				
Develop a positive professional relationship with the survivor	**x**	**x**	**x**	**x**
Establish a good rapport with the survivor & ensure the survivor feels safe	**x**	**x**	**x**	**x**
Assess for emergency care for physical injuries, mental state, reduce anxiety, and make the survivor comfortable	**x**	**x**	**x**	**x**
Provide empathetic listening, natural eye contact and sitting at same level as the survivor	**x**	**x**	**x**	**x**
Obtain informed consent from the patient prior to any physical examination, procedure, or treatment	**x**	**x**	**x**	**x**
Explain to the survivor before each step of the examination, procedure, or treatment	**x**	**x**	**x**	**x**
Explain all services available to the survivor including PEP and emergency contraception	**x**	**x**	**x**	**x**
Take history & basic clinical examination	**x**	**x**	**x**	**x**
Conduct relevant examination and referral if needed	**x**	**x**	**x**	**x**
Conduct specialized examination and in-depth investigations	**x***	**x**	**x**	**x**
Take sample for DNA examination to		**x**	**x**	**x**

send to Forensic Services at Polices				
Manage minor injuries including minor surgical procedures	x	x	x	x
Facilitate to provide Emergency Contraceptive for sexual assault	x	x	x	x
Provide tetanus prophylaxis	x	x	x	x
Provide STI Prophylaxis	x	x	x	x
Provide HIV Prophylaxis (PEP)	x	x	x	x
Manage possible major injuries including surgical interventions		x	x	x
Arrange follow up appointment	x	x	x	x
Review progress with survivor	x	x	x	x
Referral to higher level health care institution (if needed)	x	x	x	x
4. Completing medico-legal evidence and documentation				
Document history and examination in a timely manner	x	x	x	x
Collect samples for laboratory examinations including necessary forensic samples	x	x	x	x
Complete medico-legal forms and submit to relevant authorities	x	x	x	x
Keep a record of all documentation for medico-legal perspective	x	x	x	x
Provide medical expert opinion in legal cases upon request.	x	x	x	x
Report to relevant authorities immediately as per their requirements (FPA, Gender, Police)	x	x	x	x
5. Provide/ arrange for psychosocial support				
Provide basic counselling (psychosocial first aid)	x	x	x	x
Provide or prefer to higher level centers for psychosocial mental health care	x	x	x	x
Arrange for trauma, and HIV counselling	x	x	x	x
Arrange referral for social services and other community services	x	x	x	x

* *some specialized services are available*

3.2.2. Minimum standards

Minimum standards for providing medical care would include:

Location, Furniture, and Setting

GBV services should be integrated into all healthcare points of entry including emergency departments and outpatient and inpatient departments in hospitals and clinics. Especially when providing services related to sexual and reproductive and child health/family planning, sexually transmitted infections, HIV, genito-urinary medicine, pediatric and maternity care, physiotherapy and injury, and mental health services.

- Written guideline or a protocol must be available.
- GBV services should be provided in private, easily accessible and disability accessible rooms (preferably with external access) with access to toilets.
- In a small facility or where there is inadequate space, healthcare providers shall ensure privacy and confidentiality.
- The examination room should have chair(s)/sofa, curtains, an examination table, sufficient light preferably fixed (a torch may be threatening for children), infection protection equipment and supplies for collecting specimens, magnifying glass and a weighing scale for children.
- Basic resuscitation facilities must be available, and referral must be made when needed.
- In all facilities, there should be at least a designated area for clinicians, nurses and counselors to meet, depending on the availability of space.
    - Whenever possible, there should be separate child-friendly rooms with toys, drawing materials, colorful walls,and posters.
    - Printed forms for medico-legal documentation must be easily accessible, and provision must be made for secure storage of completed forms and other forensic evidence.

Skilled healthcare professionals

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

Over and above that, selected healthcare providers from each facility who are providing medico-legal services should receive adequate training on engaging survivors, collecting forensic evidence, documenting and reporting on survivors and perpetrators, and dealing with survivors with challenging and complex needs such as suicidal/homicidal survivor, angry/aggressive survivor, drug or alcohol abusing survivor, and mentally disturbed survivors.

If a chaperone is not available in the facility when the survivor presents at the health facility, in GBV cases, this support needs to be provided by the relevant government authority e.g., Ministry of Gender, Family and Social Services or the Maldives Police Services whenever available and appropriate.

Medical supplies

1. All health facilities must have the supplies necessary to provide the minimum standard of care for GBV survivors, which includes but not limited to; post-exposure prophylaxis (PEP); and emergency contraception, supplies and equipment for preventing and controlling infection including antiseptics and antibiotics, sterile stitches and dressing trays, sanitary napkins, pregnancy test kits.
2. Facilitate extra clothes for survivors whose clothes may be taken for evidence and/or sanitary supplies.
3. Minimum recommended items for collecting forensic evidence should be available in a pre-prepared kit.
    a. syringe, speculum, proctoscope, high vaginal swab, sterile swabs, scissor, sterile sample collection bottle for blood and urine, comb for collecting foreign matter from pubic hair, sterile gloves, magnifying glass, different sizes of zip lock bags, plastic fingernail scraper.

Medications

- Treatment for STIs
- Post Exposure Prophylaxis (PEP)
- Emergency contraception (EC)
- Tetanus Toxoid (TT)
- Analgesics
- Anxiolytics
- Sedatives
- Local anesthesia for suturing
- Antibiotics

3.2.3. Medico-legal services

Different levels of health institutions should provide the services as described in Table 3.2.

3.2.3.1 Roles and responsibilities for provision of medical services

1. **Nurse**
    a. Receive the survivor warmly in a dignified manner and arrange for appropriate care
    b. Provide initial listening and basic counseling while ensuring confidentiality
    c. Deliver the prophylaxis and other preventive medical interventions prescribed by the doctor
    d. Record and complete documentation of the services provided
    e. Assist in filling medico-legal record (MLR) and other reporting documents and ensure adherence to national reporting requirements

2. **Doctor** (Medical officer or where concerned specialists are available the case shall be handled by specialist)
    a. Explain the consultation process and available services
    b. Obtain informed consent
    c. Take history
    d. Conduct physical examination including vaginal and rectal examinations when indicated
    e. Mental state examinations (if skilled); if not refer to a higher level of care
    f. Request for investigations and collect relevant samples as indicated, depending on

nature of GBV

g. Manage minor and major physical injuries, including complicated conditions and major operative procedures (depending on the availability of specialists) if not refer
h. Provide GBV survivors with time-sensitive PEP and emergency contraception (of sexual assault) and TT
i. Provide STI, HIV prophylaxis if indicated
j. Identify and attend to anxiety and psychological trauma as needed (according to the competency of the Healthcare Provider) and/or refer to a center with mental health services
k. Accurately and promptly, document the findings from history (whenever necessary use quotes of direct speech of the survivor) and clinical examination and treatment given.
l. Complete MLR form with the provided annexes and ensure adherence to national reporting requirements
m. Refer the case to a higher center where indicated

3. **Laboratory technician, radiologist, pathologist** *(where available or refer if indicated)*
   a. Perform the tests requested by the specialist/medical officer and perform analyses of tests done and provide a report.

4. **Healthcare provider trained in this area, Counselor, Psychologist or Psychiatrist** (where available)
   a. Provide emotional support and psychosocial care for the survivor and if needed for the perpetrator.
   b. The service providers will:
      i. establish good interpersonal relations with GBV survivors and treat them respectfully and in a culturally appropriate manner based on guiding principles
      ii. provide survivors with:
      i. individual counseling based on their needs
      ii. post-traumatic counseling (if skilled)
      iii. HIV pre- and post-test counseling (if skilled)

iv. adherence counseling

v. any other related services as prescribed by the attending doctor

c. Refer the case to a higher center where indicated

5. Health facility managers

a. Plan and facilitate:

i. Orientation of all staff to this guideline for Health Care Practitioners on prevention and response to gender-based violence, and on national reporting requirements and protocols

ii. Provision of an easily accessible and safe space for survivors, while waiting for services

iii. Procurement of medical equipment and medication necessary for providing health care for survivors, and assist survivors in a timely manner

iv. Coordination with Ministry of Gender, Family and Social Services (if in the atolls, Family and Children's Services Centers (FCSCs)); Maldives Police Services; Family Protection Authority (FPA); island council; and any relevant agency

v. Ensuring documentation and reporting to the relevant authorities are completed (Ministry of Gender, Family and Social Services - if in an atoll Family and Children's Services Centers, Maldives Police Services and Family Protection Authority as per the legal requirements of the Domestic Violence Prevention Act 3/2012 and follow relevant government guidelines for reporting.

vi. Ensuring that monthly and yearly records of MLR forms filled are maintained at the facility for reporting and audits. Refer to section 6.2. Documentation and Data Management, for more information.

3.2.3.2 Roles and Responsibilities for facilitating Forensic (medico-legal) services

Healthcare providers (including medical specialist, medical officer, nurse, community health officer, and laboratory technician, if applicable) should assist the police in collecting the required samples for forensic investigations.

a. Ensure availability of items necessary to collect forensic evidence
b. Collect and document findings from the forensic-related investigations
c. Document findings related to forensic evidence from history and physical examinations in the MLR
d. Complete the MLR and any other forensic-related documents
e. Serve as an expert/factual witness in court, if summoned by a magistrate or judge

If a medical doctor is not in attendance in that facility, then other healthcare professionals must facilitate for sample collection and refer according to the level of facility and type of GBV case.

PART 3

GUIDING PRINCIPLES

GUIDING PRINCIPLES: HUMAN RIGHTS AND ETHICS RELEVANT TO GBV CARE

In addressing GBV, in the health system, the healthcare provider may have to interact and intervene with three individuals with three different interests and mindsets: the survivor, her/his children, and the perpetrator.

In this difficult exercise, the healthcare provider must ensure the safety of the survivor, his/her children, as well as that of the safety of the Health Practitioner. Therefore, special attention needs to be given to some aspects of ethical and moral issues, in addition to the clinical aspects of care. Additionally, unlike most of the clinical conditions seen in the routine health care provision, GBV care entails other dimensions such as societal attitudes, safety issues for the survivor, and her children; assurance of care, safety and legal support for the health practitioner; perpetrator's health and socio-economic needs, negative pressure and influence of perpetrator, his family and friends; and the legal expectations on the care provider, as well as the attitudes and the past experiences of the care providers themselves.

The following guiding principles need to be adhered to in managing cases of gender-based violence presented to health care services.

4.1. Guiding Principles

4.1.1. Confidentiality and privacy

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

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

The child's views and opinions should be heard and discussed together with the parent/guardian.

Disclosure of medical information (such as medico-legal record form and other health information) by the healthcare provider and healthcare professional may be allowed in the following situations, but after informing the survivor.

- Other treatment providers involved in the care of the survivor
- Healthcare service payers (medical insurance agencies), only to the extent necessary to cover the cost of treatment
- Officials of the court of law/justice
- Officials investigating the case
- A person requested by the survivor (or legal guardian in case of children under 18 years). However, even if requested by the survivor, medical information shall not be provided by the healthcare professional or healthcare provider to media or to any other third party, without seeking legal advice)

It is imperative to recognize the importance of maintaining confidentiality at all points of care provision pathway from the point of entry at the reception to the point of exit from the health facility. This is as important as maintaining documents and records. It is advisable to maintain a filing system under lock and key identified by a number only, with a master list of care receivers (logbook) kept by one person, the officer in charge[41].

If any reports or statistics are to be made public, all potentially identifying information should be removed and only aggregate numbers and data made public. Such statistical reports need to be communicated with the relevant department/division of Ministry of Health and endorsed before disclosure to media or public. These records will be maintained by the health facility and quarterly statistical data must be shared with the relevant department/divisions of Ministry of Health.

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

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

[41] Family health bureau Ministry of Health Sri Lanka. (2012). *Gender –based Violence information booklet for health care providers.*

4.1.2. Safety

All actions taken on behalf of a survivor needs to protect the right to a life free from fear and violence and should be aimed at restoring or maintaining safety. The facility should have a room with a door that could be closed and locked to discuss issues with the survivor in confidence and safely[42]. Supportive services must be given by Ministry of Gender, Family and Social Services or Family and Children Services Centre (FCSC).

