OPERATIONAL MANUAL

FOR

FAMILY PROTECTION CENTERS

One-Stop Assistance Centers for Health Care Response to Gender-Based Violence

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For UNFPA Afghanistan

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LIST OF ABBREVIATIONS

GBV – Gender Based Violence

GoIRA – Government of the Islamic Republic of Afghanistan

MoPH – Ministry of Public Health

BPHS – Basic Package of Health Services

EPHS – Essential Package of Hospital Services

BHC – Basic Health Center

CHC – Comprehensive Health Center

CID – Criminal Investigation Department

DH- District Hospital

DOWA – Department of Women's Affairs

FRU – Family Response Unit

HIMS – Healthcare Information Management System

MOWA – Ministry of Women's Affairs

PH- Provincial Hospital

PPHD – Provincial Public Health Directorate

RH- Regional Hospital

GBVIMS—Gender Based Violence Information Management System

CHAPTER 1

1- Preface

1.1. Preamble

Health Care Response to Gender-Based Violence (GBV), is one of the many ways in which UNFPA is supporting the Government of the Islamic Republic of Afghanistan (GoIRA) to tackle the socio-cultural and health problem that is adversely affecting the well-being of thousands of women, children, and men. UNFPA's 2011 assessment of services for GBV survivors in Afghanistan[1] identified one important gap identified in the health sector's response to GBV as being the absence of 'separate facilities for examination and interviewing of GBV victims.'

According to the Afghanistan Demographic Health Survey of 2015, more than 50% of women and girls have experienced some form of physical or sexual violence in their lives, more often than not, perpetrated by a family member. However, a vast majority of survivors receive no health care or other support for it, because they accept it as a part of life, or owing to social stigma attached to it, or simply due to lack of confidential and safe access to services.

GBV is not merely a health issue; it has significant social, criminal, and judicial implications, that need an integrated response mechanism to ensure the appropriate timely input of all the relevant government and nongovernment stakeholders. This is vital to enable the GoIRA to fulfill its constitutional and international commitments to accord equal rights and protection to all its citizens, and to guarantee the protection and participation of women, and prevention of all forms of violence and discrimination against them (EVAW law, UN Security Council Resolutions and CEDAW conventions).

The National Priority Program (NPP 2012), Health for All Afghans, places specific emphasis on integration of health sector response to GBV within secondary and tertiary level health care (Component 1 deliverable 1.2.3)[2], and outlines a six-step process to achieving it. Since 2012, the Ministry of Public Health (MoPH) and its international partners have successfully completed the first four steps [3], and have in-place an approved country-specific model of health care response to GBV. This is the Family Protection Center (FPC), situated within provincial, regional or national level hospitals, and designed as one-stop GBV response centers to provide GBV survivors with integrated services responding to their needs.

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[1] *Assessment Of Services Provided To Victims Of Gender based Violence By State And Non-State Agencies In Pilot*

[2] ***Deliverable 1.2.3:*** *Integration of professional assistance and referral services for victims of gender –based violence (GBV)*

[3] Step I: Development of the Concept Paper on health sector response to GBV
Step II. Development of country specific model of health sector response to GBV
Step III: Capacity building of health service providers to ensure that professional multilevel assistance, safety and confidentiality standards are in place
Step IV: Piloting of the Model in selected provinces
Step V: Revision of the Model and full integration of the services into health care sector
Step VI. Monitoring and quality control assurance through continues capacity building of health professionals.

In 2012, the MoPH and UNFPA, in collaboration with other international partners and government stakeholders, piloted the Hospital Based One-stop GBV response center, the FPC, to serve as a hub for integrated management and response to the multi-faceted problems of GBV survivors, in a coordinated and efficient manner. Beginning with two such centers within provincial level hospitals in Kabul (Ibnesina Emergency Hospital) and in Jalalabad, by 2016, FPC services were extended to 12 provinces, and the intent is to further extend so that there is at least one FPC in each provincial center as the referral facility for health and multi-sectoral response and assistance to GBV survivors.

As the long-term vision is that the FPC will eventually become fully integrated into the MoPH's Essential Package of Hospital Services (EPHS), there is need for a uniform protocol of operation that can be followed by all FPCs across the country, and which affords itself to monitoring and evaluation for quality of services and performance.

The manual is designed to provide clear operational protocols and guidelines for the establishment and operation of the MoPH-approved model of the FPC, and lend itself to future modifications as needed, to ensure effectiveness, sustainability and cost-effectiveness and eventual, full ownership by the host EPHS health facilities.

The ensuing Operational Manual will identify pre-establishment criteria required for qualifying as a host facility, the physical infrastructure needed for setting up an FPC and outline the scope of services an FPC will offer. It will provide standard lists of equipment and supplies needed in an FPC setup, for delivering services.

The following chapters will also include easy-to-follow description of roles and responsibilities of individual technical members of the FPC team, providing clear Terms of Reference (TORs) and guidelines to ensure uniform standard management of GBV cases at the FPC, case referral to and from multi-sectoral partners, and proper use of approved tools for management, coordination, recording, and reporting of GBV cases.

The manual will be titled "Family Protection Center (FPC) Operational Manual 2017", and will come into effect as soon as it is approved and endorsed by the MoPH and other involved line ministries and institutions including the Ministry of Women's Affairs, Afghanistan Independent Human Rights Commission, Ministry of Justice, and the Ministry of Interior. Following formal endorsement and approval of the manual, the planning, execution, supervision, documentation and reporting of the Hospital Based FPC shall be performed as per the manual.

1.2. Definitions

a) GBV means Gender Based Violence

While Gender Based Violence can affect men and boys, since the majority of victims in Afghanistan are women and girls, its official description in the MoPH's national gender strategy (2012 – 2016) includes primarily, "physical, mental and sexual abuse and traditional harmful practices like child marriage, giving away girls for dispute resolution, forced isolation in the home, exchange marriage and "honor" killings – cause suffering, humiliation and

marginalization for millions of Afghan women and girls. Such practices are grounded in discriminatory views and beliefs about the role and position of women in Afghan society."[4]

According to the health sector response to GBV model for Afghanistan, GBV is any "act that results in physical, sexual and psychological harm to both men and women and includes any form of violence or abuse that targets men or women on the basis of their sex. Unequal power relations between men and women significantly contribute to gender violence. GBV can apply to women and men, girls and boys.]

b) Violence Against Women means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[5]

c) 'Focal persons' means individual representatives of GBV stakeholder organizations, who will facilitate relevant referral and services support to GBV cases and commit to participating in monthly case management meetings and follow up

d) GBV stakeholders means Ministries of Public Health, Women Affairs, Interior, Justice, Afghanistan Independent Human Rights Commission, and their provincial offices, and women rights groups and NGOs working with GBV survivors and shelters, UNFPA, UN Women and other UN agencies, other donors and partners working in the area of GBV.

e) Case-management Committee meetings are monthly meetings of focal persons from governmental and non-government GBV stakeholders chaired by the FPC leadership to follow up and track progress of GBV cases presented at FPC

f) GBV sub-cluster coordination meetings are quarterly meetings of senior representatives of GBV stakeholders chaired by MoPH (or its provincial/district offices), MoWA (or its provincial/district offices) or AIHRC (or its provincial/district offices).

g) Women Protection Center means the shelter established and operated for GBV survivors for a temporary stay by Ministry of Women Affairs or women rights NGOs for protection of survivors.

h) Survivors/victims/violence-affected are different terms used in this manual to refer to the women, children, and other persons who visit the FPC after experiencing GBV, and seek assistance. The term survivor is a positive and empowering reference to GBV affected people, who decide to seek help to recover from it. All different terms refer to the clients at the FPC.

1.3 Objective of Manual

[4] ***National Gender Strategy 2012 - 2016***

[5] ***CONCEPT NOTE: BUILDING COORDINATED MULTI-SECTORAL RESPONSE TO GENDER-BASED VIOLENCE -- Health Sector Response to GBV Model 2012***

The purpose of this operational manual for FPCs is to guide the establishment, service delivery, recording, referral, monitoring, quality assurance, and reporting of FPC.

While the manual primarily addresses the activities and needs of the health sector aspect of GBV response and provides specific guidance to health sector personnel involved, it is vital that other relevant line ministries endorse it to ensure their full understanding and agreement.

1.4 Users of Manual

The manual provides specific detailed assessment guidelines for establishment of an FPC, its set up, staffing structure and TORs for specific roles, equipment and kit of medical and non-medical supplies.

Its **primary** users will be the FPC team and the hospital management for whom the manual provides detailed guidance on organization, structure, and day to day management, and the EPHS M&E team of the MoPH, the HMIS, and the gender directorate, who will have overall responsibility for quality assurance and performance control.

S**econdary** users of this operation manual will be other state and non-state GBV stakeholders; their understanding and endorsement of referral protocols will be vital for the success of the integrated response model.

International donors and partners will be the **tertiary** users, for whom it will provide useful information about how the model works, and help in rationalizing future support.

The aim is to ensure provision of quality care according to agreed-on standards uniformly to survivors of GBV and to facilitate easy replication and set up of new centers to expand the network in unserved parts of the country.

CHAPTER 2

2. Family Protection Center (FPC)

2.1 What is a Family Protection Center of FPC?

Family Protection Center or FPC is a 'one-stop assistance center' or 'service hub' (as described in the Concept Note of 2012, for health sector response to GBV model) to serve as an entry point to integrated response to GBV. It will align with the MoPH's SOP for Health Sector Response to GBV, and adhere to the guiding principles set out in the general SOP, to respond to six categories of incidents of GBV: **sexual violence, sexual assault, physical violence, forced marriage, denial of basic needs such as food or shelter, psychological / emotional violence[6],** which also effectively cover the definitions of GBV adopted by the IASC, which includes Rape, Sexual Assault, Sexual Exploitation, Sexual Abuse, Physical violence/ intimate partner violence, Forced Marriage/ Early Marriage, Psychological/ Emotional abuse and Denial of resources, Opportunities or Services (or economic violence).

A plan to integrate FPC services in the health care sector is clearly outlined in the National Priority Program Health for All Afghans, and in the long run, it would be logical to expect it to become a component of BPHS / EPHS owned by the Ministry of Public Health, with referral linkages between them, and with other social, legal, and criminal justice stakeholders.

Embedded within a provincial, regional or national hospital, the FPC enables the health care system to offer a wide range of choices and solutions for women, girls, and children subjected to abuse, in a safe and confidential manner, and diminish security risks for GBV victims and service providers through networking with multi-sectoral GBV stakeholders; the FPC also provides technical and institutional support to the Forensic Medicine Unit of the public health system.

The Family Protection Center integrates professional assistance (psycho-social, medical and legal support and referral services into the health sector) and acts as a one-stop assistance center, providing GBV survivors with necessary basic services, evidence collection, and information support in one place. It functions as a multi-agency coordination model allowing GBV survivors to receive maximum assistance for minimum investment of resources.

2.2 FPC Ownership

As per the NPP 5, and its role within the health sector response to GBV, services offered by the Family Protection Center or FPC are integral to the MoPH's maternal and sexual health interventions, and also have mental and psychosocial components. It is owned by the MoPH and positioned within the EPHS structure in each provincial center, with referral focal points within primary health facilities at district and village levels (BHC, CHC, DH).

While it isn't an immediate possibility, in the long term, it is expected the MoPH will lead the establishment, equipping, and operation of FPCs. The ministry will fund all FPC services through its on-budget or off-budget funding sources, and be responsible for recruitment, capacity

[6] For detailed definitions of six types of violence refer to SOP Health Sector Response to GBV pages 9,10

development, and monitoring of FPC staff to ensure its full integration within the EPHS structure. Thus steps should be taken to prepare for the gradual full ownership of the FPC within EPHS. This will be done through direct involvement of the hospital management in oversight and support of the FPC, and through capacity building of medical and nursing staff in diagnosis and management, and sharing of tools for referral and recording of GBV cases.

While FPCs will be responsible for health care assistance to GBV survivors, investment and full participation of other GBV stakeholders is vital to ensure an integrated and timely response to the needs of GBV cases. For this, the FPC manual must be shared with and endorsed by individual stakeholders following which, a memorandum of agreement must be signed with each of them defining mutual obligations and roles for ensuring full collaboration and support with follow up of individual GBV cases.

CHAPTER 3

3 FPC structure

As proposed in the SOP for health care response to GBV, Family Protection Center or FPC should eventually become an integral part of the Ministry of Public Health's EPHS, and have direct reporting linkages with the BPHS and EPHS directorate and the Gender Directorate of the MoPH

3.1 Physical Set up

The FPC will be situated within the precincts of a provincial, regional, or national hospital, and will be directly managed and supervised by the technical management of the health facility. As per the approved design, an FPC may be set up within a provincial, regional, or national level hospital. While men and boys also experience GBV and the FPC would eventually be able to offer services to male survivors as well, female survivors face more barriers to accessing needed care, and situating the FPC within a hospital will allow for access to larger numbers of women and girls, keeping in mind the sensitiveness and confidentiality of the issue.

The FPC will be positioned in a discreet but easily accessible location within the hospital, to allow for a level of privacy. It will be composed of two adjoining rooms – a reception and a physical examination / psychosocial counselling room. The physical exam and counselling room will be a larger more spacious room (approximate dimensions 5m x 3m), properly separated from the reception area, and will have the means to ensure privacy and confidentiality of staff-patient interactions. The physical exam / psychosocial counseling room will be able to accommodate three or four seats, a medicine cabinet, a lockable file cabinet, a screened off examination table, and will have an adjoining wash closet, or at a minimum, a hand washing basin.

The reception will be a smaller room (approximate dimensions 3m x 2m) with two work tables with chairs, seats for receiving visitors, desktop computer with printer, a stationery and supplies cupboard, and a file cabinet.

The name, Family Protection Center, allows it an overtly non-specific identity, preempting any stigma attached to visits to the center.

