

Gender-Based Violence

FACILITATION GUIDE

*Standards for the provision of high quality
post-violence care in health facilities*



**World Health
Organization**

Gender-Based Violence Quality Assurance Tool: Facilitation Guide

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Glossary of Terms

Biosafety refers to the containment principles, technologies, and practices that are implemented to prevent the unintentional exposure to pathogens and toxins, or their accidental release.

Clinical Enquiry/Case Finding refers to asking questions about IPV to patients who either disclose they have experienced violence, or patients who show signs and symptoms of IPV. This should be done no matter what the condition of IPV services in order to provide appropriate and timely care.

Chain of custody is a formal chronological documentation of the custody and possession of evidence. It is used to establish the integrity of the evidence collection in a court of law.

Confidentiality means keeping all information relating to an individual private, including but not limited to personal identifying information and health concerns, unless the individual gives consent for disclosure.

First-line support is the immediate care given to a GBV survivor upon first contact with the health or criminal justice system. The WHO defines “first-line support” using the acronym “**LIVES**”: **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals.

Forensic evidence includes items such as blood, semen, DNA, hairs, fingerprints, fibers, etc. obtained by scientific methods such as ballistics, blood tests, and DNA tests used in court.

Gender-based violence is any form of violence against an individual based on that person’s biological sex, gender identity or expression, or perceived adherence to socially-defined expectations of what it means to be a man or woman, boy or girl. The most common forms are sexual assault, intimate partner violence against women and child abuse, but GBV also includes physical and psychological abuse, threats, coercion, arbitrary deprivation of liberty, and economic deprivation, whether occurring in public or private life. GBV is rooted in gender-related power differences, including social, economic and political inequalities. It is characterized by the use and abuse of physical, emotional, or financial power and control. GBV takes on many forms and can occur across childhood, adolescence, reproductive years, and old age. GBV includes but is not limited to:

- **Intimate partner violence (IPV):** Behavior by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviors. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to intimate partner violence include domestic violence, wife or spouse abuse, and battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting. In this tool, IPV is included under the umbrella term of GBV unless otherwise specified.

- **Rape** is defined in this tool as contact between the penis and the vulva or the penis and the anus involving penetration; contact between the mouth and penis, vulva or anus; or penetration of the anus or genitals of another person by a hand, finger or other object, however slight. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.
- **Sexual assault** can include rape but can also include non-penetrative unwanted sexual contact such as molestation, kissing or fondling.
- **Sexual violence** is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Informed assent is the expressed willingness to participate in services after a provider explains all aspects of the examination or procedure to the patient in a manner s/he can fully understand. For younger children who are too young (i.e., younger than the age of consent in his/her country) to give informed consent (definition below), but old enough to understand and agree to participate in services, the child’s “informed assent” is sought.

Informed consent is the expressed willingness to participate in or receive services after a provider explains all aspects of the examination to the patient in a manner s/he can fully understand. Age of consent varies by country. Particular emphasis should be placed on the matter of the release of information to other parties, including the police. This is especially important in settings where there is a legal obligation to report an episode of violence (and hence details of the examination) to relevant authorities. It is crucial that patients and parent/caregivers understand the options open to them and are given sufficient information to enable them to make informed decisions about their care.

Intimate partner: A husband, wife, cohabiting partner, boyfriend, girlfriend, lover, or ex-husband, ex-wife, ex- partner, ex-boyfriend, ex-girlfriend or ex-lover.

Key populations at risk for HIV include, but are not limited to: men who have sex with men, transgender individuals, sex workers, persons who inject drugs, and prisoners.¹ Some of these populations, such as transgender individuals, may also be at higher risk of some forms of GBV.

Patient is used in this tool to include GBV victim, survivor, client and other terms that are commonly used in GBV care. “Patient” was chosen because it is an objective term that can be appropriate for the clinical context, but can be adapted to suit the country or facility’s preference. When a patient has experienced sexual assault, s/he is referred to as a sexual assault survivor.

¹ UNAIDS and PEPFAR’s current definitions, which focus on key populations at higher risk for HIV infection, exclude bisexuals and lesbians; however, these populations are at higher risk of experiencing GBV in some populations and need services and counseling tailored towards their needs. They are thus included here.