Additionally, health service providers and professionals must ensure privacy when survivors are being asked about GBV. It could be explained to the partner or the person accompanying the survivor that each survivor is seen alone for part of their visit. If the examining healthcare provider is of different gender than the survivor, then health professional or health employee of same gender as survivor will accompany the Healthcare provider during clinical examinations of survivor.

Asking a survivor of domestic violence about GBV in front of the partner during screening or a routine enquiry can put the survivor in danger, therefore, caution must be exercised in phrasing the question and the body language of the healthcare provider and if healthcare provider senses it is dangerous, issue needs to be raised in private consultation or depending on unlikely immediate risk to survivor and their children's safety, raising the issue could be postponed to another time. All healthcare providers should familiarize themselves to existing guidelines and reporting to recognize and report such cases.

Safety and security of the people who are helping the survivor, such as family, friends, and healthcare providers/GBV workers need to be taken into consideration, and risk assessments made with shared decision making.

Taking photographs should only be limited for medical and investigative purposes by treating and by authorized Police officers for investigative purposes.

[42] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*

4.1.3. Being non-judgmental / non-discriminatory

All survivors of GBV have the right to receive respectful and high-quality healthcare, regardless of their race, sex, age, national or social origin, marital status, religion, or socioeconomic status.
All members of the society including the doctors and other health professionals have past experiences, opinions, views, and attitudes towards gender and towards what constitutes as gender-based violence, instilled in their mind. It is very important that these should not be allowed to influence the way they provide care to the survivors.

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

Common expressions coming from care providers such as "no wonder you get molested when you wear such clothes", "If you go out alone at night you are inviting trouble" indicate the biases that make healthcare providers though unintentionally damage the morale and the rehabilitation of the survivor. It is the right of each individual to receive non-judgmental care irrespective of the providers personal values33. It is also important for healthcare providers to be aware of situations that tend to excuse male gender-based violence whilst blaming the survivors for perpetrators' behavior.

4.1.4. Dignity and Respect

Survivors of violence have the right to be treated with dignity and respect, and not be blamed for the violence perpetrated against her/him. Opinions, thoughts, and ideas of adult survivors who are adults shall be listened to and treated with respect.

Children and adolescents (under 18 years of age) are under the guardianship of their parents but need to be treated with respect in order to strengthen their self-esteem and self-respect. Although the decision making will be by the parents, the Child Rights Protection Act Article 38 states that parents/guardians must consider the evolving capacities of the child in deciding all matters that affect the child. And as per international best practices, the child's views must be heard, and due weight must be given to that view in accordance with their age and level of maturity. Decisions on the examinations will be made by the social service personnel at Ministry of Gender, Family and Social Services or in FCSCs, depending on the relationship between perpetrator and the survivor.

The GBV survivor has undergone a very traumatic, degrading, and humiliating experience. Treating

the survivor with kindness, consideration, empathy, respect, and dignity is very important for the survivor's recovery, apart from it being his/her right.

The prior sexual history or status of virginity of the survivor are not relevant to an incident of gender-based violence. Objectively examining the survivor, presenting the findings to relevant authorities, and providing health care and referrals to associated services is the role of the healthcare provider, without personal values and biases influencing the care process.

As far as possible, avoid requiring the survivor to repeat their story in multiple interviews. This is especially important for children in order to avoid re-traumatization.

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

4.1.5. Self determination

The survivor's right to make own decisions, including sexual and reproductive health decisions must be respected by the healthcare providers.

All healthcare providers must ensure the survivor is provided with information on all available medical services to a GBV survivor, as per the guideline and those available at the health facility, as well as information on referral to another facility. The healthcare providers need to advice and answer any questions asked by the survivor that enable them to choose the course of action that best fits their individual needs.

The healthcare providers must ensure the survivor understand the procedures and protocols and must respect the survivor's decision to refuse medical procedures and/or take legal action. However, healthcare providers have a "duty of care and the responsibility" to report acts of domestic violence and child abuse to Ministry of Gender, Family and Social Services, to the Maldives Police Service and the Family Protection Authority (FPA) as per the Domestic Violence Prevention Act (Law No 3/2012) and this needs to be explained to the survivor and the legal obligations must be fulfilled. A duty to report is also stipulated in the Child Rights Protection Act, where chapter 22, clause 124-126, clearly describes that non-reporting of violence against children is a crime punishable by three years in prison.

4.1.6. Access to information and health services

The survivors have the right to health-care services of good quality, which are made accessible and available irrespective of the survivor's education level, socio-economic status or migration status. Healthcare providers must ensure the health services use a survivor centered approach. Healthcare professionals must understand that the survivor has the right to know what information has been collected about their health and to have access to this information, including medical records.

As members of the society, healthcare professionals have their own opinions and beliefs towards GBV and about the scope of services that health practitioners can be expected to provide. It is very important that these beliefs should not be allowed to influence the way they provide care to the survivors. The HP must facilitate provision of all available health services to the survivor, including provision of prophylaxis, emergency contraception and referral based on the level of the health facility. They may refer their clients to the nearest secondary or tertiary referral facility based on the health assessment and treatment requirement of the survivor.

4.1.7. Human Rights

GBV has been recognized as a violation of survivors' human rights including their right to freedom from discrimination, to life, to integrity and security of the person, and to the highest attainable standard of health. All healthcare providers must ensure all healthcare providers and support staff at health facilities obtain basic levels of training to be familiar with the rights of GBV survivors.

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

- Women centered care is offered in the health services. "The services are delivered in a way that ensures that a woman gives fully informed consent, respects her dignity, guarantees confidentiality and is sensitive to her needs and perspectives."
- Policies protocols and hospital procedures that address GBV should place "gender perspectives in the center of all policies and programmes".

- Adequate gender –sensitive training be offered to healthcare providers by including "comprehensive and mandatory gender sensitive curricula"

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

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

4.2. Ethical considerations in managing GBV

It is important for the care provider to realize that under the human rights principles, every survivor has a right to decide. Survivor has the right to choose what kind of care they want.Survivor may decide to stop telling their story or stop the examination at any time. The survivor has the right to decide whether they want legal or any other services, the health facility offers. Healthcare professionals has a duty of care to inform and offer all possible services and treatment required for the survivor's health and welfare to enable the survivor to make an informed decision.

However, the Domestic Violence Prevention Act has made it the "duty of care and the responsibility" of the healthcare providers to report acts of DV and all forms of child abuse or suspected abuse of children to Police and FPA. Additionally, the case should be notified to MoGFSS. The healthcare provider should explain the reporting mechanisms to the survivor and or the responsible caregiver and the legal obligations must be fulfilled.

4.2.1. Ethical principles of counselling

Ethical principles governing counseling survivors of GBV are[43]

- **Principle of autonomy:** Survivor has a right to make decisions about all spheres of their life andcircumstances. It is the responsibility of the counselor to treat with respect, enhance the ability of the survivor to act autonomously and enable to promote her

[43] Center for Enquiry into Health and Allied Themes (CEHAT). (2012*). Ethical Guidelines for counseling women facing domestic violence.*

well-being.

- **Principle of non – maleficence:** It is the counselor's duty to cause no harm to the survivor by way of an act of commission or omission. The intervention needs to be informed by a sound analysis of the consequences of every action and should be based on a risk benefit analysis.

- **Principle of beneficence:** It is a counselor's duty to do good and actively work towards the best interests of the survivor.

- **Principle of veracity and fidelity:** The survivor should not be misled about expectation and no other interests come in the way of the survivor's interests.

- **Principle of justice:** Counselor should be fair and not discriminate on any basis. The counselor should understand that survivors usually go back to the perpetrator even after coming forward, and that they may repeat this behavior several times before being able to break free. Counselors provide services without prejudice and with patience.

4.2.2. Informed Consent

Informed consent must be obtained in a language is understood by the patient.

In obtaining informed consent, in the case of adults:

- The healthcare provider makes correct and adequate medical information available to the survivor and ensures that the survivor has understood the available treatment options and the decisions he/she will have to make (e.g. compliance to treatment and choices of treatment options).
- Due to the medico-legal aspect of GBV, it is important that the survivor gives verbal consent and/or signs a consent form after the provider has ensured that she/he has fully understood the information provided.
- The healthcare provider shall explain the procedure regarding forensic evidence collection and police involvement with regard to informed consent and forensic evidence collected from the survivor
- The healthcare provider shall inform the GBV survivor that she/he has the right to refuse consent to all or some aspects of medical consultation and treatment.

In obtaining informed consent in cases involving survivors under 18 years of age:

- Always promote the child's best interest
- Comfort the child
- Treat every child fairly and equally
- Promote the child's resiliencies
- Accept if the child is unable to communicate regarding the act of violence. However, if the child does communicate his/her views, it should be given due consideration in accordance with the age and maturity of the child, in consultation with the parent/guardian.

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

Care seekers often come in to conflict with the care providers because of unexpected outcome (often adverse), unexpected cost and unmet expectations. In providing medico-legal services in the Maldives, cost or medical unexpected outcome is usually not a determining factor that leads to conflict.

It is mostly due to unexpected expectations and concerns of the care seeker which is often beyond the care provider and sometimes built up on the inadequate or erroneous information and knowledge of the care seeker that may lead to unexpected conflict.

However, the healthcare provider may unknowingly contribute to the conflict by generating animosity in the care seeker on the basis of behaviors given in table 4.1.

Table 4. 1 How healthcare providers may contribute to conflict

Predisposing factors	Precipitating factors
Rudeness	Adverse outcomes
Delays	Iatrogenic failures
Inattentiveness	Mistakes
Miscommunication	System errors
Apathy	

Often survivors of violence and medical practitioners will have different expectations for the outcomes of their interactions. Understanding expectations of the survivor can be the key to manage

expectations effectively. Information on services provided can be put on posters in waiting areas, on the service provider website and on telephone answering machines. Clinicians can also offer further appointments to go through things, and to give additional information verbally. Written information to read or use at home needs to be considered very carefully since this can put the survivor at further risk of violence. Table 4.2 gives a summary of patient expectations commonly experienced in the context of a survivor.

Table 4. 2 Summary of patient expectations commonly experienced in the context of the survivor

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

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

This is also significant in cases of child abuse where the parents are anxious, often agitated and genuinely worried about the child which may be beyond the medical concerns the provider is focusing on. In this situation it is essential to be survivor empathetic and understanding towards the parent or the guardian.

Given below are a few tips to avoid conflicts resulting in law suits;

- Prevention of litigation begins the moment a professional relationship is established with a survivor – **treat survivor and caregivers with respect and dignity** throughout the care process

- Communicating clearly with the survivors and caregivers is a key issue in preventing litigation – **use appropriate communication skills and build good rapport and a professional relationship with each client.**

- Words mean different things to different people. Avoid medical language - **choose words**

carefully respecting the local customs and sensitivities.

- Avoid criticizing another Healthcare Provider's management with words or gestures - You too may be blamed one day.

- Prepare survivors for any pain, or discomfort, they can reasonably expect before starting the examination or procedure. Let them know. Do not expect them to know. Involve the survivor and his/her family (if the survivor so desires) directly in the care as much as possible. Explain all the steps of any procedure, before starting the procedure and during the procedure. Check understanding and encourage the patient to ask questions.

- Consider the socio-economic status of the survivor – Explain any cost implications, insurance coverage, particularly for expatriates.

- Telephone numbers of the Police to be available so that assistance could be sought in case of a situation that poses a risk to the healthcare provider or other staff.

- Assistance may be sought from the Ministry of Gender, Family and Social Services, Police and FPA to resolve situations that may arise as a result of providing care and fulfilling medico-legal obligations by the healthcare providers.

- Make sure that there is adequate documentation in the clinical notes, and in medico-legal records and ensure reporting to relevant authorities (Ministry of Gender, Family and Social Services, Police and Family Protection Authority) as mandated by law.