3.2 Staffing Structure

The FPC will have an all-female staff including a FPC In Charge, a medical / psychosocial counselor, and a data officer/ legal counselor. As a unit integrated within the hospital facility, the first line of reporting for the FPC in charge will be directly to the hospital senior management, who will be responsible to provide full administrative, logistical, and supervision support. The FPC in charge will also report to the GBV focal person within the MoPH gender directorate, and at provincial levels, to the gender and GBV focal person within PPHDs as

relevant. The following rough organogram defines the roles and relationships within the structure within the MoPH

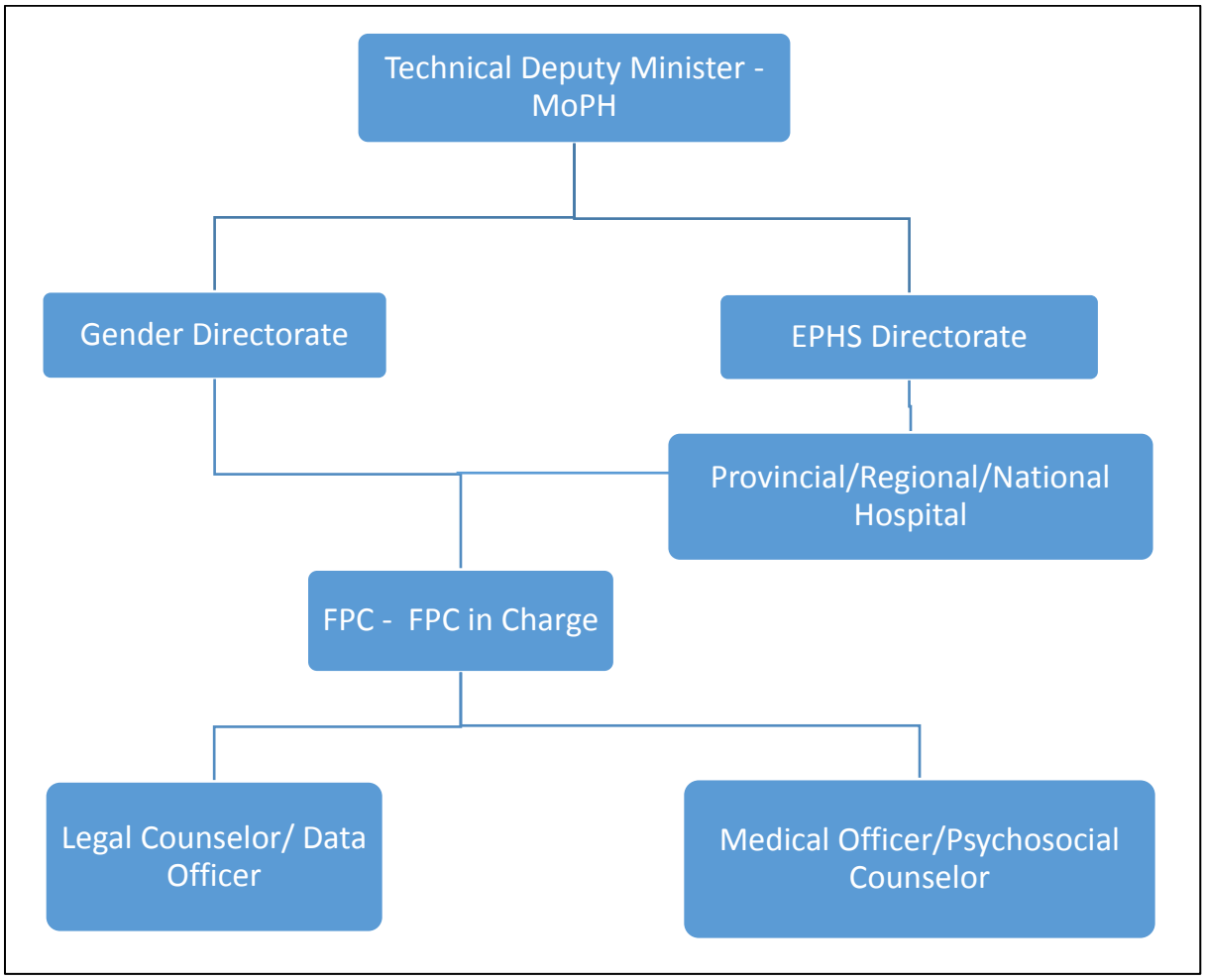


Figure 1 FPC Organogram

All roles and responsibilities of FPC staff will strictly follow the established and approved standard operating procedures for health sector response to GBV

The FPC in charge will be the administrative head responsible for the center. She will be responsible for supervising FPC team members, organizing and equipping of facility and resources, and for regular coordination with the hospital management to facilitate smooth operation of the FPC and to ensure adequate support from the hospital. On arrival at the the FPC a GBV survivor will be received by the FPC in charge, who will explain the role of the FPC, and obtain informed consent from the survivor or he / his custodians.

She will oversee all FPC activities to ensure they are implemented as per set standards and guidelines. She will hold periodic meetings with the Gender Directorate of the MoPH at the center, and with the PPHD focal person in the provinces to report on activities. She will also be

responsible for maintaining regular communication with the hospital management, and participating in any hospital technical discussions and meetings to represent the FPC. Desired qualifications and detailed TOR for this position are included as an annex at the end of the manual.

The medical officer / psychosocial counselor will be supervised by the FPC in charge, and will be the first point of contact for the GBV survivor referred to the FPC. She may be a medical doctor, or experienced nurse or midwife trained as a psychosocial counsellor. She will provide private and confidential physical examination to the patient, and offer psychosocial counselling in a supportive and respectful manner.

The medical officer / psychosocial counselor will explain simply and clearly to the GBV survivor, what the medical examination entails, and any investigations and interventions that may be needed. She will use the standard approved intake form to register and record all personal details of the case.

She will conduct a physical examination of the patient after obtaining consent, and strictly following guidelines as laid out in the SOP for health sector response to GBV. She will prescribe prophylactics, and medication or treatment as needed, and referral for further investigations or more advanced care within other departments of the hospital, or in specialized centers outside.

In addition to physical examination the medical officer / psychosocial counselor will offer counselling support in a respectful and understanding manner, and determine if the survivor needs further follow up sessions. A patient may be asked to return for 4 to 6 follow up psychosocial counselling sessions. At a later stage, family psychosocial sessions may also be planned if the survivor expresses the need for them.

Under no circumstances can a GBV survivor be forced or coerced into accepting any advice of the medical officer. All decisions will be in control of the survivor, and will be treated with complete respect and confidentiality.

The GBV survivor will have full control over the use of identifying and non-identifying information in the record file related to her case. No information in the patient's file may be used or shared without her expressed permission. The medical officer / psychosocial counselor will complete the medical form, and refer the survivor/patient to the data officer/ legal counselor for legal advice and referral if requested.

The medical / psychosocial counselor will report directly to the FPC in charge, and will participate regularly in monthly case management meetings to track health care referrals and discuss specific issues faced by GBV survivors. Her responsibilities will include filling of consent, intake, and medical formats, administering any initial medical assistance needed, and listening attentively and recording the survivor's description of her condition, to help her /him make free and informed decisions about further medical interventions needed, and prescribe appropriate referral. In cases of sexual violence or rape, she will offer advice and referral for blood tests for STDs, Hepatitis, and HIV/AIDS, and for post contact contraception. She will also facilitate linkage with the forensic medicine laboratory, if forensic evidence is needed. Desired

qualifications and detailed TOR for this position are included as an annex at the end of the manual.

The FPC legal counselor / data officer has two distinct roles. She will ensure complete data entry of registration and documentation of each case presented at the FPC, and provide advice and referral on legal action options, or criminal justice assistance. The legal counselor/ data officer will be responsible for maintaining a well-connected network with multi-sectoral service providers.

Following completion of medical and psychosocial visit of the GBV survivor, the legal counselor will provide criminal justice, social or other referral information and advice, recommended and accepted by the survivor. She will get referral authorization from the survivor before connecting her/him to relevant officials within CID, justice agencies, AIHRC or MOWA, prosecutor's office, and provide guidance and support to minimize inconvenience or delay with assistance at the referral site.

She will follow up each individual case to its resolution through ongoing communication with relevant GBV stakeholders involved.

As data officer, she will input all case data into the MoPH GBV database and prepare case management reports for presenting at GBV sub-cluster meetings, and provide briefs to the FPC in charge to prepare her for the weekly meetings with the hospital senior management.

The legal counselor / data officer will also be responsible for the secure physical storage of case files and identifying information, so that confidentiality of case management is not compromised. She will present specific legal and security issues at case-management meetings for follow up. The legal counselor / data officer will input case file data into the GBV database provided by the MoPH, to which she will have direct access, and will be in direct communication with the GBV data collection officer at the MoPH Gender Directorate for responding to any follow up questions or information needs. She will share responsibility to ensure safe and confidential treatment of case information and secure storage of physical records, with the other two members of the FPC team. The legal counselor/data officer will report directly to the FPC in charge, and will cooperate and collaborate with both team members. Desired qualifications and detailed TOR for this position are included as an annex at the end of the manual.

The **Hospital Leadership** i.e. the senior management team, including the technical and administrative heads will provide direct supervision and support to the FPC facility. They will hold regular meetings with the FPC in charge to be updated about the operations of the FPC, and its integration within the hospital structure. It will be the hospital leadership's responsibility to ensure sustained close linkages of FPC team with health care personnel in other departments of the facility, to promote better coordination for cross referrals and other services. The weekly meetings will also enable the hospital management to identify and address any administrative or logistical issues of the FPC, and to maintain a smooth functioning FPC.

The medical chief of the hospital will, over time, undertake to enable all the hospital's technical staff to build their capacity in basic identification and response to GBV as per approved standard protocols and procedures. He/she will also attend GBV sub-cluster meetings to demonstrate the hospital's role in the GBV response provided by the FPC.

3.3 Staff Capacity Building

Quality assurance of services and adherence to standards and protocols is only possible with adequately qualified and trained staff at the FPCs. Adequately qualified and experienced staff will be recruited to lead the FPC and to serve as medical/psychosocial officer, and legal advisor/data officer. It is strongly recommended that all FPC staff take a pre-deployment mandatory intensive training in the standard operating procedures for health sector response to GBV approved by MoPH, and be able to demonstrate familiarity with procedures and standard forms through an exit test at the end of the training.

The MoPH and its PPHDs can also integrate within their work plans, quarterly short refresher training workshops for FPC staff and other DH and PH, CHC, BHC doctors, nurses, and midwives in identifying and responding to cases of GBV. This will enhance overall capacity and retain focus on performance standards.

3.4 Equipment and Supplies

The FPC will be appropriately equipped to provide needed services and support in a comfortable and safe environment. The reception will have work tables and chairs for the three staff of the FPC, and will be equipped with desktop computer, a filing cabinet, and comfortable seats for three to four people including the survivor and any accompanying family member/s or representatives of referral agencies.

The physical examination and counselling room will be separate from the reception, and will have a door that can be closed and curtained windows, to provide privacy and safe space for the survivor and, when needed, for her close family members. There will be a screened off physical examination table to perform physical check-ups, to offer privacy to the patient for undressing and changing. The physical exam room will be equipped with a medical cabinet stocking medical equipment for preliminary medical examination of patient, supplies for immediate pain or injury care, material for dressing and a limited range of drugs, disinfectants, and cleaning agents. It will also have a secure file cabinet with lock and key for storing case files. The physical exam room will have an adjoining WC, or at a minimum, a wash basin and clothes' hanger. Complete standard lists of medical and non-medical equipment, drugs and supplies to be stocked in the FPC are annexed at the end of the manual.

CHAPTER 4

4. FPC Services

The FPC will facilitate integrated response to the following six categories of GBV as elaborated in the approved Standard Operating Procedures for Health Sector Response to GBV:

1. Physical assault
2. Sexual violence
3. Sexual assault
4. Forced marriage
5. Denial of essential resources such as food and shelter etc. and
6. Psychological and emotional violence resultant from various associated forms of GBV.

The six categories of GBV will be identified as described in the approved GBVIMS manual. They align with the description of GBV in the National Gender Strategy (2012 – 2016), and are covered within the scope of the definition of GBV in the IASC guidelines.

All FPC staff will be required to undergo mandatory training in the SOP for Health Care Response to GBV, as well as in the use of GBVIMS tools.

4.1 Client care

The FPC clients are GBV survivors -- typically individuals (generally women and girls, but could include boys and young men) who have been through extreme physical, emotional, and psychological trauma, often at the hands of immediate family members. They may be in a state of shock or demonstrate fear or mistrust of other. It is therefore imperative that any health care response to GBV should involve the best quality care possible, provided in a safe, empathetic and understanding manner, according full respect and autonomy of decision making to the client herself.

FPC staff must interact with survivors in a supportive non-judgmental manner, and be respectful to the wishes of the client, and her decisions and choices regarding assistance she/he would like. At no point should a survivor be pressured to accept any recommendations from the FPC team. The client must be helped to feel safe to describe her situation and express her needs, and should be assured full confidentiality of all information she is willing to share. All investigations, medical assistance, and referral advice should be explained clearly to the survivor, giving her the right to accept or reject any advice. Protocols for GBV care outlined in the GBV response SOP must be strictly followed by all FPC personnel.

All FPC staff must undergo pre-deployment mandatory training in the already approved standard operating procedures for GBV case management and be required to take a certification exam before being appointed to any role.

4.2 Confidentiality and respect

Gender based violence is a crime often perpetrated by members of the immediate family or people socially connected to the victim, or more powerful. As a result, reporting it is highly sensitive, often perceived as bringing shame to the victim and her family. Consequently, it

largely goes unreported. Reporting GBV can have serious social and security repercussions for the victim and her family, and can even pose threats for the care provider. Thus it is of extreme importance to stress the need for complete confidentiality of all exchanges between survivors of GBV and FPC staff, as well as of all case documents. Individuals referred to the FPC should be assured that no information shared with the care providers at the FPC will be disclosed to any person or referral institution without the expressed permission of the survivor herself.

The survivor is a victim of a crime, and it is imperative that FPC staff recognize that. Physical examinations must be conducted in a manner that respects the personal dignity of the survivor, and her need for privacy. At no time during medical care, psychosocial counselling, or legal counselling, should a patient be blamed for anything she feels or says. Her decisions whether to go for further assistance or not, should be respected, and under no circumstances should she be pressured to accept any intervention, advice for referral, or information sharing. The survivor herself, or in case of a minor, the custodian of the survivor, should have full control of all decisions pertaining to the response she may want.