Privacy is being free from intrusion or interruption, without being able to be seen or heard.

Provider is used in this tool to refer to health care workers of any type (e.g., physician, nurse, social worker, midwife, psychologist, and medical assistant). This is because the number and type of providers who deliver GBV services differs across facilities and across countries.

Screening is a structured process used to detect a disorder or health condition. This is distinct from clinical enquiry/case finding (see above) because the provider is asking questions whether or not the patient discloses violence or shows signs and symptoms of IPV. There are two main types of IPV screening/enquiry:

1. **Routine screening/enquiry** for all patients in a particular setting (e.g. asking all ANC patients or all HIV patients). **This should only be done in settings that meet minimum standards as per WHO guidelines.² To enquire and then offer no services/ poor quality services could re-traumatize the survivor and create a lack of trust in services, and is not recommended.**
2. **Universal screening** of all patients in all settings (patients are asked no matter what service they receive). **Universal screening is not recommended.** There is insufficient evidence that it leads to a decrease in IPV or health benefits, and it also may overwhelm already overburdened health systems.

Toluidine blue dye is applied to the female external genitalia on the fossa navicularis and can also be used in cases of anal assault—simple application and removal allows clinicians to highlight and document microtrauma otherwise not seen.

² WHO minimum requirements for asking about IPV (WHO 2013):

- A protocol or standing operating procedure exists for providing post-GBV services
- A questionnaire, with standard questions where providers can document responses, exists
- Providers offer first-line support
- Providers have received training on how to ask about IPV or SV
- Private setting, confidentiality ensured
- A system for referrals or linkages to other services within the facility is in place

Introduction

The Gender-Based Violence Quality Assurance Tool (GBV QA Tool) is a resource for health providers, facility managers, and program planners to assess, improve, and ensure the quality of post-GBV healthcare. It is closely aligned with World Health Organization (WHO), President’s Emergency Plan for AIDS Relief (PEPFAR), and US Agency for International Development (USAID) guidelines and technical considerations, and can be used as a tool to initiate post-GBV care services, as well as to assess existing post-GBV care services. It was developed with the support and tools of many partner organizations, and can be used by any partner or government to improve post-GBV care.

Jhpiego and the U.S. Centers for Disease Control and Prevention (CDC) developed the tool with the support of PEPFAR in 2015-2017. PEPFAR also supported an earlier version that Jhpiego Mozambique developed in partnership with the Ministry of Health (MOH), which was adopted nationally. Jhpiego and CDC adapted and expanded the tool for global use through the following process:

- Literature review of over 20 global and national guidelines and tools for the delivery of post-GBV services was conducted.³
- Expert review with international GBV experts informed the adaptation. Participating organizations included WHO, USAID, US State Department, EngenderHealth, International Association of Forensic Nurses, Medical Research Council South Africa, PSI, Johns Hopkins School of Nursing, and Johns Hopkins Bloomberg School of Public Health.




Field testing – The tool was informally tested in Rwanda and Haiti in 2016, and formally field-tested (including the submission of a research protocol to the local IRB board and MOH) and validated in Uganda in 2017. After the field test in Haiti, Jhpiego produced a “Minimum Care” version for resource-poor settings where GBV services are delivered in rudimentary facilities and cannot be equitably compared with well-resourced facilities.

Both the full and minimum care versions of the tool and guide will be available in French.

The GBV QA Tool covers 28 standards on the following areas of post-GBV care. The Minimum Care Version covers 24 standards (see further details below).

Section	# Standards
I. Availability and Appropriateness of Services	1
II. Facility Readiness and Infrastructure	2
III. Identification of Patients Who Have Experienced IPV or SV	3
IV. Patient-Centered Clinical Care and Communication	11

³ See Works Cited in Appendix I on p.21

Section	# Standards
V.  Forensic Examination and Handling of Evidence	2
VI. Referral System and Follow Up of Survivors	2
VII. Training and Quality Improvement	2
VIII. Health Care Policy and Provision	1
IX.  Outreach	1
X. Reporting and Information Systems ()	3
TOTAL	28⁴

The GBV QA Tool seeks to ensure that post-GBV care is accessible and available; essential infrastructure, equipment, and services are in place; providers deliver respectful, high-quality, appropriate, and timely care; relevant policies and procedures are followed; and staff have appropriate training and skills to deliver care.