PART 4

MEDICAL MANAGEMENT

MEDICAL MANAGEMENT OF GBV (ADULTS)

5.1. Introduction

A person who has suffered GBV may have experienced significant physical and psychological trauma and may be in a state of agitation or withdrawal. They often feel fear, guilt, shame, and anger or often all of them. Healthcare professionals should understand this and prepare her/him; obtain informed consent for the examination; conduct the examination in a compassionate, systematic, and complete manner; and document all observations and what the client had told, adequately and accurately. Medical management of GBV survivors involves treating potentially life-threatening injuries, potential infections, and unwanted pregnancies that may occur as a result of the violence. The management of medical emergencies and injuries should be a priority, but at the same time, it is the duty of the healthcare providers to provide the time-dependent preventive treatments. The guidance provided here is based on the Clinical and Policy Guidelines published by WHO[44,45].

Providing accurate and detailed information and obtaining consent as described earlier from adult survivors and guardian of children and adolescents (under 18 years) should not be ignored even in situations where a legal request has been made by authorities. It is important to remember that even if suspected or confirmed Domestic Violence case it requires mandatory reporting to the authorities (Ministry of Gender, Family and Social Services, Police and Family Protection Authority) as per DV Law.

5.2. First line support

First-line support is an essential part of the care that can be provided to survivors of sexual violence and intimate partner violence (IPV). It involves responding to a woman who discloses violence in a way that is supportive, helps to meet her needs, and prioritizes her continued safety without intruding on her privacy. First-line support provides practical care and responds to person's emotional, physical, safety and support needs without intruding her privacy. Survivor-centered care, focusing on the survivor's concerns and autonomy involves five simple elements. The mnemonic

[44] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*
[45] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*

LIVES is used to aid remembering these five steps as shown in Table 5.1.

Table 5. 1 Elements of survivor centered care [46].

LISTENING	Listen to the survivor closely, with empathy, and without judging
INQUIRING ABOUT NEEDS AND CONCERNS	Assess and respond to the survivor's needs and concerns – emotional, physical, social, and practical (e.g. childcare)
VALIDATING	Show the survivor that you understand and believe them. Assure them that they are not to be blamed for what has happened
ENHANCING SAFETY	Discuss a plan to protect the survivor from further harm and to prevent violence from occurring again
SUPPORTING	Support the survivor by helping him/ her to access information, services, and social support

Listening is the most important part of good communication and on the basis of first-line support. It gives the survivor a chance to say what he/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 and to meeting her practical needs and ensuring her safety.

Inquiring and asking a survivor about her needs and concerns is a way to learn what is most important for the survivor. It is important to respect his/her wishes and respond to his/her needs.

Validating lets a survivor know that his/her feelings are normal, that it is safe to express them, that he/she has a right to live without violence and fear, and that you believe what he/she says without judgement or conditions.

Enhancing safety means helping a survivor to assess his/her situation and make a plan that helps him/her to stay safer in the future. It often involves small, incremental steps that can reduce the risk or severity of further violence.

[46] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*

Supporting survivors' needs are generally beyond what can be provided in a health facility. Nevertheless, discussing the survivor's needs with her, telling her about other sources of help, and assisting her to get the additional help he/she wants is part of a health-care provider's essential support.

The management of medical emergencies and injuries should be a priority, but at the same time, the time-dependent preventive treatments should be provided along with reporting and documentation must be ensured.

5.2.1. Receiving the Survivor

- Greet the survivor by their preferred name
- Introduce yourself
- Ask if the survivor wants to have a specific support person present.
- During examination, ensure the survivor is offered the option of having an impartial observer (a chaperone) present wherever possible. This applies whether or not you are the same gender as the survivor. A relative or friend of the patient is not an impartial observer and so would not usually be a suitable chaperone, but you should comply with a reasonable request to have such a person present as well as a chaperone.
- Explain the procedure and what to expect in sensitive manner and encourage asking questions.
- Inform the adult survivor/guardian that she/he can interrupt, ask questions, or stop the procedure if they feel so.
- Ensure that the confidentiality will be maintained and as well as the national legal obligations that the Healthcare Provider will have to fulfill.
- Always maintain informed consent with survivor.

5.2.2. Informed Decision Making

- Provide information on the medical consequences related to GBV and DV
- For sexual violence cases, provide information on the risk of STIs, Hepatitis B, HIV, pregnancy (pubertal girls and women), availability of testing for pregnancy, STI, Hepatitis B and HIV and prophylaxis for the diseases and Emergency Contraception (EC).
- Provide information on the steps in clinical management, the services available at the facility and possible need for referral.
- Ensure that the survivor has understood the process of examination and treatment options

available (e.g. compliance to treatment and choices of treatment options). to allow the survivor to make an informed decision

- Explain the procedures for gathering forensic evidence (in liaison with Police) and that any evidence gathered may be used as evidence in court.
- Explain to the survivor that she/he has the right to refuse consent to all or some aspects of medical consultation and treatment, reporting and collection of forensic evidence
- Explain the importance of documenting the medical examination for future treatment and also for legal investigation, and as a protective measure if the survivor decides to change his/her mind about reporting and using legal protection services.
- Explain that a medico-legal record (MLR) form will also be filled at the health facility.
- Explain adequately that the non-health aspects will be dealt with by police, social services officers and the legal system.

5.2.3. History taking

- Let the survivor tell the story the way she/he wants to, and the clarifications and questioning should be done gently and at the survivor's own pace.
- Avoid questions that suggest blame such as "What were you doing there alone?"[47].
- Be patient; go at the survivor's pace and do not interrupt his or her train of thought. Observe whether the survivor becomes upset or distressed and allow time for breaks.
- Do not rush her/him to answer your questions.
- Reassure the survivor that you are there to help. Avoid asking leading or suggestive questions.
- If the incident has occurred recently, inquire whether she/he had bathed or washed her/himself or douched.

The main elements of history taking are:

General information

- Name
- Address (current)
- Permanent address

[47] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*

- ID number
- Hospital/Health facility number
- Residence, telephone number
- Sex
- Date of birth (or age in years)
- Date and time of the examination
- Name(s) of any staff or support persons' present

Description of the incident

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

It is important to get details of exactly what happened in order to check for possible injuries. For example,

1. When and where the assaults took place?
2. Was there penetration (oral, vaginal, or anal)?
3. Did the perpetrator use physical or psychological force?
4. Did the perpetrator use a physical object?
5. How many perpetrators were there?
6. Was it a single assault or was it repeated over hours or days?
7. Did the survivor lose consciousness, and was the perpetrator known to the survivor?
8. What did the survivor do after the incident (e.g. clean, wash)?

Gynaecological history (for females)

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

Emotional/mental health status

While accepting that most healthcare providers are not trained to assess mental health status and are not in a position to provide expert evidence on such matters, basic assessment is done essentially to identify the need for mental health support. The survivor should in no way be re-victimized, stigmatized, or blamed for experiencing gender-based violence/domestic violence or for putting themselves in a position where they were victimized.

Within the capacity of the Healthcare Provider look for evidence of the following:

- Depression
- Anxiety
- Mood problems
- Suicidal/self-harm ideation
- Substance abuse

Past medical and surgical history

Ask about possible medical conditions, allergies, substance abuse, vaccination, and previous surgery. These questions would help to determine the best treatment and offer follow-up healthcare.

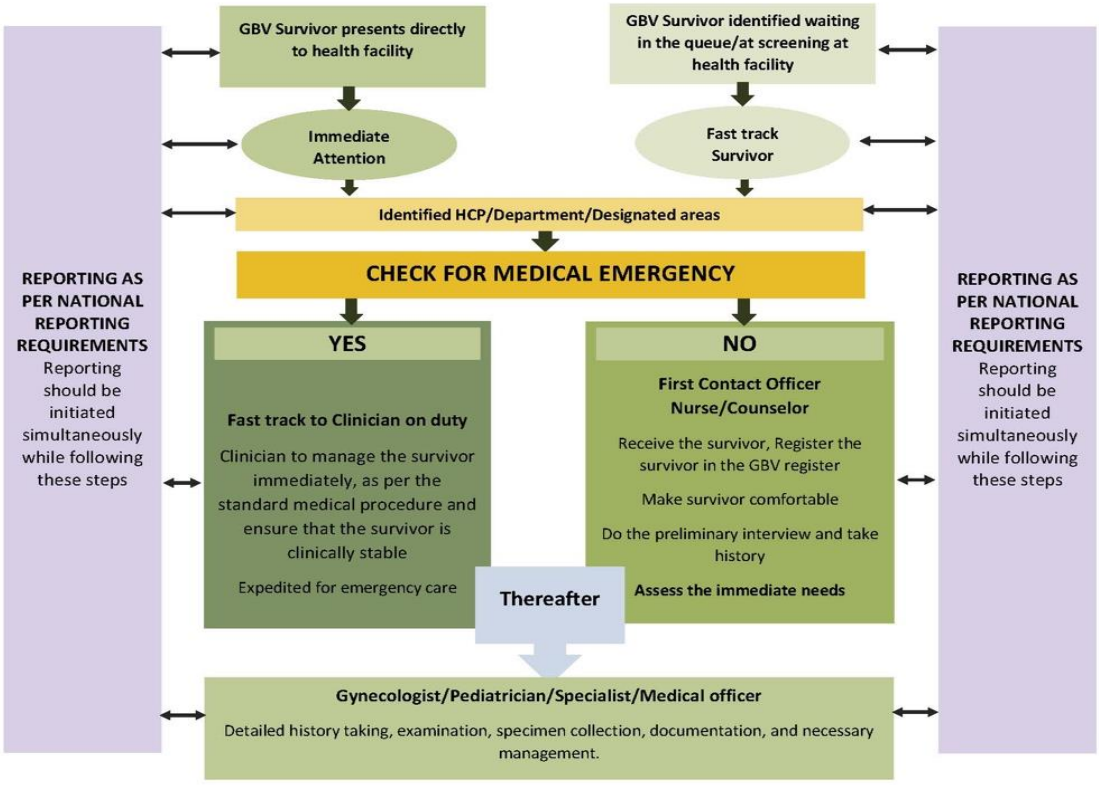


Figure 5. 1 Pathway of GBV care within a hospital

5.2.4. Physical Examination

General considerations for physical examination

- Confirm that voluntary informed consent had been taken for the examination and for obtaining any samples for forensic evidence
- Make sure instrument/equipment etc. are ready before starting
- Assure the survivor that he/she is in control. She can ask questions, stop the examination at any time and refuse any part of the examination.
- Look at the survivor and explain before you touch. Watch for signs of discomfort and trauma and give wait time as needed. Ask often if the client is okay and if you can proceed. Be very careful not to increase the client's distress
- Take the basic vital signs at the start
- Never ask a survivor to undress or uncover completely. Examine the upper body first and then the lower half. Give an appropriate gown[48]
- The clothes should be collected for forensic examination and put in a paper sheet/ bag when sexual and physical violence has occurred. If the survivor is going to be undressed, she can do this over a large sheet of paper to collect debris such as vegetation, insects, dirt, and hairs that would support her information about the assault or violence
- Conduct the examination systematically
- Wherever relevant, collect specimens for laboratory testing at the same time

Head to toe examination

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

[48] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*

Genital and anal examination (relevant in cases of rape and sexual abuse)

A genital examination is a sensitive examination, particularly the speculum examination. Therefore, use the general guidance above to help the survivor to feel as comfortable as possible. Remember to let the survivor know when and where you will touch them and ask for permission when conducting each part of the examination.

Most women are averse to this part of the examination, and the Healthcare Provider must be patient and considerate. Explaining the procedure to the survivor would minimize this.

Even when female genitalia are examined immediately after a rape, identifiable damage to genitalia is found on examination, in fewer than 50% of instances. Cultural sensitivities may prevent the survivor consenting to a vaginal, digital or speculum examination, particularly if she is not married and her wishes need to be respected.

Examination of the genital and anal areas for women

- Help the woman to lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her body and expose only the parts of her body you are examining,
- Make sure that you have a good light source to view injuries.
- Systemically examine genitalia in this order and note injuries etc.
    - Mons pubis
    - Inside of the thighs
    - Perineum
    - Labia majora
    - Labia minora
    - Clitoris
    - Urethra
    - Introitus
    - Hymen
    - Anus
- Take all the swabs, in the following order:
    - External vaginal swab

- Internal vaginal swab
- High vaginal swab and rectal swab
- The other swabs are oral swabs for secretor factors in cases where oral sex is implicated
- Skin swabs when a suspicious seminal stain is present on the skin
- If collecting for DNA analysis take swabs from around the anus and the perineum before the vulva[49]
- Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.