4.3 Informed consent

Informed consent of the GBV survivor is a legal and ethical obligation of the GBV response team at the FPC, and they will be held answerable to it Before providing any services at the FPC, the FPC officer in charge will explain the purpose and role of the FPC and its team, and assist the patient in completing and signing the consent for sharing information form. If the GBV survivor is non-literate or a minor, the FPC in charge will read out the consent agreement clearly, and explain it carefully until the client has sufficient understanding to be able to execute informed consent.

4.4 FPC services

The FPC shall provide the following six kinds of services through multi-faceted coordination with other agencies

4.4.1 Identification

Identification of GBV is to establish that a woman or, child, youth, or man has experienced GBV. A GBV case may present at the FPC in a number of ways.
-self-referral by GBV survivor (*when an individual seeks assistance claiming she/he has been a victim of GBV*)
-referral by family (*when family member/s bring an adult or minor GBV survivor to the FPC seeking help*)
-referral by OPD of the hospital or by another department (*when the GBV survivor visited another section of the hospital for an unrelated medical complaint, and was suspected to be a GBV survivor by the care provider and referred to FPC*)
-referral from a lower level health facility (BHC, CHC, DH, private sector health clinics, others) (*when individual was identified as possible GBV survivor during a visit to a lower level health facility, and was referred to FPC by GBV focal person within the health facility*)
-referral from AIHRC or its offices, MoWA, its directorates or other offices, police or security personnel, women prisons or safe homes, or women rights and community groups (*when GBV*

survivors approach any of these agencies for assistance first.). A simple referral slip addressed to the FPC will be used for referral in by other health stakeholders, but will not be mandatory.

Cases referred to the FPC will be formally identified as GBV cases if they fall within the definitions of the six categories in the SOP for health care management of GBV, after preliminary investigations by the medical officer.

4.4.2 Registration and Case Records

Five different types of standard formats will be used to register and maintain records in case files. They will be completed by the medical officer / psychosocial support counselor. The data officer/ legal counselor will input all information in the forms into the GBV database, and file physical records securely in a locked file cabinet with restricted access. The case files will be used for referral, follow up, coordination, and reporting by the FPC In Charge. The standard formats used are:

1- Case Intake form – This form records detailed personal information about the survivor, mode of referral to the FPC, and any prior assistance provided
2- Consent form – This form allows the GBV survivor to control the information about her/his case, and to decide who or with which referral agencies the information can be shared. The consent form is a declaration by the GBV survivor, and will be signed by her/him after selecting from among the suggested options.
3- Medical information form – This form records the medical condition of the GBV survivor, and all medical interventions she/he has been prescribed
4- Referral authorization form records the formal referral choices for multi-sectoral assistance made by the GBV survivor, based on the recommendations of the FPC staff.
5- Referral sheet is the coded form a GBV survivor carries to the agency or services she/he is referred to for further assistance.

These standard formats are provided in the approved GBVIMS manual, and are also annexed as samples, at the end of this manual.

All FPC staff members must be trained in the correct use of these forms to ensure accurate collection and recording of data.

The data officer / legal counselor will store physical case records in a secure cabinet, and be the only one with access to the keys to the cabinet. At FPC level, she will be the only person with access to the GBVIMS database, wherein she will input all case data promptly as required.

4.4.3 Medical services

Medical services will include trauma and general and reproductive health care, using a standard kit of medical equipment and tools (included as annex at the end of this manual), and following detailed case management instructions provided in the SOP for Health Care Response to GBV. All medical assistance provided will be recorded in a medical record form annexed at the end of the manual.

Immediate trauma and general and reproductive health care will be provided by the medical officer. These will include the following:

1- Full physical examination
2- Dressing of wounds and administration of antibiotics/ tetanus in case of lacerations or wounds
3- Prescription of any medications needed for immediate relief
4- Pregnancy test in case of sexual assault or rape
5- Administration of emergency contraception pill
6- Administration of prophylactics for possible HIV or STD exposure
7- Referral for blood testing for HIV or other infections to hospital lab
8- Referral for blood tests for STDs to hospital lab
9- Referral for any infection prevention measures including immunization against tetanus
10- Referral to forensic laboratory, if collection of forensic evidence is needed and requested by patient
11- Referral to relevant hospital ward for advanced level medical or reproductive health care as needed or to a higher level health facility outside
12- Provision of medical certificate based on findings, if requested.

Preliminary physical exam and treatment of physical health needs of GBV survivors will be provided by the medical officer/psychosocial counsellor, who will be a qualified health care practitioner, trained in psychosocial counseling for GBV survivors. She will carefully examine for any physical signs of violence or abuse, including dehydration or malnourishment. She will administer pain relief or dressing or treatment for wounds, and ascertain if further medical investigation is needed. She may prescribe and administer emergency contraceptive pills or prophylactic drugs for HIV and Hepatitis prevention, and refer survivor for further medical assistance including vaccination if needed. She will be responsible for strictly following standards and protocols as set out in the approved SOP for Health Sector Response to GBV.

4.4.4 Psychosocial Assistance

Psycho-social counselling will be provided to survivors, and family members if necessary for enlisting their support for the survivor. The medical officer / psychosocial counsellor will be trained in identifying emotional and psychosocial trauma, and providing psychosocial counseling for adult and child survivors of GBV. primarily as active and supportive listening. She will help the GBV survivor describe her experience of GBV, encourage her to decide on the interventions of her choice, and generally attempt to put her at ease.

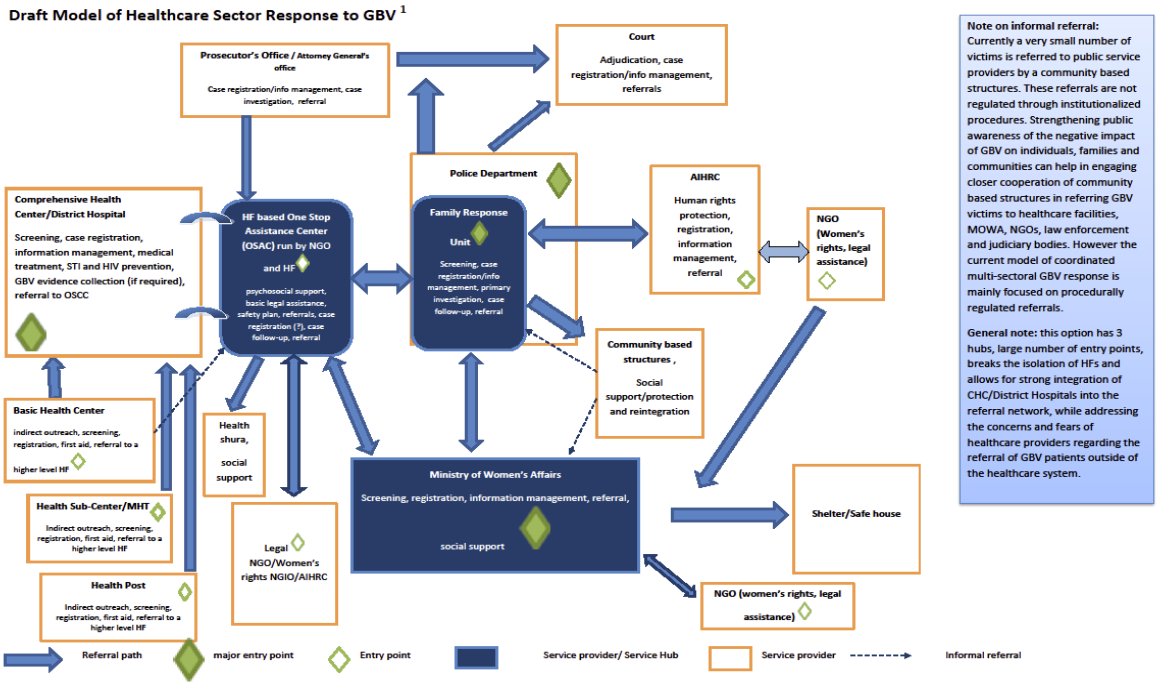
The medical officer /psychosocial counselor will conduct psychosocial counselling sessions in a separate room with the survivor. No family member or other individual accompanying the GBV survivor will be allowed to be present unless she/he expresses the wish for them to be present, or if the case in question is a minor who needs an adult she/he knows and trusts to be able to talk. The placement and arrangement of the counselling and examination room will ensure complete privacy and safety for the survivor.

A training manual developed and approved by the MoPH's Gender directorate and Mental Health directorate will be used to ensure a uniform standard and protocols for psychosocial assistance for GBV survivors. Currently a 10-day training program developed by the Mental Health directorate of the MoPH is used for training of the medical officer/psychosocial counselors in the FPCs. A copy of the training modules is annexed at the end of this manual.

After the initial interview, a GBV survivor will be encouraged to return for six to eight follow up counseling sessions, depending on the severity of the need. If beside psychological trauma, the survivor also fears the prospect of further humiliation or rejection by the family, family counseling sessions may also be offered to help the family understand the survivor's need for support, and to ensure acknowledgement of her status as the wronged party, and her full reintegration within the family. In very severe cases, the medical officer /psychosocial counselor may see the need to refer the GBV survivor for further help to a mental health facility.

4.4.5 Referrals

Cases of GBV identified by lower-level health care facilities, or by other stakeholders may be referred in to the FPC. The following diagram in the NPP for Health Sector Response to GBV presents the diverse sources of referral in and destinations of possible referrals out from the FPC. Standard referral sheets will be made available and explained to GBV focal persons within stakeholder agencies, and will be used to refer survivors to the FPCs, and from FPC to other relevant service providers. See case management tools annexed at the end of the manual.



[1] Developed by UNFPA Afghanistan

Survivors referred to an FPC will be given first level assistance, and connected to other GBV stakeholder agencies for specialized care and support. Referrals services will be offered at the FPC for the following reasons:
- to other departments of the hospital or to specialized care centers for advanced medical care, if needed.
- to MoWA or NGO operated shelters or safe homes for temporary protection for the survivor in life-threatening cases, if the need is expressed by survivor or family.
-to security and criminal justice agencies like the CID, including referral to forensic medicine, police Family Response Unit officials, and local governance offices to take action against perpetrator, and to ensure security for survivor in hospitals, safe houses, and in their communities.
- to the prosecutor's office if a legal case needs to be made on behalf of the survivor
- to the AIHRC or its offices or to NGOs for accessing free legal services of a lawyer, when survivor lacks financial resources to hire a lawyer.

Referral out will be done through assigned and trained focal persons in stakeholder agencies including specialized health care facilities, Afghanistan Independent Human Rights Commission (AIHRC) and its provincial offices, Family Response Units of the Police, courts of justice, ministry and directorates of women affairs, and women right NGO partners.

The need for referral will be explained to the patient but any referrals will be made by her own decision, whether to a health care facility, a criminal justice, or legal agency, to AIHRC, Women's Affairs, or to women rights organizations for advocacy or social support.

The medical officer / psychosocial counselor will offer advice about health and psychosocial referral options and recommend them; the survivor will decide what further assistance she wants. Based on the informed consent of the GBV survivor, she will facilitate referral to higher level of specialized health care facilities, or for administration of prophylaxis against STD, Hepatitis, and HIV, and emergency contraception. If needed, she will also refer patients for blood and other sample collection for medical and forensic investigations. She will then refer the patient to the legal counselor/data officer.

The data officer / legal counselor will explain available legal and other options for action against the perpetrator of violence and for protection of the survivor, according to her case. She will help the survivor to decide freely, what if any legal or security assistance is needed, and complete the referral authorization form based on the patient's decision, and facilitate linkages with agencies and GBV response focal persons within the criminal justice system (FRU, CID) or the legal system, connecting them to appropriate individuals at the prosecutor's office, paralegal and legal counsellors, police, Human Rights Commission, or other government bodies, if the need is expressed by survivor. She will provide clear guidance and instructions to the patient to enable her to access referral care with minimum delay or inconvenience, and will intervene and facilitate in case of hurdles faced by the survivor, to ensure smooth access to legal and security assistance up to the end of the case management plan.

Based strictly on the survivor's informed decision, or in case of a minor, the decision of her/his custodians, the data officer / legal counsellor will give them a referral slip connecting them to a

relevant agency, which could be the GBV focal person at the nearest Family Response Unit of the Police if a police complaint is to be lodged, or to the prosecutor's office, if legal action is desired against the perpetrator. Referrals may also be made to the GBV focal persons at the AIHRC or its provincial offices or to women rights NGOs that provide free legal services to GBV survivors. Advocacy and follow up support for speedy resolution of legal cases of GBV survivors will be provided through GBV sub-cluster meetings.

If the GBV survivor is perceived to be in any immediate danger from the perpetrator/s, she may be referred for temporary protection to the MoWA or NGO supported 'Safe Homes' or 'Women Shelters' until her case is resolved. The data officer / legal counselor will maintain an update list of contacts in the AIHRC, MoWA, the prosecutor's office, FRU and the police, as well as women rights NGO that provide protection and legal support for GBV survivors.

4.4.6 Case Follow up

Case Follow up will be the responsibility of the FPC. Each GBV case registered with the FPC will be carefully documented and followed up regularly by the FPC team until its resolution, or when the survivor or her/his custodians decide not to take any further action. Case files will be closed only when one of these two things happen. Case files of open cases will be reviewed every week, and notes on progress in different referral sectors recorded as notes. The FPC in charge will receive weekly briefings about follow up of each case from her team. Progress with various actions will also be followed up at monthly case management meetings with focal persons from relevant stakeholders. The FPC in charge will report follow up results to the head of the hospital, and will present reports at GBV sub-cluster meetings each month.

Case follow up will be implemented at different levels, and will be undertaken through the system up to the resolution of each case, or up to the point where the GBV survivor decides to stop.

At the FPC level the FPC in charge officer will have overall responsibility for case follow up. She will hold weekly meetings with her team where the medical officer / psychosocial counselor and data officer/ legal counselor will present a weekly review of cases they handled, and the progress with medical and psychosocial assistance and legal, criminal justice and rehabilitation assistance. The FPC in charge will provide needed advice and support with overcoming obstacles, for the satisfactory completion of the case management protocol.

The medical/ psychosocial counselor will follow up cases referred for further health-related investigations and treatment, or for mental health care. She will also offer up to six follow up psychosocial counselling sessions to the patient and one to two family counselling sessions, if needed.