There are **five main objectives** of the GBV Quality Assurance Tool’s implementation process:

1. Establish service delivery standards for post-GBV clinical care according to best clinical practices.
2. Provide a means of measuring the quality of post-GBV care in clinical settings with a standard tool through **external** quality assurance (i.e., through site visits by supervisory staff, PEPFAR mission staff, implementing partners, ministry of health staff, istrict health managers) and **internal** quality assurance (i.e., continuous quality improvement by the facility itself).
3. Identify key gaps and challenges in service provision.
4. Create action plans to improve identified gaps and challenges in service provision.
5. Recognize and reward achievement of the standards through sharing data on progress and celebrating successes with facilities, key stakeholders and partners, and the international GBV prevention and response community. This can be done, for example, by the MOH organizing an event or site visit by a high-level official to highlight the facility’s achievements, or a celebration at the facility organized by providers themselves.

GBV in PEPFAR

Preventing and responding to GBV through HIV prevention, care and treatment platforms is a PEPFAR priority. GBV can increase the risk of HIV transmission through marital rape; sexual assault or rape; sexual violence against children and adolescents; child marriage; and violence

⁴ The Minimum Care Version only contains 24 standards. It does not include the sections on Forensics or Outreach, or a standard in the Reporting and Informations Systems section about evaluation systems to analyze GBV data.

perpetrated by clients against sex workers, and potentially female genital mutilation/cutting. Given the ways in which these two health problems and their risk factors overlap, preventing HIV cannot be accomplished without efforts to prevent and respond to GBV as well. The PEPFAR Monitoring, Evaluation and Reporting (MER) indicators include a required indicator for documenting the number of individuals who are provided the minimum package of post-violence care services, consistent with WHO guidelines (WHO 2013), in a PEPFAR-supported facility. Prevention of GBV is also critical, and PEPFAR programs are encouraged to include evidence-based GBV prevention programming in their portfolios. PEPFAR supported the development of this tool to ensure that post-GBV health services are standardized, high quality and accessible.

Why Quality Assurance for Post-GBV Care?

There are many guidelines and recommendations that outline what services survivors of GBV should be offered in a clinical setting, included in Appendix I – Works Cited. However, there has not, to-date, been a comprehensive set of standards to assess the quality of post-GBV care in clinical settings. Efforts to provide post-GBV care cannot stop at merely ensuring services exist, but must also ensure they are provided with high quality. Ensuring high quality services increases the likelihood that those who use the services will feel supported by their health care providers and will speak favorably and recommend services to others, helping to increase demand for services that are consistently under-utilized.

Adapting the Tool to National Contexts and Following National Guidelines

Many governments have already developed national guidelines and various tools for the provision of post-GBV care in clinical settings, some of which are referenced in Appendix I – Works Cited. This tool is meant to complement and build upon such efforts, and should not override any national law or guidance. **In fact, specific standards in the tool will need to be adapted to comply with national law.** For example, countries may differ in terms of policy about what types emergency contraception (EC) to administer. Before using this tool, it is necessary to review any national guidelines and adapt the tool to ensure there are no conflicts or contradictions. If any discrepancies are identified, it is also an opportunity to work with national, local, and facility leadership to revisit the policy to ensure it reflects evidence-based standards and best practices of high quality care and meets the needs of survivors of GBV. If no national guidelines exist and further guidance is needed, please refer to Appendix I - Works Cited for best practice international guidance.

Moving from Quality Assurance Assessments to Continuous Quality Improvement

Aside from external assessments, the tool can also be used by providers and facilities independently, without requiring external support. Toward that end, it is essential to introduce the purpose and structure of the tool to those who will use it, to adapt the tool to the national

context and facilities' needs, and to build ownership around its use. This can be done through a workshop with ministry staff, post-GBV care providers, and facility managers/leadership.