- Do speculum and digital examinations
  - This should be done after taking swabs. Under no circumstance should this be done prior to taking the swabs. Use water or saline when introducing but no lubricants.
  - An internal, speculum examination is very sensitive and should be done only if there has been vaginal penetration and if there are any of the following indications: bleeding, pain, foul smelling discharge, or to reassure the survivor that there are no serious injuries.
  - Speculum examination on women who are not married and on girls cause much pain and may cause injury, so it should only be done when essential (e.g., when the child may have had internal bleeding from a penetrating vaginal injury). In such situations, examination under anesthesia is preferable in children and girls using a paediatric speculum. Use a very small speculum in unmarried adult women.
  - Postmenopausal women have decreased hormonal levels, resulting in reduced vaginal lubrication and a thinner and more friable vaginal wall. If sexually assaulted, they are at a higher risk of vaginal and/or anal tears and injury, and transmission of STIs, including HIV. Use a narrow speculum for the 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.

- If and when required do anal examination
  - Note the shape and dilatation of the anus

[49] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*

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

Examination of the external genital and anal areas for men

- Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus, and anus.
- Note if the survivor has been circumcised.
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
- Note the shape and dilatation of the anus
- Torsion of the testis is a medical 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.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

Documentation

- The attending specialist doctor (e.g. gynecologist/pediatrician/surgeon) shall complete the medical section of the MLR. In the absence of a specialist, the medical officer shall fill and complete the medical section of the MLR.

- Health facility shall designate a person to be responsible for safe custody of the documentation; reporting forms, medical records, MLR and forensic specimens, till they are handed over to the administration /laboratory or the Police.

- Use the pictograms provided in the annexures of the MLR to clearly give the location and measurement of the injury and describe it in words, taking care to document and record the type, size, color, location and form of any bruises, lacerations, injuries, and bleeding.

- Additionally, ensure reporting to the institutions mandated by DV Act (Ministry of Gender, Family and Social Services (if in an atoll respective FCSC), Police (if in an atoll respective police station), and Family Protection Authority).

Laboratory investigations

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

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

Basic laboratory investigations

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

Detailed laboratory investigations

- Testing for HIV
- DNA testing on seminal or other samples collected
- Examination of hair, nail cuttings or scrapings, etc.

5.2.5. Treatment of GBV survivors

General considerations

- All GBV survivors should be fast tracked and should not be allowed to queue in the line
- Healthcare providers should, as much as possible, follow the stated procedures, on taking the history of the survivor, document clearly and completely since written evidence may be needed in court.
- Treatment will depend on how soon after the incident, the survivor arrived at the hospital.

Preventive/prescribing treatment

- **If the survivor presents before 72 hours had passed, offer:[50].**
  - STI prophylaxis
  - Prevention of pregnancy by Emergency Contraception
  - Prevention of HIV by PEP
  - Hepatitis vaccination (based on vaccination status)
  - Prevention of Tetanus
  - Provide wound care
- **If the survivor presents after 72 hours had passed:**
  - If the lab tests are positive or has symptoms of STI, treat according to local guidance
  - If the survivor presents between 72 hrs. (3 days) and 120 hrs. (5 days) after sexual exposure/ rape, emergency contraception is moderately effective and should be given[51]. However, the survivor should be aware that the medicine is less likely to be effective when taken at 120 hours when compared with immediate use. It is not effective after 120 hrs.
  - Tetanus prophylaxis could be given.

Assisting the male survivor

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

[50] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*
[51] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*

Assessment of Risk/Danger in domestic violence

Of the survivors who undergo violence, particularly domestic violence, only a small percentage of survivors would present to a health facility, as most of the time they would directly report to Police or Gender. Often a survivor who undergo more serious forms of violence and who need medical attention would go to a health facility. Even while attending to these cases ensure simultaneous reporting to the institutions mandated by DV Act (Police and Family Protection Authority), and Ministry of Gender, Family and Social Services (if in an atoll respective – FCSC) shall be notified.

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

If the care provider feels that there are significant suicidal or homicidal ideation/thoughts, the survivor safety should be ensured by the facility and should not be left alone. Counseling and/or psychiatric evaluation shall be obtained or survivor should be referred to a facility which provides this service. Be aware, that unless someone intervenes, for some women and children, domestic violence can result in serious injury or even death.

The following in Table 5.2 are some of the risk factors for danger in domestic violence.

Table 5. 2 Risk factors for danger in Domestic Violence.

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

Guidance on medico-legal documentation and reporting for GBV/DV cases

- Healthcare Professional should conduct all examinations to the best of their ability and skills; complete and submit the MLR.
- Where the survivor presents to the health facility, MLR must be duly filled and completed for any suspected or confirmed cases of GBV/DV irrespective of Police involvement (by conducting examination and report to the best of their ability expected from that category of the staff, and document the findings in the MLR).
- Where the request may be made by the police for a medico-legal examination related to GBV/DV, healthcare providers are required by law (DV Prevention Act) to conduct an examination and report to the best of their ability expected from that category of the staff, and document the findings in the MLR.
- Where the Police request for an MLR, assist in providing a copy.
- In a rare situation where a doctor is not available, another healthcare professional must attend to first aid and assess the immediate needs and attend and report to relevant authorities **AND** refer to the next level (after attending to immediate medical needs / and noting down the obvious injuries etc.) If there is a choice a female healthcare professional is desirable for examining female survivors.
- Where a second opinion on a medico-legal examination or the report is required, a written request should come from either the Police or the Judiciary. The second opinion should be taken from another relevant specialist.
- Where a referral is required to a higher center it must be facilitated without any delays.
- The template by Ministry of Health for Medico-Legal Report Form is given in Annex 1 (Annex 1: Medico-Legal Report (MLR) Form).

The health facility manager must ensure that any case of GBV/DV is reported as per Domestic Violence Prevention Act to the Police and FPA and notified to Ministry of Gender and Family (if in atoll to Family and Children's Services Centers (FCSCs).

Purpose of reporting by healthcare professionals to police and FPA and Gender is to ensure other relevant services are provided to survivor and to link with other services.

Guidance on how to describe physical injuries for documentation purposes is given below.

Table 5. 3 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)
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)
Color	Observation of color 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 on the wound (e.g. dirt, glass)
Age	Comment on any evidence of healing. (Note that it is impossible to accurately identify the age of an injury, and great caution is needed 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

5.2.6. GBV/DV Referral Pathways

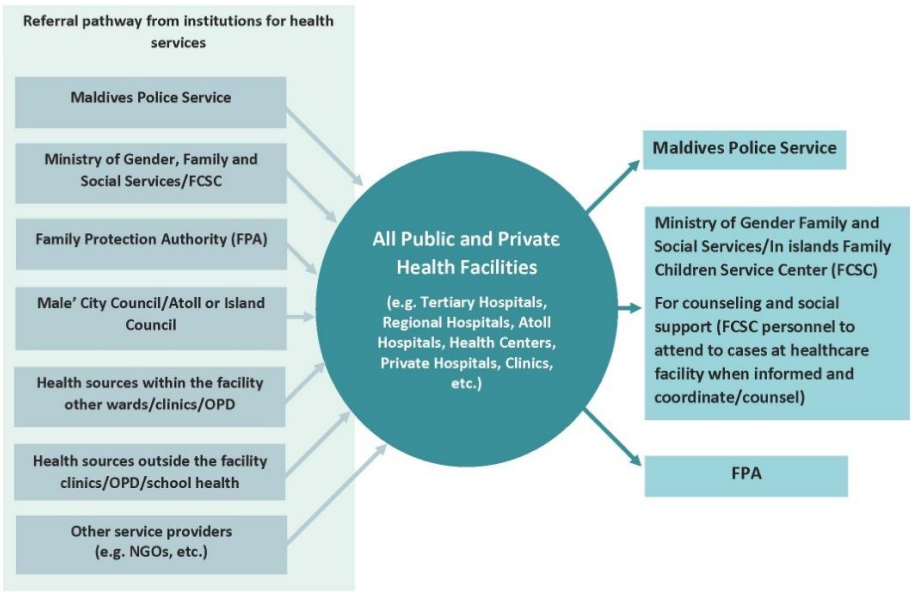


Figure 5. 2 Referral pathways for GBV survivors

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

Assisting the survivors to access the available resources and following up to find out whether the survivor was able to use the referral services is essential. The survivors' feedback on the quality of care received is important to advocate for any improvements and changes required to ensure the highest possible care is provided.

Points to be considered regarding referrals

- Most institutions have to refer and in turn accept survivors between the institutions for providing different kind of services.
- The dual role of each institution needs to be understood.
- It is important for the healthcare provider to explain to the survivor the purpose of the referrals related to health aspects.
- The referral should be clearly beneficial to the survivor and is not merely to fulfill a formality
- In the process of referral, due regard to confidentiality (including data protection requirements), respect, sensitivity and the dignity of the survivor must be attended to.
- It is important to agree with referring institutions which information is absolutely necessary and the manner in which it can be conveyed, so that minimal harm is done to the survivor in sharing information[52]
- Island Councils play a role distinct from other institutions which provide identified services. Their role is essentially to facilitate by making services available to the survivors in situations such as the need for transport to atolls or Male'. In addition, the information on the trends and types of violence may help them to initiate targeted preventive activities, in collaboration with healthcare providers.
- FPA plays a dual role by providing counseling services as well as facilitating the provision of services by other agencies.
- FPA is mandated by the Domestic Violence Act 3/2012 to assist and oversee the response to DV by all sectors of the government, including that of the health sector.

[52] Center for Enquiry into Health and Allied Themes (CEHAT). (2012). *Ethical Guidelines for counseling women facing domestic violence.*

Table 5. 4 Purposes of referrals

Referrals to the Health Facility from	What purpose/ Any criteria relevant	Referrals from the Health Centre (Outward)	What purpose/ Any criteria relevant
Police	Medical management & Medico-legal examination	**Police**	Police Action & Initiate legal response
Women's Development Committee (WDC)	Medical management & Medico legal examination	**WDC**	Support the survivor appropriately, Facilitate transport, etc.
Island Council	Medical management & Medico legal examination	**Island Council**	Support the survivor appropriately, Facilitate transport Monitor the need for provision of support for prevention and responding to GBV and liaise with agencies to ensure support is provided
FPA	Medical management & Medico legal examination	**FPA**	• Assistance to the survivor if there is a need. • Facilitate any steps in care provision • Data collection from all health facilities and analysis of DV data and respond at national level (a requirement of DV Act) • Compile reports • Detailed information on individual survivors must be submitted if requested by FPA
FCSC	Medical management & Medico legal examination	**FCSC**	• Assistance to the survivor • Counselling and Social Services • For emotional support
Mental health service	Medical management & Medico legal examination	**Mental health service**	Emotional support and counselling
NGOs	Medical management & Medico legal examination	**NGOs**	Advocacy, support and

In addition to the institutions referring to the health facility, internal referrals from other departments of the health institution such as maternity, surgical, pediatric departments must be considered.

Additionally, Maldives Police Service has a role in storing and transporting evidence in the form of samples collected by the healthcare professionals in the health facility. MPS should ensure the chain of custody of all forensic evidence materials collected.

Counseling services by counselors need to be sought and best be provided in the health facility by inviting or referral.

If the survivor attends without a caregiver, chaperoning social services including counseling need to be provided by Ministry of Gender, Family and Social Services or relevant government authority.

As an initial response to receive medical care if needed (urgent and non-urgent as needed) it is most desirable for the survivor to access a health facility, as soon as possible after the incident. It could be the island Health center or Atoll hospital or the Hospitals at atolls. If in greater male' region IGMH, Hulhumale' hospital, Villimale' hospital or private hospitals and clinics.

In cases where the survivor first contacts/reports to other organizations such as Police, Ministry of Gender Family and Social Services, WDC, Island Council, FCSC, FPA, etc. and comes/or is brought to the health facility for medical attention, she/he should be accepted examined medical treatment and prophylaxis as required and also the mandatory reporting and documentation must be followed.