The data officer /legal counselor will follow up legal and criminal justice referrals to ensure the victim gets needed support. She will keep regular tabs on the progress of each case, and prepare a case report at the end.

Individual cases will also be followed up after all possible assistance has been provided, to ensure continued wellbeing of the survivor. This may be done by any member of the FPC team,

and will be reported at the weekly FPC meetings. All follow up actions will be carefully recorded with dates and descriptions in a separate case register updated and maintained by the FPC in charge officer.

The FPC will host monthly case-management meetings with relevant health and non-health stakeholders with whom referral of patients is underway, to follow up on progress of case management, and to resolve any problems so that assistance to the patient in question can be facilitated and expedited. The case management meetings will be chaired by the FPC In Charge, and attended by all FPC team members.

At the hospital level GBV case management information will be followed up at regular routine meetings between the FPC In Charge and the head of the hospital. She will brief the head of the hospital and answer any specific questions regarding the performance of the FPC team, and inform them of any challenges faced. The senior management of the hospital will seek to ensure any administrative or technical problems are resolved to facilitate smooth operation of FPCs, in line with their role within the health sector response to GBV protocol.

At district/provincial level case follow up will be through various levels of coordination meetings. Monthly GBV sub-cluster meetings will be held with GBV stakeholder organizations, either at the provincial offices of AIHRC, the DoWA, or at the PPHD at the provincial level, and at the MoPH's Gender directorate at the Center. These meetings will be used to present brief monthly reports, discuss operational and coordination challenges, and arrive at solutions. The FPC officer In Charge will participate in GBV sub-cluster meetings, and brief stakeholders about the nature of cases managed by the FPC, progress, achievements, and challenges. She will also convey any concerns with coordination expressed by the medical officer or legal counsellor, and enlist support and closer cooperation from GBV partners.

At the Ministry (MoPH) level monthly taskforce meetings will be held between representatives of the GBV taskforce from MoPH, MoWA, MoI, MoJ, AIHRC, women rights and civil society groups, and international partners working on GBV including UNFPA, UN Women, and other donors and partners. FPC reports from different provinces will be compiled and shared, for discussion to ensure efficacy of inter-agency referral, and to resolve any issues with coordination between stakeholders. Sub-cluster meetings will also use the GBV reports to identify trends in GBV incidence and reporting, which can feed into advocacy for policy changes, efforts for strengthening existing interventions, or initiating new interventions. GBVIMS data received and analyzed within the Gender Directorate of the MoPH, will be presented to stakeholders at GBV taskforce meetings for deliberation and arriving at any action points as needed.

FPC SERVICES AT A GLANCE

No.	Services	What (description)	By Who	Where	Referral
1	Identification	Establishing case of GBV	Medical officer/psychosocial counselor	FPC Physical exam and psychosocial counseling room	May be by GBV survivor or family members, health care professionals NGOs, Human Rights Commission, Police/ justice department, MoWA, DoWA
2	Registration and Case Records	Completion of five formats for GBV case records: Case Intake form, Consent form, Medical information form, Referral authorization form, Referral sheet [7]	Medical officer/psychosocial counselor Data officer/legal counselor	FPC	Leads to referral for further multi-sectoral assistance from GBV stakeholder agencies
3	Medical Services	Physical exam, basic wound /trauma care, prophylaxis for prevention of STDs, HIV or Hepatitis, emergency contraceptives	Medical officer/psychosocial counselor	FPC physical exam and psychosocial counseling room	May lead to referral to specialized medical care facilities within or outside the hospital, to forensic lab or for further medical investigations
4	Psychosocial counseling assistance	Psychosocial assessment of survivor's condition, and supportive and respectful listening; family counseling to enable acceptance and integration of survivor, and to enable family to support the survivor through recovery process	Medical officer/psychosocial counselor	FPC physical exam and psychosocial counseling room	May lead to referral to mental health facility or other advanced care.

[7] Sample forms included as annexes

5	Referral assistance	Referral services will be provided for the following reasons: -for forensic lab examinations -for advanced medical care -for immunization -for advanced mental health care -for legal advice -to the prosecutor's office, AIHRC or its provincial offices, MoWA or DoWA, women rights groups, for legal assistance -to FRU for registering a police case against perpetrator of violence -to women protection NGOs or MoWA/DoWA in case there is need for staying in shelter or safe house -to women rights NGOs for assistance with rehabilitation through training and/or economic empowerment opportunities	-medical officer/psychosocial counselor -data officer/legal counselor -FPC in charge officer	FPC	Referrals will be recommended to the GBV survivor in accordance with perceived needs by FPC staff, and all necessary information about the referral recommendation provided. The GBV survivor has full control over the decision to opt for any referral. FPC staff will only suggest interventions, provide information, and facilitate any referral the survivor may choose to follow.
6	Case follow up assistance	-Individual cases will be followed up by the staff member who facilitates referral, to make sure, the GBV survivor was able to access expected help. -Case follow up will be	This will be done at different levels: -at FPC level, case follow up will be done by the FPC team during case management meetings,	-at FPC during case managemen t meetings -meetings with the head of	Any further referrals needed may ensue as a result of the case follow ups, and efforts will be made to continue to facilitate relevant support to the GBV survivor, and

		undertaken by the team at weekly FPC meetings. -Head of the hospital will also follow up FPC cases during routine meetings with the FPC in charge -monthly case management meetings will also provide opportunities to follow up on individual ases with stakeholder representatives -GBV case management will also be followed up at sub-cluster meetings between GBV stakeholders	and by FPC in charge at sub-cluster meetings -The head of the hospital will also follow up GBV cases with the FPC In charge -case management will also be followed up by the GBV focal person at the PPHDs and the gender directorate at the MoPH during GBV taskforce meetings	hospital -at GBV sub-cluster meetings -at GBV taskforce meetings	in some cases, to their families until the case reaches a satisfactory conclusion.

CHAPTER 5

5 Data Collection, Recording, and Use

Proper collection and use of GBV data is vital for assessing the effectiveness of the current response model, and for developing and instituting changes or reforms for improved service delivery and stronger coordination between stakeholders and donors. Sharing of ethically collected and stored data about GBV response between stakeholders and service providers, will, enable better coordination between service providers. Reliable data on GBV response will assist government ministries, UN Agencies and other state and non-state stakeholders to consolidate their efforts for more effective GBV response, to minimize the effects of GBV on the population, particularly on women and girls. Evidence-based data on GBV will also enable policy advocacy and for seeking donor support.

The GBVIMS is a part of the MoPH's data management system, with formal processes and steps to document and report on services provided to GBV survivors. The system allows for uniform data collection, analysis and reporting from the FPCs to the GBVIMS database within the MoPH.

5.1 Data Collection

Data collection at the FPC will be accomplished using the standard approved tools prescribed by the MoPH:

1- Consent form
2- Authorization for information sharing
3- GBVIMS Intake form
4- Medical form
5- Referral form including referral authorization

FPCs will be provided with the prescribed forms and tools. At the time of establishment of an FPC, all three FPC staff will receive a two-day formal practical training, in the correct use of the data collection tools by a HMIS/GBVIMS team at the MoPH. The initial training may be followed up by brief on-job refresher sessions during monitoring by the GBVIMS specialist from within the ministry. The training may be conducted within the FPC, hospital, or PPHD/ MoPH. Training material will be drawn from the GBVIMS manual.

Individual case files will be coded, and except for the consent form, no other tool will contain the GBV survivor's name, to ensure confidentiality of information, and to protect the victim and her family, as well as the care providers from risk of retaliation or other negative repercussions from the perpetrators.

5.2 Data Recording and Storage

Data recording and storage will be accomplished with utmost attention to its security and confidentiality. All physical data collected at the FPC will be stored in individual coded case files, in a secure cabinet under lock and key. The case files will be accessible only to the data officer / legal counselor.

The data officer / legal counselor will also be the only FPC team member with direct access to the MoPH GBVIMS database, and will receive training in inputting data into the database.

Note: A patient will have the right to request her case file at any time following her initial interaction with the FPC, and will be free to request removal of any of the physical forms. In this situation, the data officer will comply, and hand over the requested form to the patient, and enclose a dated note explaining which completed format has been removed.

5.3 Data Reporting

GBV data will be reported as follows. The data officer / legal counselor will input all case data collected at the FPC, promptly into the GBVIMS national database.

The data officer / legal counselor and medical officer / psychosocial counselor will create a weekly case-management roster in Excel format, for tracking individual cases through referral, and for reporting at the weekly FPC meetings, and at meetings with hospital management to resolve any issues, and to request supports needed.

Weekly reports will be compiled and presented by the data officer / legal counselor at monthly case management meetings. The GBV data reports will be used to track coordination through the referral cycle, to bring cases to a resolution, and to ensure all needed linkages to associated services have been provided, and all possibilities of further support to the GBV survivors, have been exhausted.

The FPC in charge will present the monthly compiled data at GBV sub-cluster meetings. The data report will be the basis of discussions about trends in GBV, its reporting, the efficacy of the existing integrated response model, what more needs to be done, and to collectively identify solutions to fill specific gaps in services.

5.4 Use of GBVIMS data

Primary data collected at FPC level, will be used for case follow up and presentation at various GBV fora including hospital management meetings and GBV sub-cluster meetings and enable planning of future corrective actions and strategies.

The data fed into the GBVIMS database by FPCs across the country, will be sorted, compiled, and analyzed by a trained data analyst within the Gender Directorate of the Ministry of Public Health. She/he will be the sole entity within the MoPH with access to raw data from the FPCs. She will prepare monthly reports including gender and age disaggregated data, reflecting GBV trends in various provinces, response interventions accessed by survivors, outcomes of FPC interventions, and gaps that need to be filled, for submission to the Gender Director and her technical and research associates.

The gender directorate will use the data reports as evidence to advocate for further coordination, policy and strategy changes, revision of the FPC model, and to inform future public health strategy and plans.

The Gender Directorate will present action points using evidence from the GBVIMS reports, and report outcomes to the GBV task force each quarter, and disseminate them through quarterly publication of reports to other MoPH directorates, the Minister and Deputy Minister's offices, GBV stakeholder state and non-state agencies, and international GBV partners and donors.

GBVIMS reports will be shared with the MoPH's M&E department for further follow up and monitoring of FPCs across the country. M&E reports of the MoPH and its provincial directorates will refer back to the GBVIMS reports for purpose of data verification.

The information will also be used to lobby for fund allocations at monthly GBV taskforce meetings and other donor forums, as needed.

As GBV response becomes fully integrated within the public health system over time, there is need for a uniform data reporting format for GBVIMS data to be integrated within the Health Management Information System (HMIS). Incompatibility issues between the GBVIMS and the HMIS must be resolved, to enable smooth data flow from the GBVIMS into one integrated HMIS. Until then, health sector response to GBV, and GBVIMS remain segregated from the health care sector information bank. For full integration, the HMIS will need to work with the GBVIMS data analyst to work around the special circumstances for storing and release of GBV data, and devise ways in which GBV data can become an integral part of the HMIS

CHAPTER 6

6 Monitoring and Quality Assurance Procedures and Management

6.1 Quality Assurance Procedures

As an integral component of EPHS, first level responsibility of quality assurance of GBV response through the FPC, will be shared by the hospital management, who will ensure availability of all needed material and human resources. A standard accreditation score card for the FPC will be incorporated into the Hospital Accreditation formats, to be used for quality assurance within the hospital. A suggested format for the FPC is provided as an annex at the end of the manual. The technical head of the hospital, the operation head of the hospital, and the FPC in charge will receive training in set quality assurance standards for the FPC, and learn the use of standard checklists and tools for measuring quality of facilities and services, and for identifying areas in which improvements are needed to achieve desirable standards.

6.2 Monitoring

The FPC, as a section of the provincial, regional, or national hospital, will be covered by the same EPHS monitoring protocol as the other departments in the hospital.

1. Independent roles of FPC team members in accordance with TORs
2. FPC weekly meeting roster
3. FPC and hospital management meeting roster
4. Case management meeting roster
5. Staff capacity to manage, document, and follow up GBV cases presenting at the FPC.
6. Physical organization of FPC
7. Storage of physical case files
8. Availability of equipment and supplies as per standard lists
9. Correct use of tools for recording and reporting on cases
10. Psychosocial counseling session records
11. Number of cases assisted, referred, or closed.

In addition, the gender directorate of the MoPH will undertake independent monitoring of FPCs at least once a year to verify routine progress reports submitted by FPCs, and to ensure satisfactory functioning. The following set indicators will be measured against targets in the annual action plan:

1- Number of GBV cases registered by FPC,
2- Number of GBV referred from FPC
3-Number of GBV cases referred to FPC
4- Number of GBV case management committee meetings organized
5- Number of the GBV cases successfully closed

Sample monitoring tools used by the MoPH and PPHDs are included as annexes at the end of the manual.

Monitoring may be undertaken by a team comprised of a GBV expert and the data collection officer from the gender directorate. If weaknesses or gaps are identified, the monitoring report will recommend corrective measures including capacity building of staff or other changes. Monitoring reports will be shared with the GBV Taskforce meetings, and recommendations and assistance sought from stakeholders, as needed.

Joint monitoring with GBV stakeholders may also be planned once a year, to enable GBV partners to better understand the functions of the FPC, assess the quality of services provided, and to establish specific challenges to effective referral between them, and propose corrective measures collaboratively. This will enable better informed reviews of the FPC as the entry point for the health sector's integrated response to GBV.

CHAPTER 7

7 Stakeholder Coordination and Collaboration

Close collaborative linkages will be developed with GBV stakeholders from different sectors, to enable cross referrals, to enable integrated multi-sectoral assistance for GBV survivors, and to ensure follow up of each case to its conclusion.

7.1 With BPHS HFs

The FPC in charge will coordinate directly with focal persons from BPHS health facilities (BHC, CHC, DH). As per MoPH-approved protocols for GBV response, designated GBV focal persons at BHCs, CHCs, DHs, and the health care staff at BPHS health facilities including mobile health teams.