The different types of assessments that can be conducted using the adapted tool include:

- **External assessments** implemented by persons external to the facility. These assessments are usually conducted by central/regional/district level of ministries of health. Options for external assessments may include:
 - **Facilitated supervision** when the purpose of the visit is to identify performance gaps and recommend interventions.
 - **Verification assessments** when the purpose of the visit is to confirm compliance with standards of care to recognize progress. Representatives of the patients and communities served should be involved in the process in an appropriate way. For instance, they could have representatives on the team conducting the assessment of the facility.
- **Self-assessments** conducted by the individual providers on their own work. The provider uses the performance assessment tool as a job aid to verify if s/he is following the recommended standardized processes during the provision of care. These assessments can be performed as frequently as desired or needed.
- **Internal assessments** are implemented internally by facility staff. These can include:
 - **Peer assessments** to mutually assess the work among providers.
 - **Internal monitoring assessments** when managers and/or providers use the tool more comprehensively to periodically assess the quality of services to determine if they are being improved, i.e., continuous quality improvement every three to four months.

Ultimately, the goal of this tool is to support ongoing quality improvement based on the the key areas of post-GBV service delivery. By conducting ongoing quality improvement, health facilities will work to ensure that post-GBV care is accessible and available; essential infrastructure, equipment and services are in place; providers deliver respectful, high-quality, appropriate and timely care; relevant policies and procedures are followed; and staff have appropriate training and skills to deliver care.

Two Versions of the Tool: Full and Minimum Care

This tool can be used and adapted for a wide range of contexts. It is purposefully meant to include the optimal level of standards in order to inspire providers and facilities to ensure delivery of the highest quality post-GBV care possible. The full version should be used to assess the quality of care in well-resourced, designated post-GBV care facilities, such as One Stop Centers where key post-GBV care is offered in one location.

However, in facilities with fewer human and financial resources, facilities that are just starting to set up their services, or facilities in marginalized areas (rural, urban slum, conflict area, etc.), the full version may be unrealistic to use. For that reason, there is also a “minimum care” version of the tool, which excludes more aspirational verification criteria (**marked with a + symbol**). The assessor should review both versions and use her or his judgment to determine which version is appropriate. The Scoring Feedback Form is suitable for use with both the full or minimum versions of the tool.

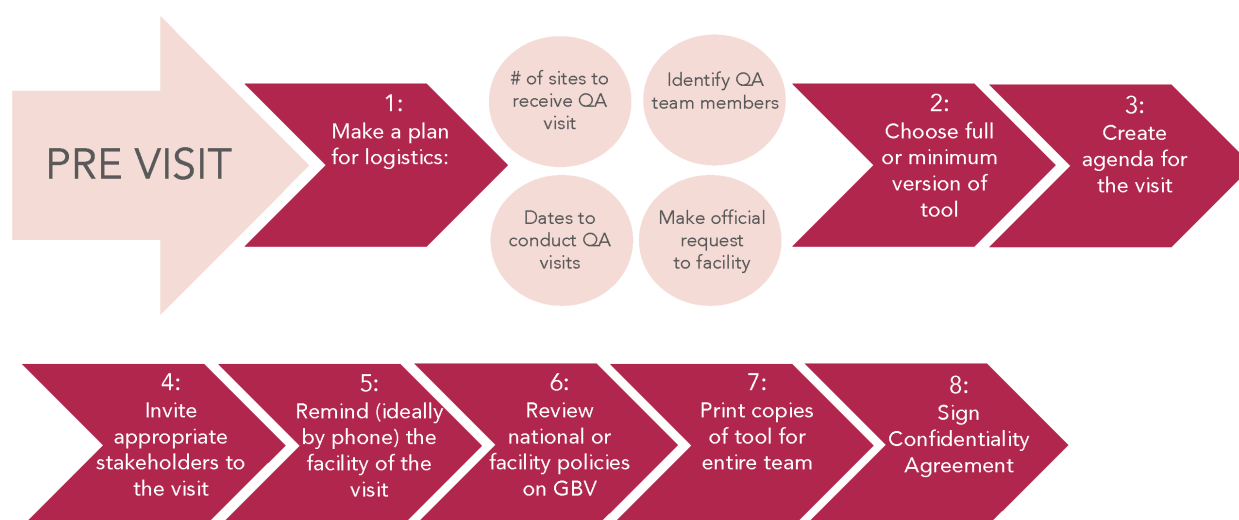
Step-By-Step Instructions for Implementing a QA Process

There are multiple steps necessary for preparing for, conducting, and responding to the findings of the QA external assessment, which can also be adapted for QA *internal* assessments. The steps for the QA external quality assessments include:

Step 1: Preparing for a QA Visit

In this tool, we refer to the user as “the assessor,” which can be anyone seeking to improve the quality of post-GBV care, such as a program planner, ministry representative, health provider, or facility manager. It can be an individual or a team of assessors.