5.2.7. Psychosocial Care and Support

General Considerations

- GBV survivors undergo marked emotional abuse evident immediately, short term or long term.
- The duration and depth of traumatic effects would depend on the individual and the circumstances of the GBV.
- Listen but do not force the survivor to talk.
- One key principle in providing basic counseling is "not blaming the survivor" for the incident
- Healthcare professionals should be empathetic when listening and be able to provide basic counseling to GBV survivors, including children and adolescents and refer for counselling.
- Where professional counselor services are available, trauma counseling must be offered when indicated.
- Counselor, where available, should apply the survivor-centered approach to counseling by strengthening the survivor's ability to decide for himself/herself. This approach focuses on "DOING GOOD and NOT DOING HARM" when counseling the survivors.
- The counselor should at all times adhere to professional ethics and apply the principle of "doing good and not doing harm" and recognize that survivor is the decision maker[53].

[53] Center for Enquiry into Health and Allied Themes (CEHAT). (2012*). Ethical Guidelines for counseling women facing domestic violence.*

5.2.8. Follow-up care, treatment, and referral

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

5.3. Working with children and adolescents who are experiencing GBV

Introduction

Managing GBV in children and adolescents under 18 years of age is distinct and different in many ways from the management of similar GBV in adults. This section of the guideline attempts to identify such differences from the point of service provision and needs to be considered as a supplementary guidance in order to enhance the knowledge of the Healthcare professionals, gained in undergraduate studies and training.

- All forms of child abuse including GBV/DV whether suspected or confirmed, requires mandatory reporting.
- The concept of evolving capacities is acknowledged in the Child Rights Protection Act and should be considered when consent is obtained from the parents or the guardian for children and adolescents under 18 years of age. For the ages between 15-18, informed consent by survivor must also be obtained as required by Health Service Act 29/2015.
- The healthcare professional should provide the child, adequate explanation and sensitization on the medical issues relating to care provision, depending on the age and the capacity of the child.
- Due care must be taken to ensure child survivors are informed, so that they are comfortable with following any procedures or examinations and their verbal consent is obtained prior to any medical examination.
- Never force a child to undergo examination. Build a rapport with the child to make him/her more comfortable with the examination, and obtain his/her views, which will be given due consideration in accordance with his/her age and level of maturity, in consultation with the parent/guardian.
- The parent or legal guardian should provide informed consent for examination of the child and collection of forensic evidence unless he or she is the suspected perpetrator. In this case, a representative from the Ministry of Gender, Family and Social Services (in case of atolls relevant FCSC) or the relevant authority may give permission to examine.
- Healthcare providers need to recognize children and adolescents as a vulnerable group that require timely attention, treatment with empathy, and support and follow-up to the satisfaction of the child,

parent, or guardian and acceptable to the sensitivities of the community

- Healthcare professionals should be aware of the facts on growth and development of the child and the anatomical status of children and adolescents as distinct from the adult.

General Considerations

- Any child or adolescent who is a survivor of GBV shall be prioritized and fast tracked to ER if any urgent medical management is needed.
- For those not requiring urgent medical treatment, health facility should have arrangements made to receive the child/adolescent in an allocated child friendly place in the health facility.
- As far as possible, the child should be examined in a child friendly environment with toys, dolls and drawing materials, etc. where these can be used as communicative devices.
- Sometimes admission to the facility may be needed to give adequate time to calm the child/adolescent prior to examinations and if needed to do an examination under anesthesia.
- Involvement of the designated team or focal point at the health facility, MoGFSS/ FCSC and Police in early stages is important for management while the child/adolescent is in a safe place.

5.3.1. Types of GBV in children

- Sexual violence may include completed or attempted sexual contact and acts of a sexual nature not involving contact. Sexual violence in children and adolescents may include the following[54]
    - Contact sexual abuse (e.g., touching the child's genitalia or the child touching an adult's genitalia)
    - Penetrating injury (e.g., penile, digital, and object insertion into the vagina, mouth, or anus) and non-penetrating injury (e.g., instance of fondling or sexual kissing)
    - Non-contact sexual abuse, which may include exhibitionism or voyeurism
    - The involvement of a child in verbal sexual propositions
    - The making of pornography and showing pornography

[54] World Health Organization. (2022). *Violence Against Children*. https://www.who.int/news-room/fact-sheets/detail/violence-against-children

- Female genital mutilation
- Online sexual exploitation, corruption, and extortion of children
- Child exploitation (e.g.: for prostitution)

- Emotional or psychological violence includes restricting a child's movements, unfair criticism, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment.
- Maltreatment (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by parents, caregivers and other authority figures, most often in the home but also in settings such as schools and orphanages.
- Youth violence is concentrated among children and young adults aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes bullying and physical assault with or without weapons (such as knives), and may involve gang violence.
- Bullying (including cyber-bullying) is unwanted aggressive behavior by another child or group of children who are neither siblings nor in a romantic relationship with the victim. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.
- Although males can also be victims, intimate partner violence disproportionately affects females. It may occur among romantically involved but unmarried adolescents it is sometimes called "dating violence".

When directed against girls or boys because of their biological sex or gender identity, any of these types of violence can also constitute gender-based violence.

5.3.2. Perpetrators of Child and Adolescent GBV

Perpetrators could be any one from the community. Child sex offender's registry is established under the Special Provisions Act to Deal with Child Sex Abuse Offenders and is maintained by Ministry of Gender, Family and Social Services[55], and is a register of convicted sexual offenders of children. Often, the

[55] Ministry of Gender, Family and Social Services. (n.d.). *Child Sex Offenders Registry.* http://www.offenders.mv

perpetrator is someone known to the child and someone in the capacity of providing "protection" and is a trusted individual.

Incest or child and adolescent sexual abuse within the family is one of the most invisible forms of violence. It is usually perpetrated most often by a father, stepfather, grandfather, brother, uncle, or another male relative in a position of trust and occasionally women in these family roles. In some cases, mother may deny it to protect the name of the family and that of other children. This must be dealt with sensitivity and it is mandatory to report any such suspected or observed cases.

5.3.3. History taking

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

The history taking procedure will depend on the emotional and physical state of the child and adolescent survivor. In some cases, the interview may be difficult due to the distress, fear, and sense of insecurity in the child/adolescent.

In some cases of child/adolescents, the parent or guardian may be asked to wait outside, and the child/adolescents may be interviewed alone for at least part of the time.

A strong alliance and rapport between the counselor, healthcare provider and the child/adolescent and the guardian is crucial to successful sessions and in preventing conflicts and resultant legal action against the Healthcare Professional. For younger children, if possible, make sure that there are crayons or other toys to keep them busy during the conversation and any assessments.

Introduce yourself to the survivor and the guardian

- For adolescents, they should be asked if they want to be alone or with a trusted adult
- Explain in simple and non-medical words that the child/adolescent is familiar with and can understand
- Reassure the survivor that the examination findings will be kept confidential
- Explain what is going to happen during each step of the examination in words that is understood by the child and will not scare or distress them further
- Obtain informed consent from the survivor/guardian/parent (in obtaining consent from

parents/guardian for children and adolescents under 18 years of age, consideration must be given to the concept of evolving capacities of children as specified in the Child Rights Protection Act; and for the ages between 15-18, informed consent by the survivor must also be obtained as required by Health Service Act 29/2015)

- Stop the interview, in case the child/adolescent is uncomfortable or show signs of distress

The medical history shall cover any known health problems including allergies, immunization status, and medications. In addition, family history of any such incidents should be recorded.

Particulars of the child/adolescent survivor

- Name, address, date of birth, age, sex, address on admission (current address, permanent address, ID number, hospital /health facility contact number, date and time of examination)
- Name, address, contact number of parent/guardian
- Name(s) of any staff or support person present during the interview and examination
- Description of the incident by the child/adolescent survivor or the guardian

It is important that the healthcare provider understands the details of exactly what happened in order to check for possible injuries

- Did the assailant use a foreign object?
- Determine whether the survivor has taken a bath, urinated, vomited, etc., since the incident occurred, as this may affect the collection of forensic evidence
- In case of adolescents who had attained menarche, the last regular menstrual period, any sexual encounters in the recent past, if so the date of the last and whether any protection was used

GBV of children and adolescents is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation and whether the child/adolescent has a secure place to go to.
- How the abuse was discovered.
- Who did it, and whether that person still has access to the child online or otherwise.

- If it has happened before, how many times had it occurred; the date of the previous incident; whether there have been any physical symptoms (e.g. bleeding, dysuria, discharge, difficulty walking, etc.); and
- Whether any siblings or children/adolescents in the same residence or in the community are at risk
- In addition to the survivor and the health professional, there should be a support person or trained health worker in the examination room.
- Encourage the child/adolescent survivor 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/adolescent survivor can understand.
- Never restrain or force a frightened, resistant child/adolescent survivor 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/adolescent's fear and anxiety, and may worsen the psychological impact of the abuse.
- For child survivors, it may be useful to have a doll on hand to demonstrate procedures and positions. Show the child survivor the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

Table 5. 5 Indicators of child sexual abuse[56]

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

[56] Family health bureau Ministry of Health Sri Lanka. (2012). *Gender –based Violence information booklet for health care providers.*

5.3.4. Examination of the child/adolescent survivor

'Guidance on general principles on examining an adult survivor' applies in case of examining a child or an adolescent and will not be repeated here, hence refer to previous sections for guidance.

Special considerations for children

With adequate preparation, most children will be able to relax and participate in the examination. If the child cannot relax, this may be because he or she is in pain. If this is a possibility, consider a mild painkiller and wait for them to take effect.

Examination

(Adapted from Clinical Guidelines for Rape and IPV Survivors WHO[57]):

- Note the child's weight, height, and pubertal stage
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed

For girls

- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymeneal tissue and the size of the vaginal orifice are not sensitive indicators of penetration
- Do not carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size)
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of unmarried adolescents and pre-pubertal

[57] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*

child is usually done under general anesthesia.

For boys

- Check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.

Anal examination

- All children (boys, and girls), should have an anal examination as well as the genital examination.
- Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it
- Record the position of any anal fissures or tears on the pictogram
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation
- Do not carry out a digital examination to assess anal sphincter tone

Laboratory testing

General principles that apply to adult survivors would apply here. Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations:

- The child presents with signs or symptoms of STI
- The suspected offender is known to have an STI or is at high risk of STI
- There is a high prevalence of STI in the community
- The child or parent requests testing
- In some settings, screening for gonorrhea and Chlamydia, syphilis and HIV is done for all children who may have been raped

The presence of any one of these infections may be diagnostic of rape, if the infection is not likely to have been acquired perinatally or through blood transfusion.

5.3.5. Treatment for the child and adolescent survivor

- Emergency contraception (EC) can be offered to girls who have attained menarche as long as they reported within 120 hours (5 days) of the rape. If the survivor presents before 72 hours had passed offer emergency contraception. If the survivor presents between 72 hrs. (3 days) and 120 hrs (5 days) after sexual exposure/ rape, emergency contraception is moderately effective and should be given. However, the survivor/parent/guardian should be aware that the medicine is less likely to be effective when taken at 120 hours when compared with immediate use. It is not effective after 120 hrs.
- Regarding STIs, HIV, hepatitis B and tetanus, child/adolescent 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 medication regimens.
- Presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis is suggested for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex, particularly in settings where laboratory testing is not feasible.
- For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic case management is suggested for vaginal/urethral discharge (gonorrhoea, chlamydia, trichomoniasis) and for genital ulcers (genital herpes, syphilis and chancroid), particularly in settings where laboratory testing is not feasible.
- As much as possible, screen for gonorrhoea and chlamydia using a nucleic acid amplification test (NAAT) and screen for syphilis and HIV using a rapid dual HIV–syphilis test. The presence of a laboratory diagnosis of an STI in a child is diagnostic of sexual abuse.
- For post-exposure prophylaxis to prevent HIV transmission (PEP), follow the regimen provided in the national protocol for PEP for HIV in children.

5.3.6. Psychological assessment, referral and follow up care

Follow the same procedures as for adults for psychological assessment, referral, and follow-up, including provision of psychological first aid (PFA) to the child/adolescent and parent/guardian until referrals can be made. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or that sexual abuse of the child/adolescent is continuing.