The coordination will make it possible to ensure that the identified focal persons at these BPHS facilities, which are the first point of contact for most GBV survivors, are adequately trained in identifying probable GBV cases, and providing basic medical care. The FPC in charge will see that the BPHS focal persons are connected to focal persons within higher level health facilities, or directly to the FPC, to enable referral of patients needing further, medical, psychosocial, legal, or other social protection assistance. The GBV focal persons from lower level facilities will be encouraged to refer suspected GBV cases for further assistance to the FPC. Focal persons from lower level health facilities will also be invited to participate in monthly case management meetings, where they will be involved in case follow up, and also benefit from practical on-the-job training in procedures related to health sector response to GBV. The MoPH and its provincial directorates will devise strategies to enable focal persons to attend the meetings without a cost burden of transportation.

7.2 With specialized care facilities

GBV survivors visiting the FPC may need advanced level medical investigations, immunization, or care for injuries, burns, reproductive health complications, or psychosocial or mental health care. The FPC in charge will network with relevant facilities either within the host hospital, or other health care institutions providing necessary services, and facilitate referral of patients for specific interventions using standard referral forms. GBV survivors may also be identified during their visits to other departments of a hospital for unrelated complaints. When that happens, the GBV focal person concerned will refer the patient for help to the FPC in charge. Partner facilities will be invited to attend case management meetings, and GBV sub-cluster meetings to follow up on case management.

7.3 With justice department

A GBV focal person within the justice department will be connected with the FPC through attending monthly case management at the FPC, and GBV sub-cluster meetings held within the PPHD or MoPH or at the DoWA, or AIHRC's provincial offices. The legal advisor at the FPC will inform GBV survivors of laws against gender-based violence, and about legal options they may choose from. If needed she will refer the case to a designated lawyer at the Attorney General's Office, or to defense lawyers specialized in dealing with cases of GBV, within other stakeholder agencies (MoWA, AIHRC).

Further general coordination with legal and justice department stakeholders will be effected through monthly GBV sub-cluster meetings. These meetings will enable to emphasize the complementary and essential roles of the different stakeholders, strengthen referral mechanisms between stakeholders in responding to GBV, and identify areas where changes or improvement are needed.

7.4 With police

Coordination with the GBV focal person in the police force, in particular within FRUs, (if there is one in the area) will be undertaken, both for case referral if the GBV survivor or family members decide to register the case of violence with the police, and to ensure security of survivor and family members or FPC staff if there is imminent threat.

GBV focal person within the local police set up, preferably a female police officer, will be invited to participate in monthly case management meetings to discuss specific issues with referred case/s. She will also be invited to attend GBV sub-cluster meetings to represent the police's role in GBV prevention and response, and to inform other stakeholders of the services that can be provided.

In case a GBV survivor or her immediate family members decide to file a police case against the perpetrator/s of GBV, the medical officer will immediately assist them in preserving evidence, which could include clothes or other evidence discovered during the physical exam. The legal counselor will connect them to the GBV focal person within the forensic medicine department, who will assist with correct preservation of evidence, and collection of samples of body fluids etc. needed for further investigation. The legal counselor will also inform the GBV focal person within the nearest Family Response Unit, and refer the survivor to the FRU to register a complaint. In case the survivor is too severely debilitated to go to the FRU, the FRU official may be requested to come to the FRU to register the case for further investigation and action by the police.

7.5 With Women's Affairs' directorates

The FPC in charge will maintain regular communication and coordination with relevant focal points within DoWA at provincial level, and through the MoPH Gender Director with MoWA at the Central level. MoWA is a partner and primary stakeholder in the MoPH's health sector response to GBV, since it promotes and contributes to the rights and protection agenda in the NAPWA. MoWA will be a key participant in the GBV task force at the center and its provincial focal persons will participate actively in GBV sub-cluster meeting, offering any needed facilitation and support with cases, and policy advocacy at ministerial level, and also contribute to lobbying with international donors and partners for sustained support of GBV response. MoWA and DoWA may also be requested to facilitate access to legal assistance and other humanitarian support, including temporary protection for survivor in safe houses, if needed.

7.6 With women rights groups

The FPC in charge will maintain open lines of communication with women rights groups and NGOs working for women's health or for support of GBV prevention and response. Local non-governmental women rights groups will be invited to be members of the GBV sub-cluster, and will be able to link victims with legal and social assistance provided by them or other NGOs or government sector institutions. NGOs working in the area of women empowerment may also be requested to contribute to socio-economic rehabilitation of survivors of violence, through offering opportunities of education or skill building or even employment.

7.7 With international partners/donors

The MoPH and its gender directorate will coordinate all GBV response efforts closely with international donors and partners, including UN agencies, UNFPA, UN Women, and UNICEF, and share progress and challenges in health sector response to GBV mechanisms and enlist their ongoing technical assistance and support in reviewing current models and overcoming challenges and shortfalls in design or services.

ANNEXES

I. Standard Formats and Tools

a. Consent form

CONFIDENTIAL

Consent for Release of Information

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

I, _____, give my permission for (***Name of Organization/facility***) to share information about the incident I have reported to them as explained below:

:

1. I understand that in giving my authorization below, I am giving (***Name of Organization***) permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs.
2. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.
3. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.

I would like information released to the following:

(Tick all that apply, and specify name, facility and agency/organization as applicable)

Yes	No		
☐	☐	Security Services	(specify): _____
☐	☐	Psychosocial Services	(specify): _____
☐	☐	Health/Medical Services	(specify): _____
☐	☐	Safe house / Shelter (specify): _____	
☐	☐	Legal Assistance Services	(specify): _____

☐ ☐ Livelihoods Services (specify): ____

☐ ☐ Other (specify type of service, name, and agency): ________________________________

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

1. **Authorization to be marked by client:** *(or parent/guardian if client is under 18)*	**Yes**	**No**
	☐	☐

Signature/Thumbprint of client: ____

(or parent/guardian if client is under 18)

Caseworker Code _______________________ **Date:** ___/___/_______

INFORMATION FOR CASE MANAGEMENT *(OPTIONAL-DELETE IF NOT NECESSARY)*

Client's Name: ____

Name of Caregiver (if client is a minor): ___________________________________

Contact Number: ________________________________

Address: ____

- -

SURVIVOR CODE

- Collect the necessary information from the survivor/ see back of the consent form
- Put all the circled letters together in order, circling the first letter or digit
- If the information is unknown, use an X to replace the missing information

Survivor Code	Example
Mother's first name:	Halima = H
Rank of birth amongst siblings (same parents):	3
Place of birth of survivor (City):	Mazar
Year of Birth of Survivor (Last two digits):	1982=82
	Example: **H3E82**

b. Authorization Letter

Authorization Letter for Sharing the Information

I hereby authorize Ms./Mr._____ who is (designation) _____ in the health facility (name) _____ in district_____ of province_____ to share the information to the organizations that I select, while considering the principles of privacy and confidentiality, the information recorded just as I reported it.

☐ Security Services (should be specified)

☐ Psychosocial Services (should be specified)

☐ Health & Medical Services (should be specified)

☐ Protection center (should be specified)

☐ Legal Services (should be specified)

☐ Welfare Services (should be specified)

☐ Others (type of service, name of agency should be specified)

Signature & Finger print of the patient custodian if she/he is less than 18 years old.

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c. GBVIMS Intake form

Incident ID	Survivor Code

Before beginning the interview, please be sure to remind the survivor that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

Administrative Information			
Staff Code	**Report Date**	**Incident Date**	**Report by survivor?** ☐ Yes ☐ No

Survivor Information			
Date of birth	**Sex of Survivor** ☐ Female ☐ Male	**Survivor's Country of Origin?** ☐ Afghanistan ☐ Other:	**Current civil / marital status**: ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

Displacement status at time of report:	**Is the survivor a Person with a disability?**	**Is the survivor an Unaccompanied Minor, Separated Child, or Other Vulnerable Child?**
☐ Refugee ☐ Asylum Seeker ☐ Resident ☐ Foreign National ☐ IDP ☐ Stateless Person ☐ Returnee	☐ No ☐ Mental disability ☐ Physical disability ☐ Both	☐ No ☐ Unaccompanied Minor ☐ Separated Child ☐Other Vulnerable Child

Details of the Incident	
Stage of displacement at time of incident ☐ Not Displaced / Home Community ☐ Pre-displacement ☐During Flight ☐ During Refugee ☐ During Return / Transit ☐ Post-displacement	**Time of day that incident took place:** ☐ Morning (sunrise to noon) ☐ Afternoon (noon to sunset) ☐ Evening/night (sunset to sunrise) ☐ Unknown/Not Applicable
Incident location / Where the incident took place:	

☐ Survivor's Residence	☐ Garden/ Open Field
☐ Perpetrator's home	☐ Water points
☐ International Border	☐ Shelter / Safe House
☐ Check Point	☐ Street
☐ Health Center / Hospital	☐ Registration point
☐ Market / Shopping Center	☐ Distribution Settings
☐ Police Station / Security	☐ Transportation
☐ Religious Center (Mosque, Church)	☐ Public toilets/latrines
☐ School/Education institution	☐ Work Place (factory, office)
☐ Unoccupied/Abandoned Building	☐ Prison / Detention Centre
	☐ Other: _____

Incident Area	**Province**	**District**	**Area**

Type of GBV	
(Please select only ONE of the below. Refer to the GBVIMS GBV Classification Tool for further clarification.) ☐ **Rape**)includes gang rape, marital rape) ☐ **Sexual Assault** (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation) ☐ **Physical Assault** (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature) ☐ **Forced Marriage** (includes early marriage) ☐ **Denial of resources, opportunities or services (**includes denial of inheritance, earnings, access to school or contraceptives, etc) ☐ **Psychological / Emotional Abuse** : (includes threats of violence, forced isolation, harassment / intimidation, gestures, etc) ☐ **Non-GBV** (specify)	1. **Did the reported incident involve penetration**? If yes → classify the incident as "Rape". If no → proceed to the next incident type on the list. 2. **Did the reported incident involve unwanted sexual contact**? If yes → classify the incident as "Sexual Assault" If no → proceed to the next incident type on the list. 3. **Did the reported incident involve physical assault**? If yes → classify the incident as "Physical Assault". If no → proceed to the next incident type on the list. 4. **Was the incident an act of forced marriage**? If yes → classify the incident as "Forced Marriage". If no → proceed to the next incident type on the list. 5. **Did the reported incident involve the denial of resources, opportunities or services**? If yes → classify the incident as "Denial of Resources, Opportunities or Services". If no → proceed to the next incident type on the list. 6. **Did the reported incident involve psychological/emotional abuse**? If yes → classify the incident as "Psychological / Emotional Abuse". If no → proceed to the next incident type on the list. 7. **Is the reported incident a case of GBV?**

	If yes → Start over at number 1 and try again to reclassify the incident (If you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident). If no → classify the incident as "Non-GBV"

Was this incident a Harmful Traditional Practice? ☐ No ☐ FGM ☐ Marriage exchange ☐ Forced marriage to perpetrator ☐ Deprivation of inheritance ☐ Honor Killing ☐ Other: _____	**Was money, goods, benefits, and / or services exchanged in relation to this incident?** ☐ No ☐ Yes

Type of abduction at time of the incident

☐ None ☐ Forced Conscription ☐ Trafficked ☐ Other Abduction / Kidnapping

Has the survivor previously reported this incident anywhere else? (If yes, select the type of service provider)

☐ No

☐ Yes, other GBVIMS organization, specify:

☐ Yes, non-GBVIMS organization, specify:

Has the survivor had any previous incidents of GBV perpetrated against them?

☐ No ☐ Yes

If yes, include a brief description:

Alleged Perpetrator Information	
Number of alleged perpetrator(s) ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 ☐ Unknown	**Alleged perpetrator relationship with survivor** ☐ Intimate partner / Former partner ☐ Primary caregiver ☐ Family other than spouse or caregiver ☐ Supervisor / Employer ☐ Teacher / School official ☐ Service Provider ☐ Host Family ☐ Landlord ☐ Cotenant / Housemate ☐ Schoolmate ☐ Family Friend / Neighbor
Alleged perpetrator(s) sex ☐ Male ☐ Female ☐ Both	
Alleged perpetrator(s) Age* ☐ 0 -11	

☐ 12 – 17 ☐ 18 – 25 ☐ 26 – 40 ☐ 41 – 60 ☐ 61 & Older ☐ Unknown	☐ Other refugee / IDP / returnee ☐Other resident community member ☐ Other ☐ No relation ☐ Unknown

Alleged perpetrator occupation

☐ Armed Forces	☐ UN Staff	☐ Community Based Organization
☐ Armed Group	☐ Community Leader	☐ Taxi driver
☐ Police	☐ Religious Leader	☐ Unemployed
☐ Security personnel	☐ Govt. Service Provider	☐ Unknown
☐ Teacher	☐ Civil Servant	☐ Other: _____
☐ NGO Staff	☐ Landlord	

Referral Pathway Data

Who referred this survivor to you?

☐ Self-Referred	☐ Teacher/School Official
☐ Health/Medical Services	☐ Safe House/Shelter
☐ Community or Camp Leader	☐ Livelihood Program
☐ Legal Services	☐ Other Humanitarian / Development Actor
☐ Police/Other Security Actor	☐ Other Government Service
☐ Psychosocial/Counseling Services	☐ Other (specify): _____

Was survivor referred to a safe house/ shelter? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable ☐ No - Referral declined by survivor ☐ No - Service unavailable	**Referral Details:**
Was survivor referred to health/ medical services? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable	**Referral Details:**

☐ No - Referral declined by survivor ☐ No - Service unavailable	
Was survivor referred to psychosocial services? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable ☐ No - Referral declined by survivor ☐ No - Service unavailable	**Referral Details:**
Does the survivor want to pursue legal action? ☐ Yes ☐ No ☐ Undecided at Time of Report	
Did you refer the survivor to legal assistance service? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable ☐ No - Referral declined by survivor ☐ No - Service unavailable	**Referral Details:**
Was survivor referred to a police/ other security actor? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable ☐ No - Referral declined by survivor ☐ No - Service unavailable	**Referral Details:**
Did you refer the survivor to a livelihoods program? ☐ Yes ☐ No - Service provided by your agency ☐ No - Service already received from another agency ☐ No - Service not applicable ☐ No - Referral declined by survivor ☐ No - Service unavailable	**Referral Details:**

Assessment Points	
Describe the survivor's emotional state at the beginning of the interview (mark all that apply): ☐ Scared / Fearful	**Describe the survivor's emotional state at the end of the interview** (mark all that apply): ☐ Calmer than at the start of interview

☐ Sad / Depressed ☐ Anxious / Nervous ☐ Angry ☐ Calm ☐ Other:	☐ Similar to that at the start of interview ☐ More upset than at the start of interview ☐ Other, specify

Will the survivor be safe when she or he leaves? ☐ Yes ☐ No If no, why not:	**What actions were taken to ensure survivor's safety?** (mark all that apply) ☐ Safety Plan created ☐ Referral to community-based support ☐Referral to Safe House ☐Service provider to follow-up ☐Other action taken

If raped, have you explained possible health consequences of rape to the survivor (and/or to guardian based on assessment capacity and best interest of survivor if under 14)?