Figure 1: Pre-Visit



In preparation for the first QA visit, the following should occur:

1. If headquarters-based staff are involved, the introductory and planning process should be initiated 1-2 months prior to the intended QA visit. This should include relevant staff and partners who will help to prepare for and conduct the QA visit. During this process, the assessor or QA team will need to make four key decisions to plan for logistics:
 - a. the number of sites that will receive a QA visit;
 - b. the people who will be part of the QA team;
 - c. the dates for conducting the QA visits, taking into consideration travel time and the 3-4 hours needed to conduct the QA visit with the Full Version, or 2-3 hours for the Minimum Care Version (including a brief introductory meeting with facility leadership and staff and debrief meeting after the visit);

- d. whether to use the full or minimum care version of the tool for the QA assessment(s) (this can vary by site).
2. The MOH or external implementing partner (e.g., funder of facility services or quality improvement partner) reaches out to the facility leadership with an official letter that includes a description of the tool and QA process, a copy of the tool, a request for a private space to have discussions during the assessment, and requested dates/times for conducting the QA visit.
 3. The assessor, MOH and/or partner creates an agenda for the QA visits including dates, times, and locations with phone numbers and emails for the facility's point of contact.
 4. The assessor should convene and invite the appropriate stakeholders to participate in the QA visit, e.g., MOH official, implementing partner and the regional or district health management teams.
 5. The assessor, MOH and/or partner reminds the facility management (ideally by phone) a week in advance of the visit, requesting that they notify the providers about the QA visit and ensure their availability during the visit.
 6. The assessor should review any of the following, if available, prior to the visit:
 - e. National or facility policies or guidelines on GBV prevention and care, on drug regimens relevant to the provision of post-GBV care (e.g., HIV, EC); and forensic evidence collection guidelines.
 7. Work with in-country partners and review the documents above to answer the following questions⁵:
 - f. What is the definition of GBV in that country? (e.g., in some countries the definition is only for violence committed by a male against a female, or sexual assault refers only to penile-vaginal penetration)
 - g. What is the legal age of consent to have sex?
 - h. What is the legal age of consent for HIV testing?
 - i. What is the legal age to receive emergency contraceptives?
 - j. Is marital rape criminalized?
 - k. What are the mandatory reporting laws, if any?

⁵ These questions are not required to conduct the assessment but can help provide valuable context for the GBV response nationally.

- l. Is it a requirement by law to report violence to the police before survivors can receive care?
8. Ensure the team has enough hard copies of the tool (including a few extra copies to give to providers for future use) and the feedback form for the QA visit.

Step 2: Identifying and Orienting a QA Team at the Facility

As listed above, one of the first steps to use this tool is for the assessor to work with the facility to identify a facility QA team to implement the tool and facilitate the quality improvement process. The team should be comprised of providers who are involved in regular post-GBV care service delivery, such as the physician, nurse, psychologist, or social worker who provides care to GBV survivors. Some questions can also be answered by a police officer if present. We also recommend involving the facility manager and district health management teams (DHMTs) on the team, or as key stakeholders with whom findings are shared.

The assessor should emphasize ahead of the visit that s/he would like to meet with a **team** and not an individual, since facilities may send a top-performing provider instead of a more representative group.

The assessor should conduct the first assessment in partnership with the facility QA team to orient it on the tool's use for subsequent assessments, which should be conducted by the facility QA team on its own, on a quarterly or semi-annual basis. When the facility improves and is scoring consistently high across areas, the team could consider less frequent, semi-annual or annual reviews.