PART 5

CLINICAL ENQUIRY, DATA MANAGEMENT AND COLLABORATION

6.1 Screening for GBV

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

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

Screening can be either asking all patients known as "universal screening" or asking selected groups of patients based on a clinical condition such as pregnancy, "screening", also known as "clinical enquiry" or "case finding"[58]. **However, WHO guideline[59] does not recommend universal screening for intimate partner/domestic violence of patients attending health-care services.**

Healthcare professionals should ask about intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence. Screening survivors at various times is also important because some survivors do not disclose abuse the first time they are asked.

Most health systems rely on survivor- initiated reporting and service-seeking. However, developing a proactive approach to identify signs of possible abuse and supporting survivors to make a disclosure of abuse can enable for early intervention and care. This has the potential to improve health and social outcomes for survivors and their families[60] .

Healthcare professionals may suspect that a survivor has been subjected to IPV if the survivor has any of the following[61]:

- injuries that are repeated or not well explained.
- repeated sexually transmitted infections (STIs).
- multiple unintended pregnancies, miscarriages, or unsafe abortions.

[58] World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and Policy Guidelines.*
[59] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*
[60] American College of Obstetricians and Gynaecologists. (2012). *Intimate Partner Violence.* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2012/02/intimate-partner-violence
[61] World Health Organization., United Nations Population Fund., & United Nations High Commissioner for Refugees. (2020). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings.*

- unexplained chronic pain or conditions (e.g. pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches).
- repeated health consultations with no clear diagnosis.
- ongoing emotional issues, such as stress, anxiety, or depression.
- harmful behaviors, such as misuse of alcohol or drugs.
- thoughts plan or acts of self-harm or (attempted) suicide.

It is recommended for health care practitioners who are often working alone, in remote communities, to access online training and resources on prevention and response to gender-based violence, to meet their clients' health needs adequately and appropriately. It is also important to consider whether the Healthcare Provider is able to provide emotional support and other kinds of assistance if the survivor discloses GBV, and whether the resources are available within the health system, and to know how to access the available resources. Establishing a collaborative team of staff, who are trained and can support survivors of GBV can be the first step. In small facilities, all of the staff can be in the team that works to prevent GBV and respond to survivors appropriately.

Minimum requirements to be fulfilled at the health facility

- Availability of standard operating procedure and protocol
- Orientation and refresher trainings on the national protocol and first line support
- Availability of private space that assures privacy, confidentiality, non-discrimination, and non-judgmental service
- Referral mechanism in place for multi-sectoral support (mental health, social protection and legal)

When treating a survivor that has experienced IPV, there are safe and supportive ways to start a conversation with the survivor.

Before speaking to a survivor about IPV, consider the following:

- Never raise the issue of IPV unless a patient is alone. This is to ensure safety and privacy for the survivor.
- When asking about experience of violence, give adequate time for the survivor to compose themselves following a disclosure of a traumatic experience. It should be done in an empathic, non-judgmental manner, preferably in the middle of a clinical visit.

- Use language that is clear and appropriate and relevant to the local culture and community. Some survivors may not like the words “violence” and “abuse”. It is important to use the words that survivors themselves use.

Where the health professional suspects violence but the patient does not disclose it:

- Do not pressure but give him/her time to decide what they want to share.
- Build a rapport.
- Encourage to reach out for help, this can act as a sign, that the clinician is open to listen to a disclosure of abuse.
- Offer information on the effects of violence on survivor’s health and their children’s health.
- Where the survivor/informant discloses, advice about services that are available.
- Where the encounter is with a survivor, use the referral protocol that is in place to refer him/her to other services, according to his/her wishes.
- Offer the survivor a follow-up visit.
- Where the encounter is with an informant, the healthcare provider should immediately pass the information to MoGFSS.

However, it is important to remember that even if suspected or confirmed, all GBV/DV requires mandatory reporting to the Police and FPA as per Domestic Violence Act 3/2012 and MoGFSS must be notified.

6.2 Documentation and Data Management

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

Very often the medical records reveal only very limited information regarding abuse. Since such records may constitute the only documentation about the survivor's injuries, they should contain all key facts, including the use of weapons and whether any injuries (physical and mental) resulted from their use or was threatened to use.

As health records play an important role in addressing GBV it is necessary to keep clear, accurate and detailed notes on the injuries to indicate the harm caused due to violence. These documents should be stored (physically or electronically). This can help to facilitate information for future legal purpose when required. Additionally, the data obtained can be used for policy planning and implementation purposes at national level.

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

In cases of suspected/confirmed GBV/DV Healthcare providers and healthcare professionals are required to complete a Medico-Legal Record (MLR) form *(See Annex 1)* including the referral from to FPA which is provided within the annexures of the MLR form*.

Additionally, healthcare providers and healthcare professionals must keep themselves updated to any current changes to reporting and recording formats.

* For ease of reference the FPA reporting forms in English and Dhivehi are provided separately in Annex 2 and 3 of this document.

It is important to maintain confidentiality by securing the documents till they are handed over to administrative authorities or legal authorities, and accessible only to those involved in the examination and care of the survivor.

To document injuries appropriately, take the following steps.

- Explain to the survivor what you would like to document and why.

- When documenting experiences of abuse, it is advisable to use:
    - Survivors' own words
    - Use body maps and diagrams
    - For photo evidence, follow Police guidance (when applicable)
    - For any suspected or confirmed case of GBV/Domestic Violence a separate Medico-legal Report Form (MLR) must be filled along with all the annexures, in addition to any other medical records that may be filled (e.g. ANC, mental health, etc.)
    - Be aware of situations where confidentiality may be broken. Be cautious about what you write on what document, where you are doing the writing, and where you leave the records. For greater confidentiality, some health-care facilities use a code or special mark to indicate cases of abuse or suspected abuse.

When filling relevant documents such as the MLR form, ensure consistency, uniformity, and completeness in documentation.

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

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

Health facilities must also ensure that records of MLR forms filled by the facility are maintained. A guidance template to maintain these records is provided in the annexures of this document *(See Annex 4).*

This is a crucial step to ensure ongoing assessment of the GBV/DV situation within the community and to facilitate interventions for prevention both at a community and at a national level.

6.3 Building Linkages and Collaborating with other Stakeholders

Survivors of GBV/DV often face the threat of continued violence, and many have limited options but to remain at home and in the relationship. In the case of domestic violence, survivors are likely to be at continued risk, even if they do not express concern for their safety. Therefore, it is important to assist the survivor to mitigate the negative consequences, and help them find ways to avoid additional violence by assessing the immediate risk of violence, and risks to health and safety. Additionally, it is important that the health sector assist the survivor to access support from Ministry of Gender, Family and Social Services (FCSCs if in atolls) and other relevant authorities and take steps to make him/herself safe.

Healthcare providers and healthcare professionals can support in the following ways and for the following reasons:

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

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

Effective community and society interventions are based on coordination between the legal, social, health and education systems and the workplace (Bott et al, 2005). This is often further strengthened through decentralization of services. These include coordination between the following services.

a) **Social services (Ministry of Gender, Family and Social Services; FCSCs; local councils; and civil society organizations):** provide shelters, child protection and childcare, income generating activities, community support and women or peer groups.

b) **Education services:** Involve the education system in the prevention and management of GBV; promoting greater respect for girls and women and human rights, as well as non-violence; enhance school safety (separate toilets for girls in safe/supervised locations); school health education and school health services. Include education in GBV/DV in the initial training of healthcare providers, lawyers, social workers, teachers, police etc., and follow up with regular ongoing professional development.

c) **Legal and protection services (police, civil society organizations and private legal firms):** build alliance with police services, lawyers, judges and magistrates to enhance enforcement of laws related to gender-based violence/DV and to learn about how best to legally support the survivors.

d) **Drug rehabilitation services**: coordinate with National Drug Agency (NDA) for providing drug rehabilitation services for survivors who are drug users.

Although Ministry of Health takes leadership to address GBV in the health sector, ongoing collaboration and provision of necessary support from other sectors is essential for successful, effective, comprehensive and high quality health sector response.

Ministry of Health, Family Protection Authority, Ministry of Gender, Family and Social Services, Maldives Police Service, Local Government Authority, Judiciary including Department of Judicial Administration, Ministry of Home Affairs, Ministry of Islamic Affairs, Human Rights Commission of Maldives, Children's Ombudsperson's office, and non-governmental organizations including civil society organizations addressing the issue of GBV, and higher education institutions researching on violence prevention and response need to work together collaboratively, and in partnership, in order to achieve a successful response.

6.3.1. Linkages within the health sector

The Director General of Health Services is responsible for overseeing and implementing the health service delivery system within the public sector. Commissioner of Quality Assurance is responsible for regulating health services delivery system across public and private sector. Director General of Public Health is responsible for overseeing the delivery of public health prevention and promotion.

The implementation of the guidelines, providing health services and maintenance of monthly/annual health facility reports rests within the health facilities. Ensuring compliance with the guideline when providing the health services, monitoring of the MLR documentation and production of annual statistical reports rest with the Ministry of Health.

6.3.2. Public and private hospitals/clinics in the atolls

Streamlining GBV healthcare services available at hospitals in atolls by way of identifying a common reporting form and a reporting mechanism, and identifying a health provider in each atoll, who would be the lead entry point for the pathway of care for the survivor could be achieved with the collaboration of these institutions.

On a future date, providing one-point service units at atoll level, dedicated for providing services for survivors of GBV may be envisaged with the collaboration of these institutions.

6.3.3. Public and private hospitals/clinics in Greater Male' area

As some of the survivors access the private health sector in the Greater Male' area and the private sector is expected to provide parallel services to those of the public hospitals. It is important to reach a consensus and identify the mechanisms for both public and private health sectors to operate complimentary to each other in order to avoid duplication of services and to minimize burden to the state and to the survivors in time and finances. All documentation, policy guidelines and GBV training opportunities need to be accessible to health care practitioners in the private health sector.

Interdepartmental linkages within the health institutions such as regional and tertiary hospitals are important for effective implementation of national policy, action plans and health services to the survivors. Collaboration between the dedicated service center such as the FPU at IGMH and the other relevant departments such as A & E, reproductive health, child health, psychiatric/mental health, surgical departments, laboratory and medical records is very important to identify service needs, to initiate referrals, and to refer for services. Collaboration should extend to sharing experiences and

success stories through regular communications which in turn help to build up the image of the service point and to motivate the service providers to become collaborative learning communities.

Identification of an interdisciplinary team of administrators, medical doctors, nurses, counsellors, and therapists who lead support for health care needs of GBV survivors with an experienced senior doctor as the team leader can enable to develop a model of support and comprehensive health care, at each institution. Collaboration between institutions can support the effort at regional and atoll levels.

SUMMARY: ENSURING SIMULTANEOUS REPORTING TO RELEVANT AUTHORITIES FOR SUSPECTED OR CONFIRMED CASES OF GBV/DV

Health providers and health professionals must ensure simultaneous reporting of suspected or confirmed cases of GBV/DV to the following authorities:

- **Maldives Police Service**
  and
- **Family Protection Authority**
  As mandated to health providers/professionals as per *Domestic Violence Act 3/2012*
- Notification must be sent to **Ministry of Gender, Family and Social Services (FCSC if in atolls)** to facilitate other necessary support services to survivor.

Healthcare providers and health professionals must ensure complete documentation:

- History and medical documentation
- Medico-legal Report form with all annexures including referral form to FPA
- A copy of FPA referral form should be mailed separately to *reporting@fpa.gov.mv*

Healthcare providers and healthcare professionals must keep themselves informed regarding current National reporting protocols, laws, policies and best practices when responding to survivors of GBV/DV.

Additional information and guidance are provided throughout this guideline.

(Name of the institute)

Medico-Legal Report (MLR)

Type: [Assault/ Road Traffic Accident (RTA) / Domestic Violence (DV) / Gender-Base Violence (GBV) / Child Abuse / Torture / Others] *(circle the appropriate type)*			
#Medico Legal Report Reference (MLRR) Number:	**Hospital Number:**		
Patient Name:	**Age:**	**Gender:**	***Height:**
ID Card/ Passport Number:	***Date of Birth: / /**		***Weight:**
Nationality:	***Marital Status:**	***Occupation:**	
Permanent Adress:	***Current Address:**		
Arrival Date:	**Arrival Time:**		

Patient Brought by:		
Name:	**Relationship:**	
Address:	**ID Card No:**	**Mobile No:**

***Case Referred by:**	**Alleged Date of Offence: / /**	**Alleged Time of Offence:**
Date of Examination: / /	**Time of Examination:**	**Place of Examination:**

Persons Present During Examination:	
Name:	**Relationship:**
***Patients Identification Marks:** **1.** _____ _____ **2.** _____ _____	

#MLRR No. to be issued by Medical Administration
**Optional*

RELEVANT HISTORY AND PRESENTING COMPLAINTS:

For cases of Domestic Violence (DV) / Gender-Base Violence (GBV) / and Child Abuse, Annex-2 form and Annex 7 or Annex 8 or Annex 9 to be filled.