☐ Yes ☐ No ☐ No - Not Applicable (not rape)

Did the survivor give their consent to share her/his non-identifiable data in your reports?
☐ Yes ☐ No

Account of the incident/Description of the incident

d. GBVIMS Medical Form

Form for collecting confidential information by health service provider

General Information

Who or which organization did refer the patient to you?

☐ Self-referral or Mahram ☐Health Facilities ☐Psychosocial Centers ☐Community

☐ Livelihood Program ☐Protection center ☐Police/other security institutions

☐Legal Services Centers ☐ Teacher ☐ Governmental Services

☐Other Humanitarian organizations ☐Others (should be specified)

Date of Examination/ Time	SEX	Age	Marital Status			
			Single	Married	Engaged	Widow

2. INCIDENT: -----/------/----- :incidentDate and time of the ---------- AM ---------PM

Incident Location/Where the incident took place:	**Primary type of GBV Incidence** (choose the one option that applies)
☐ Bush/Forest ☐ Garden/Cultivated Field ☐ School ☐ Road ☐ Survivor Home ☐ Perpetrator's Home ☐ Other (give details)	☐Rape* ☐Sexual Assault* ☐Physical Assault* ☐Forced Marriage* ☐Deprivation from resources & opportunities* ☐Psychological/Emotional Violence*
Has the victim reported the incident to any other place ☐ Un-known ☐ Yes- ☐No	

3. Information about the suspected perpetrator

Relationship of perpetrator to the victim	Number of perpetrators

☐ Spouse ☐ Family member other than Spouse or Custodian ☐ Main Custodian other than Spouse ☐ Close friend/old friend ☐ Service Provider ☐ Others ☐ Un-known	☐1 ☐2 ☐3 ☐More than 3 ☐Un-known

Perpetrator's Occupation

☐ Government Employee ☐Military ☐ NGO Employee ☐Religious Leader/Elder

☐ Law-sector ☐Any other (must be specified) ☐ Teacher ☐ Un-known ☐ Health provider

4. Medical History and Examination

Age group	STI status of the patient, including HIV/AIDS	☐ HCV and HBS (Hepatitis)	Evidence of Pregnancy
☐ Child – below 18 years. ☐ Adult –18- 49 years ☐ Elderly - 50 plus	☐ Negative ☐ Positive ☐ Un-clear	☐ Negative ☐ Positive ☐ Un-clear	☐No ☐If yes (_____weeks)

Physical Examination

Summary of the results including Psychological Status

☐ Injuries ☐ Trauma ☐ Other (must be specified)

Explain the physical and psychological status of the victim (Brief)

Has the patient been examined for AIDS? ☐ Yes ☐ No ☐ Yes, Positive

Prescriptions and the treatment details

STI prevention Medication/Treatment:				
☐Yes	☐No	☐The victim didn't want it	☐Not applicable	☐Not available
Pregnancy Prevention Medication:				
☐Yes	☐No	☐The victim didn't want it	☐Not applicable	☐Not available
Medication for injuries:				

☐Yes	☐No	☐The victim didn't want it	☐Not applicable	☐Not available
Vaccination for Tetanus:				
☐Yes	☐No	☐The victim didn't want it	☐Not applicable	☐Not available

Any further actions on this report:

Did you refer the victim to psychosocial services centers?

☐Yes ☐No ☐Currently under treatment

☐Services are not available ☐Services are not accepted

☐ The patient left the hospital without permission

Did you refer the victim to higher medical facilities?

☐Yes, based on the following reasons:

☐Better Facilities ☐Family Planning services ☐Vaccinations

☐Consultation ☐VCT ☐Pregnancy Test ☐Other advanced diagnostics

☐No, based on the following reasons:

☐ services are provided ☐Services are not accepted ☐Services are not available

Where was the victim referred for other services?

☐ Referral/One Stop Assistance Center ☐ MOWA/DOWA ☐ AIHRC

☐ Safe house/ (Shelter) ☐ Back home ☐ Other (specify)

☐ Referral service is not available ☐ Referral service is not accepted

Is the victim willing for legal actions? ☐ Yes ☐ No ☐ Un-decided

Is the evidence collected?	**The patient wants medical certificate**	**Appointment for next visit**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Were the medical examination procedures explained in beginning stage? ☐ Yes ☐ No

Was the consent taken before starting medical examinations? ☐ Yes ☐ No

Did the patient or the relatives give consent for spreading the information? ☐ Yes ☐ No

e. Referral Sheet

Referral sheet for GBV victim in the center

Health provider code: K D/F **Health Facility code :**

Date: ___/____/_____ **Incident code: _____**

Age: _____

___ Sex:_____

Cause of refer: _____

_____

Explanation of incident: _____

_____

_____

The services provided before refer: _____

_____

_____

_____

Consent of victim or custodian _____signature of fingerprint _____

Signature of service provider: _____

Code of receiver department: _____ Date of receiver department: ___/___/_____

Incident code: _____

Finding of receiver department:

Signature of responsible person: _____

f. GBV Classification Tools

Gender-Based Violence Classification Tool[1]

To be used the Gender-Based Violence Data Management System (GBVIMS)

The humanitarian community has not been able to collect, classify and analyze Gender-Based Violence (GBV) -related information in a way that produces comparable statistics. At present, it is nearly impossible to compile and analyze data across programs and field sites. This cannot be solved without taking a new approach to how types of GBV are classified. To address this problem, the UN Population Fund (UNFPA), the International Rescue Committee (IRC), and the UN High Commissioner for Refugees (UNHCR) have developed a new GBV classification tool strictly for the purposes of standardizing GBV data collection across GBV service providers.

The criteria used to generate the classification tool's seven types of GBV were:

- Universally-recognized forms of gender-based violence
- Mutually exclusive (they do not overlap)
- Focused on the specific act of violence; separate from the motivation behind it or the context in which it was perpetrated

Each of the definitions below refers to the concept of **consent**.[2] Consent is when a person makes an informed choice to agree freely and voluntarily to do something. There is no consent when agreement is obtained through:

- the use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation
- the use of a threat to withhold a benefit to which the person is already entitled, or
- a promise is made to the person to provide a benefit.

Six Core Types of GBV.[3] The six core GBV types were created for data collection and statistical analysis of GBV.[4] They should be used only in reference to GBV even though some may be applicable to other forms of violence which are not gender-based.

1. **Rape**: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

2. **Sexual Assault**: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. *This incident type does not include rape, i.e., where penetration has occurred.*

3. **Physical Assault**: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. *This incident type does not include FGM/C.*

4. **Forced Marriage**: the marriage of an individual against her or his will.

5. **Denial of Resources, Opportunities or Services:** denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

6. **Psychological / Emotional Abuse:** infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

[1] The GBV Classification Tool was developed as part of the GBVIMS project initiated in 2006 by OCHA, UNHCR, and the IRC. The GBVIMS global team has counted on technical guidance from the Inter-Agency Standing Committee's (IASC) Sub-Working Group on Gender and Humanitarian Action, throughout the project.

[2] Many laws set an age of consent. These legal parameters do not apply to the GBV types proposed for this system. For the purposes of the GBVIMS a child is any survivor who was under 18 at the time when the incident occurred.

[3] Case definitions used in the context of GBV programming are not necessarily the legal definitions used in national laws and policies. Many forms of GBV may not be considered crimes, and legal definitions and terms vary greatly across countries and regions.

[4] Several resources were considered when preparing this document. Most importantly, the IASC Guidelines for Gender-based Violence Interventions in Humanitarian Setting, and Sexual and Gender-Based Violence against Refugees, Returnees, and Internally Displaced Persons, Guidelines for Prevention and Response (UNHCR

Explanation:

Any incident involving GBV can often involve more than one form of violence (i.e. a woman who is raped, beaten and psychologically abused during the course of an incident). **The incident recorder can only capture one type of GBV per incident.** To ensure valid and statistically comparable data, all those using the Incident Recorder must use the same approach to determine how to classify a given incident based upon the type of GBV it involved. **The types of GBV are listed in a specific order to ensure statistically comparable data.**[5] The instructions below allow us to use a process of elimination to determine the most specific incident type to use in classifying a reported incident.

Instructions for using the GBV Classification Tool

To determine the appropriate GBV classification for the incident described to you by the survivor, ask yourself the following questions in their given order.

If the answer to the question is "No" based upon the description of the reported incident, continue down the list to the next question. Stop, at the first question that can be answered "Yes" based upon the description of the reported incident. When you reach a question that's answer is "Yes" is for the description of the reported incident. The corresponding GBV type, listed next to this question, is what should be used to classify the GBV involved in this incident.[6]

The GBVIMS only records incidents reported directly by the survivor (or by the survivor's guardian if the survivor is a child or unable to report due to a disability) in the context of receiving services. Thus any incidents in which the victim has died prior to the report, are excluded from data being recorded for the GBVIMS.[7]

1. Did the reported incident involve **penetration**?
   If yes ⓪ classify the GBV as **"Rape".**
   If no ⓪ proceed to the next GBV type on the list.
2. Did the reported incident involve **unwanted sexual contact**?
   If yes ⓪ classify the GBV as "**Sexual Assault**". If no proceed to the next GBV type on the list.
3. Did the reported incident involve **physical assault**?
   If yes ⓪ classify the GBV as "**Physical Assault**". If no ⓪ proceed to the next GBV type on the list.
4. Was the incident an act of **forced marriage**?
   If yes ⓪ classify the GBV as "**Forced Marriage**". If no ⓪ proceed to the next GBV type on the list.
5. Did the reported incident involve the **denial of resources, opportunities or services**?
   If yes ⓪ classify the GBV as "**Denial of Resources, Opportunities, or Services**". If no ⓪ proceed to the next GBV type on the list.
6. Did the reported incident involve **psychological/emotional abuse**?
   If yes ⓪ classify the GBV as "**Psychological / Emotional Abuse**". If no⓪ proceed to the next GBV type on the list.
7. **Did the reported incident involve GBV?**
   If yes ⓪ Start over at number 1 and try again to reclassify the type of GBV *(If you have tried to classify the GBV multiple times, ask your supervisor or GBVIMS focal point for support)*
   If no ⓪ classify the violence as "**Non-GBV**"

Service providers are encouraged to continue to capture all the information of reported incidents needed for service provision as described by their clients in their case notes. The type of information appropriate to collect and record may differ between services.

The following were not included as core types of GBV. However, they can be analyzed indirectly.

1. Intimate Partner Violence (often referred to as "domestic violence")
2. Child Sexual Abuse
3. Early Marriage
4. Sexual Exploitation / Transactional Sex

5 The order is NOT intended to express an implied 'value' of the GBV types (i.e. rape is worse than forced marriage).

6 For example, within this system, an incident where a woman reports having been beaten by her husband and also forced to have sex with him the GBV would be classified as "rape".

7 This rule was established to avoid 3rd party reports outside of the context of service delivery.

5. Sexual Slavery
6. Harmful Traditional Practices

Explanation:

1. **Intimate Partner Violence** is defined by the relationship between perpetrator and survivor and may include multiple forms of violence (rape, sexual assault, physical assault, psychological / emotional abuse), which can lead to inconsistencies in the recording of incidents. By analysis of the type of GBV and the survivor's relationship to the perpetrator, one is able to identify and analyze which incidents took place within the context of an intimate partner relationship.

TYPE OF GBV		ACCUSED		INCIDENT CONTEXT
Rape **Sexual Assault** **Physical Assault** **Denial of Resources** **Psychological / Emotional Abuse**	**+**	**Intimate Partner / Former Partner**	**=**	**Intimate Partner Violence**

2. **Child Sexual Abuse** is defined by the age of the survivor it includes different forms of sexual violence, which can lead to inconsistencies in the recording of incidents. By analysis of two incident types (sexual assault and rape) and the age of the survivor, one is able to easily analyze which reported incidents were child sexual abuse cases.

TYPE OF GBV		ACCUSED PERPETRATOR		AGE OF SURVIVOR		INCIDENT CONTEXT
Rape **Sexual Assault**	**+**	**Any**	**+**	**Child**	**=**	**Child Sexual Abuse**

3. **Early marriage** is defined by the age of the survivor at the time of the incident of forced marriage. By analysis of the incident and the age of the survivor, one is able easily to analyze which reported incidents were early marriages.

TYPE OF GBV		ACCUSED PERPETRATOR		AGE OF SURVIVOR		INCIDENT CONTEXT
Forced Marriage	**+**	**Any**	**+**	**Child**	**=**	**Early Marriage**

4. **Possible Sexual Exploitation and Transactional Sex** are defined by the power relationship between survivor and perpetrator, as well as the circumstances surrounding the incident - not the actual act of violence (i.e. rape or sexual assault), which can lead to inconsistencies in the recording of incidents. The incident recorder includes a column in which 'yes / no' can be indicated in response to the question "were money, goods, benefits and/or services exchanged in the context of the reported incident?" which can give a sense of whether the sexual violence being reported is exploitative in nature.

5. **Possible Sexual Slavery** is defined by the circumstances during which multiple acts and various forms of sexual violence are perpetrated over a period of time. The incident recorder is only able to capture one unique incident at a time. The Incident Recorder includes a column for indicating whether the incident was perpetrated while the survivor was: a) being forcibly transported (trafficked); b) being forced to join an armed group (forced conscription); c) held against her/his will, abducted or kidnapped.

6. **Harmful Traditional Practices** are defined by the local social, cultural and religious values where the incident take place. To distinguish those acts of GBV that are harmful traditional practices specific to the context in which they took place, the Standard Intake / Initial Assessment form includes a question to indicate whether the GBV was a type of harmful traditional practice. The responses must be customized locally to define the incident as 1 of up to 4 relevant types of harmful traditional practices found in that context. The Incident Recorder will be able to quantify how many instances were marked "yes/ "no" for Harmful Traditional Practice and the frequency of the individual customized types.

TYPE OF GBV		ALLEGED PERPETRATOR		HARMFUL TRADITIONAL PRACTICE?		INCIDENT CONTEXT
Sexual Assault	**+**	**A**	**+**	**FGM/C**	**=**	**Harmful Traditional Practice**

II. Proposed ToRs for FPC Team Members

a. TOR FOR FPC IN CHRAGE

Line of Reporting

Family Protection Center in charge works under direct supervision of GBV Project Manager, and also as the FPC is proposed as a component of the EPHS, her first line of reporting will be to the hospital leadership.

Qualifications

1. A college degree, preferably university degree holder in Medicine,
2. Excellent language skills – fluent in Dari and Pashto, and working knowledge of English
3. Appropriate computer skills in relevant packages
4. Experience in work related to gender based violence and training skills
5. Past work experience of 7 to 10 years in team management and administration
6. Good communication and presentation skills

The Responsibilities of the Family Protection In charge:

General:

1. Lead establishment and running of Family Protection Center (FPC) in Regional/ Provincial Hospital and ensure FPC objectives are achieved.
2. Insure provision of comprehensive assistance to GBV survivors.
3. Represent FPC at meetings with PHD, Provincial hospitals authorities, BPHS/EPHS implementers, GBV projects implementer NGOs, AHIRC, Police, prosecutors and judges and sharing information and providing feedback when requested.
4. Ensure quality and on-time submission of progress reports to hospital leadership, GBV sub-cluster meetings, and GBV Project Manager.
5. Participate in GBV related training workshops as trainer when needed.
6. Report on weekly, monthly and quarterly basis to immediate supervisor.
7. Attend all relevant meetings/workshops requested by supervisor.
8. Ensure strict adherence to guidelines and procedures laid out in the SOP for Health Sector Response to GBV by the FPC team.

Supervisory Tasks:

1. Oversee and support work of Legal counselor/data officer, and Medical officer/ psychosocial counselor
2. Supervise and manage the coordination with focal points in the healthcare facilities linked to FPC through referral
3. Manage and oversee routine day to day activities of FPC
4. Undertake regular follow up of cases entering FPC with team members

5. Supervise stocks and ensure maintenance of standard equipment and supplies at FPC

Technical Tasks:

1. Facilitate GBV victims' visits with psychiatrist, medical doctor, gynecologist and others services as necessary
2. Assist GBV victims in designing a Safety Plan for life threatening situations
3. Set up and maintain the necessary procedures to diminish the security risks for all service providers visiting and/or working at FPC
4. Provide on the job refresher training sessions for FPC team members in correct classification of GBV and correct use of tools and SOP guidelines within the FPC.
5. Lead refresher training for focal persons in other healthcare facilities during case management meetings.
6. Manage the timely provision of services to GBV victims who come to FPC, including psychosocial counseling service, basic legal assistance, basic evidence collection, referral to other institutions depending on victims' choice and case management.

Ethical and Procedural Guidelines:

1. Maintain an attitude of respect and support toward GBV survivors.
2. Ensure adherence to procedures for confidentiality of GBV victim at every step
3. Follow ethical guidelines of GBV response established in GBV SOP
4. Intervene to minimize efforts and investment of resources required from GBV victim for seeking health care and legal services.
5. Observe necessary protocols to diminish the security risks for all service providers visiting and/or working at FPC

b. TOR FOR MEDICAL OFFICER / PSYCHOSOCIAL COUNSELOR

Line of Reporting

The Medical Officer/ Psychosocial Counselor works in the Family Protection Center (FPC) located within provincial, regional or national Hospital. She will work under the direct supervision of the FPC in charge, and coordinate all activities with other team members.

Qualifications

1.A medical degree or nurse /midwifery degree, and minimum 5 years of work experience in trauma or maternal / reproductive health care

2. Education or exposure to GBV related work preferred
3. Fluency in national languages, and working level English language skills
4. Training in standard operating procedures for health care response to GBV
5. Successful completion of two-week psychosocial counseling training (at least).
6. Advanced training in psychosocial counseling and/or past experience preferable
6. Computer literacy and data entry experience
7. Good communication and networking abilities

Technical and Administrative Responsibilities of the Medical officer / Psychosocial counselor:

1. Receive cases referred at the Family Protection Center (FPC)
2. Register cases and complete case records using standard tools (intake form, consent form, medical exam form, referral slip) for submission to Data Officer / Legal Counselor
3. Inform GBV survivor of her right to have full control over all information s/he shares, and to decide which, if any, medical investigation or assistance she chooses to receive
4. Perform physical examination of GBV survivor in a respectful and culturally sensitive manner, and classify type and level of GBV
5. Provide basic health and medical care as needed including wound care, pregnancy prevention, prophylaxis against HIV, Hepatitis, or STDs, based on the wishes and choices of the survivor or custodian of survivor, if s/he is too young or incapable of making decisions.
6. Provide GBV survivors with psychosocial support and counseling with 4 to 6 follow up counseling sessions if needed
7. Conduct 1 to 2 family counseling sessions if needed to help family deal with the GBV situation and support the victim, to prevent rejection and abandonment of GBV survivor by her/his family
8. Inform survivor and her custodians about referral needs, and assist them in making decisions about possible referral services, and complete referral authorization form
9. Connect survivor to GBV focal persons within referral organizations to facilitate easy access to services for the GBV survivors

10. Facilitate referral to forensic medicine focal person for collection of forensic evidence if desired by survivor
11. Provide survivors and their custodians with necessary information about opportunities for protection
12. Follow up medical cases referred with focal persons in relevant health care facilities
13. Strictly adhere to standards of confidentiality and ethical handling of GBV information
14. Attend weekly FPC meetings and provide updates on medical/psychosocial counseling status of cases
15. Provide monthly updates on medical drugs and supplies stock to FPC In charge, so that stocks can be replenished on a timely basis
16. Participate in monthly case management meetings with GBV focal persons in stakeholder agencies and health facilities in a referral relationship with the FPC, and provide updates on progress of cases
17. Contribute to the development of monthly FPC reports for presentation and GBV sub-cluster meetings
18. Work closely with the FPC team to build a professional team
19. Contribute to refresher training for focal persons in other healthcare facilities during case management meetings.
20. Facilitate GBV survivors' visits with medical specialists
21. Assist GBV victims in designing a Safety Plan for life threatening situations

Ethical and Procedural Guidelines:

1. Maintain an attitude of respect and support toward GBV survivors.
2. Ensure adherence to procedures for confidentiality of GBV victim at every step
3. Follow ethical guidelines of GBV response established in GBV SOP
4. Intervene to minimize efforts and investment of resources required from GBV victim for seeking health care and legal services.
5. Observe necessary protocols to diminish the security risks for all service providers visiting and/or working at FPC

c. TOR FOR DATA OFFICER / LEGAL COUNSELOR

Line of Reporting

The Data Officer/ Legal Counselor works in the Family Protection Center (FPC) located within provincial, regional or national Hospital. The data collection officer will work under the direct supervision of the FPC in charge, and coordinate all activities with other team members. Her primary responsibilities will include ensuring proper registration and record keeping of GBV cases, using specified tools for collecting data, and feeding it into the GBVIMS database of the MoPH. She will also be responsible for providing GBV survivors with legal and criminal justice advice, and connecting them to relevant people within Police Family Response Units or the legal system.

Qualifications

1. A college degree, and minimum 3 years of work experience in relevant field
2. Education or exposure to legal or paralegal work will be preferred
3. Fluency in national languages, and working level English language skills
4. Training in standard operating procedures for health care response to GBV
5. Computer literacy and data entry experience
6. Good communication and networking abilities
7. Training in SOP for Health Sector Response to GBV

The Responsibilities of the Data officer / Legal counselor:

1. Receive cases referred by the medical officer / psychosocial counselor at the Family Protection Center (FPC) and cross check and verify the information recorded in the registration tools
2. Brief survivor of her legal rights as a victim of GBV, and simply and carefully brief her, or in case of a minor, her adult custodian, of all legal and criminal justice options, and help them make informed decisions about next course of action
3. Provide survivors and their custodians with necessary information about opportunities for protection
4. Check authorization for information sharing and get consent for legal referral
5. Connect survivors to FRUs or prosecution lawyers if requested
6. Follow up criminal justice or legal cases referred
7. Strictly adhere to standards of confidentiality and ethical handling of GBV information
8. Provide ongoing legal counseling and support for survivors and/or family members until case is resolved
9. Upload case data on the GBV database on the day it is obtained
10. Secure all physical case files in a locked file cabinet and safe keep the keys.
11. Attend weekly FPC meetings and provide updates on legal processes and on GBVIMS data

12. Participate in monthly case management meetings with GBV focal persons in stakeholder agencies and health facilities in a referral relationship with the FPC, and provide updates on progress of cases
13. Contribute to the development of monthly FPC reports for presentation and GBV sub-cluster meetings
14. Coordinate closely with GBVIMS team at the MoPH or within the PPHDs at provincial level
15. Work closely with the FPC team to build a professional team
16. Maintain an attitude of confidentiality and respect toward GBV survivors.
17. Facilitate GBV victims' visits with lawyers, prosecutor's office, women rights' groups, AIHRC, or with police FRU
18. Assist GBV victims in designing a Safety Plan for life threatening situation

Ethical and Procedural Guidelines:

1.Maintain attitude of respect and support toward GBV survivors.

2. Ensure adherence to procedures for confidentiality of GBV victim at every step

3. Follow ethical guidelines of GBV response established in GBV SOP

4. Intervene to minimize efforts and investment of resources required from GBV victim for seeking health care and legal services.

5. Observe necessary protocols to diminish the security risks for all service providers visiting and/or working at FPC

III. Standard Lists of FPC Medical and Non-Medical Equipment and Supplies

Standard List of Equipment and Drugs/supplies at FPC

List of Equipment				
No	Name of item	No/ Yes	If yes, please write the number	Remarks
1	Kidney tray large size	□ No [1] □ Yes [2]		
2	Scissors straight 18 CM	□ No [1] □ Yes [2]		
3	Artery Forceps	□ No [1] □ Yes [2]		
4	D&C Kit	□ No [1] □ Yes [2]		
5	Vaginal Speculum	□ No [1] □ Yes [2]		
6	Stethoscope & Sphygmomanometer (BP set)	□ No [1] □ Yes [2]		
7	Otoscope	□ No [1] □ Yes [2]		
8	Thermometer Sample size	□ No [1] □ Yes [2]		
9	First aid kit	□ No [1] □ Yes [2]		
10	Dressing trolley plus bowel and dram	□ No [1] □ Yes [2]		
12	Patient Examination Table	□ No [1] □ Yes [2]		
13	Steel bucket with lid for waste bin	□ No [1] □ Yes [2]		
14	Office table	□ No [1]		

		□ Yes [2]		
15	Medicine Cupboard lockable	□ No [1] □ Yes [2]		
16	Office Chairs	□ No [1] □ Yes [2]		
17	File cabinet Safe (lockable)	□ No [1] □ Yes [2]		
List of Drugs and Medical Supplies				
No	Name of item	No/ Yes	If yes, please write the number	Remarks
1	Augmentin (Co-Amoxacilive)	□ No [1] □ Yes [2]		
2	Azithromycine	□ No [1] □ Yes [2]		
3	Benzatin Pencillin	□ No [1] □ Yes [2]		
4	Cefixime	□ No [1] □ Yes [2]		
5	Ceftriaxone	□ No [1] □ Yes [2]		
6	Cifixime	□ No [1] □ Yes [2]		
7	Ciprofloxacin	□ No [1] □ Yes [2]		
8	Doxycyclin	□ No [1] □ Yes [2]		
9	Erythromycin	□ No [1] □ Yes [2]		
10	Metronidazole	□ No [1] □ Yes [2]		
12	Ofloxacin	□ No [1] □ Yes [2]		

13	Augmentin (Co-Amoxacilive)	□ No [1] □ Yes [2]		
14	Azithromycine	□ No [1] □ Yes [2]		
15	Benzathinebenzyl penicillin	□ No [1] □ Yes [2]		
16	Zidovudine,100mg,capsule	□ No [1] □ Yes [2]		
17	Zidovudine,300mg plus Lamivudine 150mg	□ No [1] □ Yes [2]		
18	Clindamycn+miconazole vaginal	□ No [1] □ Yes [2]		
19	Clonazepam	□ No [1] □ Yes [2]		
20	Nystatin Vaginal	□ No [1] □ Yes [2]		
21	Nystatine	□ No [1] □ Yes [2]		
22	Captopril	□ No [1] □ Yes [2]		
23	Hydrocortisone	□ No [1] □ Yes [2]		
24	Nitrofurantoin	□ No [1] □ Yes [2]		
25	Rep kit (catno.cc100)	□ No [1] □ Yes [2]		
26	Spiromide	□ No [1] □ Yes [2]		
27	Silicone	□ No [1] □ Yes [2]		
28	Silver sulfadiazine	□ No [1]		

		□ Yes [2]		
29	Silver Sulphadiazin	□ No [1] □ Yes [2]		
30	Skin Closures	□ No [1] □ Yes [2]		
31	Pyodine 1 litre	□ No [1] □ Yes [2]		
32	Non Sterile Gloves	□ No [1] □ Yes [2]		
33	Sterile gloves	□ No [1] □ Yes [2]		
34	Sterile gauze	□ No [1] □ Yes [2]		
35	Citalopram	□ No [1] □ Yes [2]		
36	Clonazepam	□ No [1] □ Yes [2]		
37	Floxetine	□ No [1] □ Yes [2]		
38	Protiadin	□ No [1] □ Yes [2]		
39	Citalopram	□ No [1] □ Yes [2]		
40	Contraceptive Pills	□ No [1] □ Yes [2]		
41	Diclofenac	□ No [1] □ Yes [2]		
42	Diclofenac	□ No [1] □ Yes [2]		
43	Ferous Sulphate+folic acid (Ferfolic)	□ No [1]		