GENERAL EXAMINATION:

Pulse (per minute):		**Respiratory Rate (per minute):**	
Blood Pressure (mmHg):		**Temperature (degree Celsius):**	
Level of Consciousness:			

SYSTEMIC EXAMINATION:

SYSTEM	NORMAL	ABNORMAL	SYSTEM	NORMAL	ABNORMAL
CENTRAL NERVOUS SYSTEM			MUSCULOSKELETAL SYSTEM		
RESPIRATORY SYSTEM			ENT		
GASTROINTESTINAL SYSTEM			EYE		
CARDIOVASCULAR SYSTEM			DENTAL		

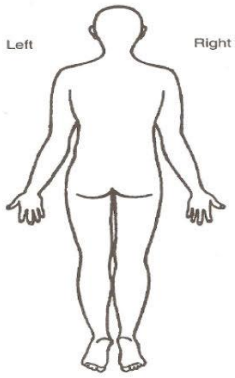
SYSTEMIC EXAMINATION (DOCUMENT ABNORMAL FINDINGS):

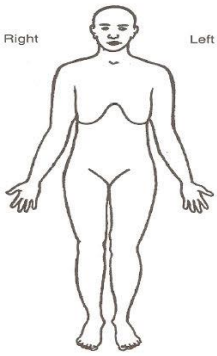
Annex 4,5,6,7 or 10 to be filled if required

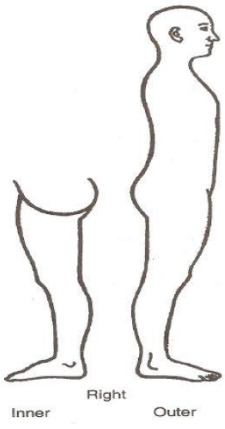
INJURIES:

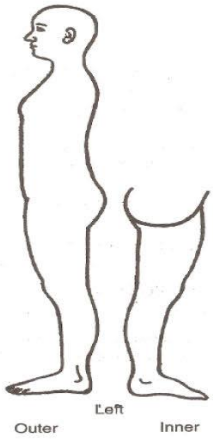
NO:	(Nature, Site, Size, Shape of Injury)

use #no. on the diagram below to represent the injury described above. Use annex diagrams if required.









SPECIAL INVESTIGATIONS(Imaging, toxicology, etc):

-Document Abnormal Findings -Attach Report if Available

PROVISIONAL DIAGNOSIS:

TREATMENT GIVEN AND REMARKS:

DISPOSITION:

	✔	Comments:
Referred:		
Discharged:		
Admitted:		

If a case is referred or admitted, the referred or admitting doctor must fill Annex 1

Statement of restrictions on the medical evaluation/investigation (Optional)

"The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with examine (the patient) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities".

Or;

"The undersigned clinicians had to carry out his/her/their evaluation with the following restriction":

Name of Medical Officer and Qualifications: _____

_____

Designation:_____ Department:_____

Signature of Medical Officer:

Date: _____ /_____ /_____ Time:_____

DOCTORS ATTENDED TO THE PATIENT:

Department	Name	Designation	Signature

ATTACHMENTS: ***Please number the Annex sheet starting from page number 7***

	✓	No. of sheets	Comments:
(Annex-1) Referral Notes:			
(Annex-2) Social History:			
(Annex-3) Forensic Expert Opinion:			
(Annex-4) Diagram (Head):			
(Annex-5) Diagram (Hands & Feet):			
(Annex-6) Diagram (Male Torso & Genital):			
(Annex-7) Diagram (Female Torso & Genital):			
(Annex-8) Diagram (Female Child):			
(Annex-9) Diagram (Male Child):			
(Annex-10) Diagram (Oral Cavity):			
(Annex-11) FPA Referral form_English:			
(Annex-12) FPA Referral form_Dhivehi:			
Investigations:			
Photographs:			

FOR ADMINISTRATIVE PURPOSE:

TOTAL NUMBER OF PAGES:

DOCUMENTS RECEIVED TO MEDICAL ADMINISTRATION:

RECEIVED BY: _____

SIGNATURE:

Annex 2: Referral form to Family Protection Authority (English)

Date: Click or tap to enter a date. Form Number: Click or tap here to enter text.

Domestic violence referral form for service providers		
Instructions - This form is to be used to report domestic violence cases to relevant institutions. - After completion of the form, please send the form to the relevant institution **and** Family Protection Authority via email to reporting@fpa.gov.mv or through fax number: 3010552. - If you need more information, please call 3010551 to reach Family Protection Authority		
Please remember to inform the respondent that their information will be shared with the institutions mandated by law and that it will be shared with FPA to be used for statistical purposes.		
Reported by: ☐ Survivor ☐ Third-party report	Incident Date: Click or tap to enter a date.	Report Date: Click or tap to enter a date.
Was this incident reported to any other institute? ☐ Yes Click or tap here to enter text. ☐ No		
Survivor Information		
Name: Click or tap here to enter text.	Age: Click or tap here to enter text.	Sex: Click or tap here to enter text.
Permanent Address:Click or tap here to enter text. Current Address: Click or tap here to enter text.		ID Card Number: Click or tap here to enter text.
☐ Disability ☐ Drug Use	☐ Mental Health ☐ Medical Illness	
Perpetrator Information		
Name: Click or tap here to enter text.	Age: Click or tap here to enter text.	Sex: Click or tap here to enter text.
Permanent Address: Click or tap here to enter text. Current Address: Click or tap here to enter text.	ID Card Number: Click or tap here to enter text.	Domestic Relationship*: Click or tap here to enter text.
☐ Drug Use ☐ Disability	☐ Mental Health ☐ Medical Illness	
Details of the Incident		
Place of Incident: Click or tap here to enter text.	Island and Atoll: Click or tap here to enter text.	

Act of Abuse, per DVPA 3/2012, clause 4 (a)*			
☐	(1) Physical Abuse	☐	(9) Harassment
☐	(2) Sexual Abuse	☐	(10) Stalking
☐	(3) Verbal and/or Psychological Abuse	☐	(11) Damage to Property
☐	(4) Financial/Economic Abuse	☐	(12) Entry into, and being present thereafter at the victim's residence without consent, where the parties do not share the same residence
☐	(5) Impregnating the spouse, without concern to her health condition and against any medical advice to refrain from impregnation for a specified period of time	☐	(13) Any other act which may be described as controlling or abusive behaviour towards the victim
☐	(6) Impregnating a woman, who is trying to remove herself from an abusive marriage, against her will	☐	(14) Coercing, intimidating, or forcing the victim to commit an act which such person would not have consented to or committed by their own volition

☐	(7) Deliberately withholding the property of a person	☐	(15) Confining the victim to a place or restricting their movement against their will
☐	(8) Intimidation	☐	(16) Attempting to commit any of the foregoing acts or causing apprehension of such acts
☐	(17) Causing a minor to witness or hear an act of domestic violence or presenting or placing a minor in such situation where such minor may witness or hear an act of domestic violence		

Did the incident involve:

☐ Death threats ☐ Choking/Strangulation ☐ Use of sharp object ☐ Neglect ☐ Rape ☐ Blackmail: threatening to leak photos/videos

Please fill the box below if there are additional important details about the reported case

Click or tap here to enter text.

Planned Action / Action taken, and External Referrals

Was client referred to medical services?

☐ Yes ☐ No - Service provided by you
☐ No - Service received prior to this visit
☐ No - Service not applicable
☐ No - Referral declined by survivor
☐ No – Service unavailable

Was client referred to psychosocial services?

☐ Yes ☐ No - Service provided by you
☐ No - Service received prior to this visit
☐ No - Service not applicable
☐ No - Referral declined by survivor
☐ No – Service unavailable

Was client referred to police services?

☐ Yes ☐ No - Service provided by you
☐ No - Service received prior to this visit
☐ No - Service not applicable
☐ No - Referral declined by survivor
☐ No – Service unavailable

Was client referred to legal services?

☐ Yes ☐ No - Service provided by you
☐ No - Service received prior to this visit
☐ No - Service not applicable
☐ No - Referral declined by survivor
☐ No – Service unavailable

Please fill the box below with the details of any referrals that were made to another institution

Click or tap here to enter text.

Contact details of person who filled the form: Click or tap here to enter text.	Name and Designation of person who filled the form: Click or tap here to enter text.

ފޯމު ނަންބަރު: Click or tap here to enter text.

ތާރީޚު: Click or tap to enter a date.

މުއައްސަސާތަކުން ގޭތެރި އަނިޔާގެ މައްސަލަތައް ހުށަހަޅާ ފޯމު

އިރުޝާދު

- މި ފޯމަކީ ދިވެހި މުއައްސަސާތަކުން ގޭތެރި އަނިޔާގެ މައްސަލަތައް ހުށަހެޅުމަށް އެމައްސަލަ ކަމާ ގުޅުންހުރި މުއައްސަސާތަކަށް ރިފަރ ކުރުމަށް ބޭނުންކުރާނެ ފޯމެވެ.
- މި ފޯމު ފުރިހަމަކުރުމަށްފަހު ކަމާ ގުޅުންހުރި މުއައްސަސާތަކުން ފޮނުއްވާނީ ފެމިލީ ޕްރޮޓެކްޝަން އޮތޯރިޓީގެ އީމެއިލް reporting@fpa.gov.mv ނުވަތަ ފެކްސް ނަންބަރު 301 0552 އަށް ފޮނުއްވުން އެދެމެވެ.
- މި ފޯމުގެ އިތުރު މައުލޫމާތު ބޭނުންފުޅުވެލައްވާނަމަ ފެމިލީ ޕްރޮޓެކްޝަން އޮތޯރިޓީގެ ފޯނު ނަންބަރު 301 0551 އަށް ގުޅުއްވުން އެދެމެވެ.

މައްސަލަ ހުށަހެޅި ފަރާތުގެ ހިއްސާކުރާ މަޢުލޫމާތު، ފޯނުގެ ޒަރިއްޔާ ހިއްސާކުރެވޭ މުއައްސަސާތަކާ ހިއްސާކުރެވޭނެ އަދި އޮތޯރިޓީން ތަޙުޤީޤުކުރާ ތަފާސް ހިސާބަށް ބޭނުންކުރެވޭނެކަން މައްސަލަ ހުށަހެޅި ފަރާތަށް ކިޔައިދޭންވާނެއެވެ.		
ރިފަރ ކުރި ފަރާތް: ☐ އަނިޔާ ލިބުނު ފަރާތް ☐ އެހެން ފަރާތަކުން	މައްސަލަ ހިނގި ތާރީޚު: Click or tap to enter a date.	މައްސަލަ ރިފަރކުރެވުނު ތާރީޚު: Click or tap to enter a date.
މި މައްސަލަ ކުރިން އެހެން މުއައްސަސާއަކަށް ހުށަހަޅާފައިވޭތޯ؟ ☐ އާއެކޭ ނަމަ: Click or tap here to enter text. ☐ ނޫނެކޭ		
އަނިޔާ ލިބުނު މީހާގެ މައުލޫމާތު		
ނަން: Click or tap here to enter text.	އުމުރު: Click or tap here to enter text.	ޖިންސު: Click or tap here to enter text.
ދާއިމީ އެޑްރެސް: Click or tap here to enter text. މިހާރު ދިރިއުޅޭ އެޑްރެސް: Click or tap here to enter text.		އައި.ޑީ ކާޑު ނަންބަރު: Click or tap here to enter text.
☐ ނުކުޅެދުންތެރިކަން ހުރި ފަރާތެއް ☐ މަސްތުވާ ތަކެތި ބޭނުންކުރާ ފަރާތެއް	☐ ނަފްސާނީ ބައްޔެއް ހުރި ފަރާތެއް ☐ ސިއްޙީ މައްސަލައެއް ނުވަތަ ބައްޔެއް ހުރި ފަރާތެއް	
އަނިޔާ ދިނި މީހާގެ މައުލޫމާތު		
ނަން: Click or tap here to enter text.	އުމުރު: Click or tap here to enter text.	ޖިންސު: Click or tap here to enter text.
ދާއިމީ އެޑްރެސް: Click or tap here to enter text. މިހާރު ދިރިއުޅޭ އެޑްރެސް: Click or tap here to enter text.	އައި.ޑީ ކާޑު ނަންބަރު: Click or tap here to enter text.	އަނިޔާ ލިބުނު ފަރާތާއި އޮތް ގޭތެރި ގުޅުން*: Click or tap here to enter text.
☐ ނުކުޅެދުންތެރިކަން ހުރި ފަރާތެއް ☐ މަސްތުވާ ތަކެތި ބޭނުންކުރާ ފަރާތެއް	☐ ނަފްސާނީ ބައްޔެއް ހުރި ފަރާތެއް ☐ ސިއްޙީ މައްސަލައެއް ނުވަތަ ބައްޔެއް ހުރި ފަރާތެއް	
އަނިޔާއާ ގުޅުންހުރި މައުލޫމާތު		
ހާދިސާ ހިނގި ތަން: Click or tap here to enter text.	ހާދިސާ ހިނގި އަތޮޅު އަދި ރަށް: Click or tap here to enter text.	
ގޭތެރި އަނިޔާގެ ބާވަތް / ގޭތެރި އަނިޔާ ހުއްޓުވުމުގެ ޤާނޫނުގެ މާއްދާ 4 (ހ)*		