		□ Yes [2]		
44	Hyocine	□ No [1] □ Yes [2]		
45	Liodicain	□ No [1] □ Yes [2]		
46	Metoclopromide	□ No [1] □ Yes [2]		
47	Multivitamin	□ No [1] □ Yes [2]		
48	Mupirocin	□ No [1] □ Yes [2]		
49	Naproxene	□ No [1] □ Yes [2]		
50	No- Spa	□ No [1] □ Yes [2]		
51	Nortriptyline	□ No [1] □ Yes [2]		
52	No-Spa	□ No [1] □ Yes [2]		
53	Omeprazole	□ No [1] □ Yes [2]		
54	Paracetamol	□ No [1] □ Yes [2]		
55	Syringe and needles	□ No [1] □ Yes [2]		
56	Contraceptive Pills	□ No [1] □ Yes [2]		
57	Diclofenac	□ No [1]		

		□ Yes [2]		
58	Diclofenac	□ No [1] □ Yes [2]		
59	Ferous Sulphate+folic acid (Ferfolic)	□ No [1] □ Yes [2]		
60	Hyocine	□ No [1] □ Yes [2]		
61	Liodicain	□ No [1] □ Yes [2]		
62	Metoclopromide	□ No [1] □ Yes [2]		
66	Multivitamin	□ No [1] □ Yes [2]		
67	Mupirocin	□ No [1] □ Yes [2]		
68	Naproxene	□ No [1] □ Yes [2]		
69	No- Spa	□ No [1] □ Yes [2]		
70	Omeprazole	□ No [1] □ Yes [2]		
71	Paracetamol	□ No [1] □ Yes [2]		
72	Syringe and needles	□ No [1] □ Yes [2]		
73	Oral contraceptive	□ No [1] □ Yes [2]		
74	Emergency contraceptive	□ No [1] □ Yes [2]		

75	Depoprovera	□ No [1] □ Yes [2]		
76	IUD	□ No [1] □ Yes [2]		
77	Oral contraceptive	□ No [1] □ Yes [2]		
78	Emergency contraceptive	□ No [1] □ Yes [2]		
79	Pregnancy Test	□ No [1] □ Yes [2]		
80	HBs Test	□ No [1] □ Yes [2]		
81	HIV Test	□ No [1] □ Yes [2]		

IV. FPC Monitoring Tools

وزارت صحت عامه

ریاست عمومی پالیسی و پلان

ریاست جندر

چک لیست براي مراکز حمایوی خانواده

ولایت :.....

نام شفاخانه: .....

تاریخ: ...../...../.....

ساعت : .....

نظارت کننده گان :

1: .....

2: .....

3: .....

سوالات بخش مرکز حمایوی خانواده

این چک لیست برای ارزیابی مرکز حمایوی خانواده تهیه گردیده است تا این مراکز را از نظر تخنیکی مورد بررسی قرار دهد در این چک لیست به هر بخش نمرات تعیین گردیده است و مجموع نمرات 43 در کل در نظر گرفته شده است بلند ترین نمره 43بوده و در صورت که مجموع نمرات از20 کمتر باشد (ضعیف) در صورت که نمرات بین 25-35 باشد (خوب) در صورت که از 35 بالا باشد (عالی) در نظر گرفته شده است .

نوت: به سوالات(بلی / نخیر) نمره در نظر گرفته شده است .

شماره	سوال	جواب	نمره از 0-1	ملاحظات
بخش منابع بشری				
1	آیا کارمندان این مرکز به اساس تشکیل مرکز حمایوی خانواده وجود دارد؟	1: بلی 2: نخیر		

۲	اگر جواب نخیر است کدام پرسونل موجود نمی باشد؟	....		
3	آیا کارمندان به صورت کامل در محل کار حاضر هستند؟	1: بلی 2: نخیر		
4	آیا همه کارمندان از طبقه اناث است ؟	1: بلی 2: نخیر		
5	آیا کارمندان (مسؤل مرکز حمایوی خانواده ، کارمند دیتا انتری و مشاور روانی)در رابطه به وظایف خویش آموزش دیده اند ؟	1: بلی 2: نخیر		
6	آیا کارمندان لایحه وظایف دارند ؟	۱: بلی ۲: نخیر		
7	آیا کارمندان از لایحه وظایف خویش آگاهی دارند؟	۱: بلی ۲: نخیر		
مجموعه نمرات 6				
بخش تسهیلات				
8	آیا این مرکز دارای امکانات لازمه کاری به اساس لیست معیار های مرکز حمایوی خانواده است ؟	1: بلی 2: نخیر		
9	اطاق کافی برای مرکز حمایوی به دسترس است ؟	1. بلی 2. نخیر		
10	آیا اتاق های جداگانه برای مشوره دهی و مدیریت واقعات وجود دارد؟	۱: بلی 2: نخیر		
11	ایا این مرکز برای نگهداری ارقام الماری قفل شده گی دارد؟	۱: بلی 2: نخیر		
12	ایا تدابیر حفاظتی برای امنیت این مرکز وجود دارد؟	۱: بلی 2: نخیر		
13	مرکز حمایوی خانواده نزدیک به کدام خدمات شفاخانه است ؟	1:واردنسایی ولادی 2:شعبه عاجل 3:وارد جراحی 4:وارد داخله 5: بخش طب عدلی 6: سایر بخش ها مشخص شود.....		
14	آیا این مرکز برای انتقال متضررین خشونت مبنی بر جندر وسیله نقلیه دارد؟	1: بلی 2: نخیر		
15	آیا به اساس لیست ادویه مرکز حمایوی خانواده لیست ادویه جات به صورت کامل موجود می باشد ؟	۱: بلی 2: نخیر		
جموعه 7 نمره				
بخش تخنیکی				
16	آیا در این مرکز طرزالعمل معیاری برای رسیدگی سکتور صحت به واقعات خشونت مبنی بر جندر (SOP) وجود دارد؟	1: بلی ۲: نخیر		
17	آیا فورمه جات اسکریننگ برای واقعات خشونت	1: بلی		

	مبنی بر جندر وجود دارد؟	۲: نخیر		
18	آیا در این مرکز فورمه جات جمع آوری ارقام از متظررین خشونت مبنی بر جندر وجود دارد؟	1: بلی ۲: نخیر		
19	آیا در این مرکز رجعت دهی شیت برای ریفر نمودن متضررین خشونت مبنی بر جندر وجود دارد؟	1: بلی 2: نخیر		
20	آیا از طرف وزارت صحت عامه دونر و مؤسسات تطبیق کننده در سه ماه گذشته نظارت صورت گرفته است ؟	1: بلی 2: نخیر		
21	آیا دراین مرکز کتاب راجستریشن برای ثبت نام قربانیان خشونت مبنی بر جندر وجود دارد؟	1:بلی 2: نخیر		
22	آیا در این مرکز فایل های شخصی از قربانیان خشونت مبنی بر جندر وجود دارد؟	1: بلی 2: نخیر		
23	آیا در این مرکز راپور از بازدید با فوکل پاینت ها موجود است ؟	۱: بلی 2: نخیر		
24	آیا خلاصه جلسات کمیته قضایا در مرکز حمایوی خانواده موجود می باشد؟	۱: بلی 2: نخیر		
25	آیا لیست ابدیت فوکل پاینت ها و شماره تلفن آنها در مرکز حمایوی خانواده وجود دارد ؟	۱: بلی 2: نخیر		
مجموعه10 نمره				
بخش هماهنگی				
26	آیا این مرکز هماهنگی لازمه را در حصه کاری با شفاخانه مربوطه دارند ؟	1: بلی 2: نخیر		
27	آیا این مرکز به شفاخانه مربوطه راپور دهی دارند؟	1: بلی 2: نخیر		
28	آیا این مرکز در موقعیت مناسب قرار دارد ؟	1: بلی 2: نخیر		
29	آیا فیدبک مانیتورنگ همراه کارمندان مرکز حمایوی خانواده شریک شده است یا خیر ؟	۱: بلی 2: نخیر		
30	آیا در این مرکز واقعات به صورت درست ثبت و راجستر میگردد؟	1: بلی 2: نخیر		
31	به چی تعداد واقعات خشونت مبنی بر جندر در این مرکز در ماه (.....) ثبت و راجستر گردیده است ؟	..... .واقعات		
32	به چی تعداد واقعات از دیگر ارگان ها به این مرکز در یک ماه گزشته معرفی گردیده است ؟	....واقعه		
33	از این مرکز به دیگر ارگان ها چقدر واقعات معرفی گردیده است ؟	....واقعه		
34	آیا در این مرکز چارت که نماینگر از نمایش واقعات باشد نصب گردیده است ؟	1: بلی 2: نخیر		
35	تعداد فوکل پاینت ها در این مرکز به چی تعداد است ؟	....		
36	آیا فوکل پاینت ها از شفاخانه های مرکزی و تخصصی انتخاب گردیده است؟	1: بلی 2: نخیر		

37	آیا فوکل پاینت ها متضررین را به مرکز حمایوی رجعت می دهند؟	1: بلی 2: نخیر		
38	آیا فوکل پاینت ها از مراکز صحی جامع و شفاخانه ولسوالی انتخاب شده است؟	1: بلی 2: نخیر		
39	آیا فوکل پاینت ها از سایر ارگان ها مانند وزارت داخله، امور زنان، عدلیه، لوی سارنوالی، حقوق بشر و محکمه فامیلی، .....برای مرکز حمایوی خانواده ها معرفی شده؟.	1: بلی 2: نخیر		
40	آیا این فوکل پاینت ها همکاری فعال و نزدیک با کارمندان مرکز حمایوی خانواده جهت عرضه خدامات برای متضرر می کنند؟	1: بلی 2: نخیر		
41	در قسمت تشویق فوکل پاینت های که خوب فعال نیستند و همکاری لازمه را انجام نمی دهند، تدابیر لازمه اتخاذ شده است؟.	1: بلی 2: نخیر		
42	آیا این مرکز پلان نظارت برای فوکل پاینت ها دارند ؟	1: بلی 2: نخیر		
43	آیا مطابق به پلان کاری با فوکل پاینت ها بازدید گردیده است ؟	1: بلی 2: نخیر		
44	آیا راپور نظارت از فوکل پاینت ها موجود است ؟	1: بلی 2: نخیر		
45	آیا این مرکزجلسات کمیته واقعات را به صورت ماهوار برگزار مینمایند؟	1: بلی 2: نخیر		
46	آیا خلاصه جلسات کمیته واقعات دراین مرکز موجود میباشد ؟	1: بلی 2: نخیر		
47	آیا مرکز حمایوی خانواده شیت جمع آوری و ذخیره ارقام از متضررین را به طور الکترونیکی به دسترس دارند؟	1: بلی 2: نخیر		
48	آیا این شیت الکترونیکی به طور محرمانه حفظ می گردد	1: بلی 2: نخیر		
49	آیا کارمندان در رابطه به شیت الکترونیکی آموزش دیده اند ؟	1: بلی 2: نخیر		
مجموعه20 نمره				
نمره نظارت کننده بر اساس چک لیست				

پیشنهادات :

وزارت صحت عامه

ریاست عمومی پالسی و پلان

ریاست جندر

چک لیست نظارتی از فوکل پاینت ها

ولایت : .....

نام کلینیک یا شفاخانه : .....

نظارت کننده گان:

1: .....

2: .....

3: .....

ساعت :.....

تاریخ: ...../...../.....

این چک لیست برای ارزیابی فوکل پاینت ها توسط کارمندان مرکز حمایوی خانواده ترتیب گردیده است که 12 نمره دارد به سوال های (بلی و نخیر) نمره در نظر گرفته شده است .

1	نام فوکل پاینت :	.....	نمره از 0-1	ملاحظات
2	وظیفه :	.....		
3	آیا شما در رابطه به پر کردن فورمه جات آموزش دیده اید ؟	1: بلی 2: نخیر		
4	آیا شما شماره تماس مسؤل مرکز حمایوی خانواده را دارید ؟	1: بلی		

		2: نخیر		
5	آیا شما رهنمور SOP را در این مرکز دارید ؟	1: بلی 2: نخیر		
6	آیا اسناد و واقعات ثبت شده مرتبط به GBV به طور مصؤن نگهداری میشود؟	1: بلی 2: نخیر		
7	آیا مرکز شما مشاور روانی – اجتماعی را دارد ؟ اگر دارد آیا کورس آموزشی GBV را اخذ نموده است ؟	1: بلی 2: نخیر		
8	آیا شما در رابطه به خشونت مبنی بر جندر ترنینگ دریافت نموده اید؟	1: بلی 2: نخیر		
9	روزانه به چی تعداد واقعات را در مرکز حمایوی خانواده معرفی میکنید ؟	..... نفر		
10	بیشترین واقعات که معرفی می نمایید از کدام کتگوری می باشد ؟	1: فزیکی 2: احساسی/ روانی 3: جنسی 4. زنا بلجبر 5. محروم ساختن از منابع 6. ازدواج قبل از وقت		
11	واقعات که به شما مراجعه میکنند اوسط سن ها از 18 سال بالا یا پایین می باشد ؟	.....		
12	آیا فورمه جات بخاطر جمع آوری ارقام در نزد شما موجود است ؟	1: بلی 2: نخیر		
13	آیا ادویه جات برای تداوی متضرین خشونت مبنی بر جندر در ساحه کاری شما موجود است ؟	1: بلی 2: نخیر		
14	شما روزانه به چی تعداد واقعات را ثبت و راجستر می نماید ؟	1: بلی 2: نخیر		
15	شما به متضررین خشونت مبنی بر جندر چی نوع خدمات را عرضه می نمایید ؟	.....		
16	آیا در تقسیم اوقات روزانه مرکز صحی موضوع خشونت مبنی بر جندر گنجانیده شده است یا خیر ؟	1: بلی 2: نخیر		
17	آیا واقعات که شما به مرکز حمایوی خانواده معرفی می نمایید از عرضه خدمات این مرکز رضایت دارند ؟	1: بلی 2: نخیر		
18	آیا شما علاقمند همکاری با این مرکز هستید؟	1: بلی 2: نخیر		
19	آیا برای بهبود کار شما کدام نظر خاصی دارید ؟			

مجموعه نمرات 12

پیشنهادات :

V. Psychosocial Counseling Training Content for FPC

Training manual for two-week training is attached.