☐	(1) ޖިސްމާނީ އަނިޔާދިނުން	☐	(9) ވާރުތަކުރުން
☐	(2) ޖިންސީ އަނިޔާދިނުން	☐	(10) ފާރަލުން
☐	(3) ބިރުގެ ހަރަކާތްތެރިވުން ނުވަތަ ނަފްސާނީ ގޮތުން އަނިޔާދިނުން	☐	(11) މުދަލަށް ގެއްލުންދިނުން
☐	(4) މާލީގޮތުން ނުވަތަ އިޤްތިޞާދީގޮތުން ދަތިކުރުން	☐	(12) އެއްބަޔަކު ދިރިއުޅޭ ދިމާލުން ކުޑަކުދިންނަށް ގެއްލުންވާގޮތަށް ކުރާ ކަންތައްތައް، ގޭތެރި އަނިޔާގެ ސިފަކުރެވޭ ދިރިއުޅޭ ގޭތެރެއިން، ކާނާ އަދި ސާފުކުރުން ފަދަ ކަންތައް ދޫކޮށްލުން، ފަދަ ނުވަތަ ވަރުގަދަ ކުރުން
☐	(5) ގޭގެ ތެރޭގެ ހަރަކާތްތަކާއި، އަންބިމީހާ ފަދަ މުސްތަޤިއްލުކަމާ ލިބެން ޖެހޭ ޙައްޤުތައް ނުދިނުން، އަންބިމީހާގެ ސިއްރުތަކާ	☐	(13) މިންނެތް ގޭތެރި އަނިޔާގެ ސިފަކުރެވޭ މުއައްސަސާގެ ކަންތައް ހުށަހެޅުން ނުވަތަ

	ބޭފުޅުންނަށް މާބަނޑުވުމުން		އުފެދުނުވެސް އަނިޔާވެރި އަމަލުތަކަށް ބޭފުޅުން އެއްވެސް ކަމެއްކުރުން
☐	(6) އަނިޔާވެރި ކައިވެންޏަކުން ދިރުވުން މަސައްކަތްތަކާ އަންހެނުންގެ ދަރުމާ ދިނުމަށް އެކި މާބަނޑުވުމުން	☐	(14) މީހެއްގެ އަމިއްލަ އިޚްތިޔާރު އޮތުމަށް، ޖިންސީ ބޭނުން ކުރުމާ، ނުވަތަ އަމިއްލަ އިޚްތިޔާރުގައި އެނޫން އަމިއްލަފައިން ނުކުރާނެ ކަމެއް އެކި ފަހަރު ގޮތަކުން ކުރުވުން، ނުވަތަ ބިރުދައްކައިގެން ކުރުވުން، ނުވަތަ ބާރުގެ ބޭނުންކޮށްގެން ކުރުވުން
☐	(7) މީހެއްގެ މުދާ އަމިއްލަ ފައިދާއަށް ބޭނުން ނުކުރާށޭ ހުއްޓުވުން ގެއްލުމާއި ހިފެހެއްޓުން	☐	(15) މީހެއްގެ ނުރުހުމުގައި އޭނާ ބަރަހަނާ ބަލައިލުން، ނުވަތަ އޭނާގެ އަމިއްލަ އިޚްތިޔާރުގައި އެއްބަސްނުވާ އަނެއް ބޭފުޅަކު ނަގާފައިވާ ފޮޓޯ، ނުވަތަ އޭނާގެ އަމިއްލަ އިޚްތިޔާރުގައި ދައްކައިދިނުން، ހިއްސާކޮށް ފޮނުވާ ފޮޓޯ
☐	(8) ބިރުދެއްކުން	☐	(16) ނިސްބަތްވާ އެއްވެސް ބާވަތެއްގެ ކަމެއް ކުރަން މަޖުބޫރު ނުވަތަ ހިންގަން އުފައްދާ ނުވަތަ އެއްވެސް ހިންގާނެ ބާރު މީހެއްގެ ހިތުގައި އުފެއްދުން
☐	(17) ގެދޮރު އަނިޔާގެ އަމަލެއް ހިނގުމުގެ މަންޒަރު ކައިރިއެއްގެ ގާތުން ދެކެން ކުޑަކުދިންނަށް ދެއްކުން ނުވަތަ އަޑު އިއްވުން، ނުވަތަ އެފަދަ އަމަލެއް ފެންނާނެ ނުވަތަ އަޑުއިވޭނެ ހާލަތެއްގައި ކުޑަކުދިން ގެންގުޅުން ނުވަތަ ހުރުވުން		

އަނިޔާގެ ބާރުގައި އަންނަނިވި އެއްވެސް ކަމެއް ހިނގާފައިވޭތޯ ނުވަތަ ފާހަގަކުރެވިފައިވޭތޯ؟

☐ މަރުގެ އިންޒާރު ދިނުން ☐ ކަރުގެ ހިފުއްޓަން/ ނޭވާ ހުއްޓުވުން ☐ ތޫނު އެއްޗެއް ބޭނުންކުރުން ☐ ހިހާމާރުވުން ☐ ރޭޕްކުރުން

☐ ވަޅި/ ބިލި ފަދަ ހަތިޔާރުތަކުން ބޮލަށް ބޭނުންކުރުން

މަސައްކަތާ ގުޅިގެން އިތުރަކަށް ފާހަގަކުރެވުނު ބޭނުންތަކާ ތިރީގައިވާ ގޮތަށް ބަޔާންކުރައްވާ

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މަސައްކަތާ ގުޅިގެން އެހެން މުއައްސަސާތަކަށް ކުރެވިފައިވާ ރިފަރަލްތައް

އަނިޔާ ލިބުނު ފަރާތް ސިއްހީ ހިދުމަތް ހޯދުމަށް ރިފަރ ކުރެވުނުތޯ؟

☐ އާއެކޭ ☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާ އިން މި ހިދުމަތް ފޯރުކޮށްދިން

☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާއަށް އައުމުގެ ކުރިން ހިދުމަތް ލިބިފަ

☐ ނޫނެކޭ – މި ހިދުމަތް ނުދޭ

☐ ނޫނެކޭ – އަނިޔާ ލިބުނު ފަރާތް ހިދުމަތް ބޭނުން ނުވުން

☐ ނޫނެކޭ – ހިދުމަތް ލިބުން ނެތުމުން

އަނިޔާ ލިބުނު ފަރާތް ސައިކޯސޯޝަލް ހިދުމަތް ހޯދުމަށް ރިފަރ ކުރެވުނުތޯ؟

☐ އާއެކޭ ☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާ އިން މި ހިދުމަތް ފޯރުކޮށްދިން

☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާއަށް އައުމުގެ ކުރިން ހިދުމަތް ލިބިފަ

☐ ނޫނެކޭ – މި ހިދުމަތް ނުދޭ

☐ ނޫނެކޭ – އަނިޔާ ލިބުނު ފަރާތް ހިދުމަތް ބޭނުން ނުވުން

☐ ނޫނެކޭ – ހިދުމަތް ލިބުން ނެތުމުން

އަނިޔާ ލިބުނު ފަރާތް ޤާނޫނީ ލަފާ ހޯދުމަށް ރިފަރ ކުރެވުނުތޯ؟

☐ އާއެކޭ ☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާ އިން މި ހިދުމަތް ފޯރުކޮށްދިން

☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާއަށް އައުމުގެ ކުރިން ހިދުމަތް ލިބިފަ

☐ ނޫނެކޭ – މި ހިދުމަތް ނުދޭ

☐ ނޫނެކޭ – އަނިޔާ ލިބުނު ފަރާތް ހިދުމަތް ބޭނުން ނުވުން

☐ ނޫނެކޭ – ހިދުމަތް ލިބުން ނެތުމުން

އަނިޔާ ލިބުނު ފަރާތް ޕޮލިހުންގެ ފަރާތުން ހިދުމަތް ހޯދުމަށް ރިފަރ ކުރެވުނުތޯ؟

☐ އާއެކޭ ☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާ އިން މި ހިދުމަތް ފޯރުކޮށްދިން

☐ ނޫނެކޭ – ތިޔަ މުއައްސަސާއަށް އައުމުގެ ކުރިން ހިދުމަތް ލިބިފަ

☐ ނޫނެކޭ – މި ހިދުމަތް ނުދޭ

☐ ނޫނެކޭ – އަނިޔާ ލިބުނު ފަރާތް ހިދުމަތް ބޭނުން ނުވުން

☐ ނޫނެކޭ – ހިދުމަތް ލިބުން ނެތުމުން

އެހެން މުއައްސަސާތަކަށް ހިދުމަތްތަކަށް ރިފަރކުރެވިފައިވާނަމަ އެ ރިފަރަލްއާ ގުޅިގެން މައުލޫމާތު މިފޯމުގައި ފުރިހަމަކުރައްވާ

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ފޯމު ފުރިހަމަ ކުރައްވާ ފަރާތުގެ ނަން އަދި މަޤާމު Click or tap here to enter text.	ފޯމު ފުރިހަމަ ކުރައްވާ ފަރާތަށް ގުޅޭނެ ނަންބަރު Click or tap here to enter text.

Annex 4: Guidance template – Monthly/yearly summary of Medico-legal reports filled for suspected/confirmed cases of Gender-based Violence/Domestic Violence by health facility*

Monthly/Yearly summary of Medico-legal reports filled for suspected/confirmed cases of Gender-based Violence/Domestic Violence by health facility

Name of facility:

Island/Atoll:

Year:

	Details	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	TOTAL (year)
1	**Total number of medico-legal reports filled by health facility**													
2	Total number of medico-legal reports filled for **confirmed** cases of **GBV/DV**													
3	Total number of medico-legal reports filled for **suspected** cases of **GBV/DV**													
	Total													
4	Total number of medico-legal reports filled for **confirmed** cases of **GBV/DV involving a child below 15 years of age**													
5	Total number of medico-legal reports filled for **suspected** cases of **GBV/DV involving a child below 15 years of age**													
	Total													
6	Total number of medico-legal reports filled for **confirmed** cases of **GBV/DV involving a child aged between 15 through 17 years**													
7	Total number of medico-legal reports filled for **suspected** cases of **GBV/DV involving a child aged between 15 through 17 years**													
	Total													
8	Total number of medico-legal reports filled for **confirmed** cases of **GBV/DV involving an adult aged 18 years and above**													
9	Total number of medico-legal reports filled for **suspected** cases of **GBV/DV involving an adult aged 18 years and above**													
	Total													

*This guidance template may change based on future requirements for reporting and audits.