Step 3: Ensuring Privacy and Confidentiality During the Visit

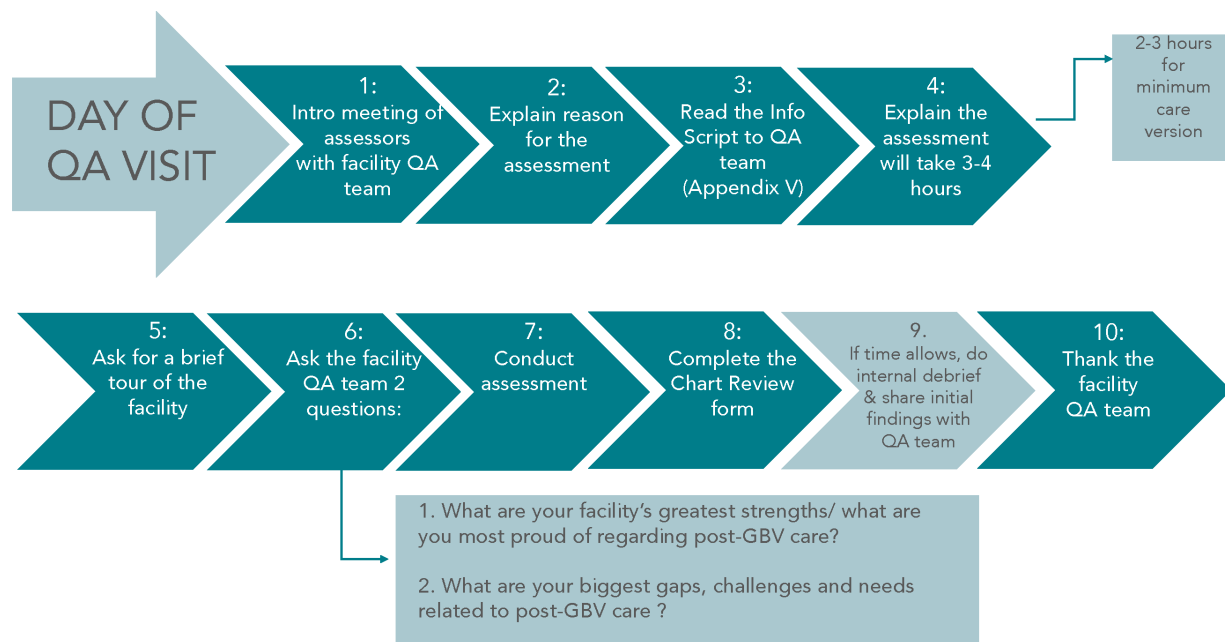
The QA team is responsible for preserving privacy and confidentiality during the QA visit. This should be done through four main efforts:

1. Prior to the visit, the QA team should sign the Confidentiality Agreement (see Appendix IV) intended to protect the confidentiality of any patients that are present during the visit and any patient information in charts, files, and registers that are reviewed as part of the QA process.
2. Chart, file, and register reviews should be conducted in a private space, where passersby will not be able to see this work being done.
3. Assessors should obtain verbal permission from facility staff prior to taking any photos of charts, posters, or other visual information, while taking precautions to ensure that no personal identifying information of any patient is captured.
4. Discussions with facility providers and staff that may include sensitive information should be conducted in a private space, where those not participating in the conversation are unable to overhear.

Throughout the assessment—including time spent walking through the facility, speaking with facility staff, and reviewing and/or capturing a photograph of any documents or visuals that include patients’ personal information—the QA team is responsible for maintaining provider, staff, and patient confidentiality. In addition, the QA team is responsible for working with facility staff to identify private spaces where they cannot be overheard while discussing potentially sensitive information about post-GBV care, providers’ responsibilities, and/or patients’ experiences. One way to help ensure arrangements are made for using private spaces available for sensitive conversations and reviewing charts, files, and registers, is to include this request in the initial letter to the facility (as stated in Step 1, above). The QA team should have an open line of communication with the facility staff and always ask for permission before taking any photographs of charts, logbooks, or other visual information while also ensuring that personal identifying information is not inadvertently included.

Step 4: Conducting the QA Visit

Figure 2: Day of Visit



The diagram above describes the necessary activities to prepare for the QA visit. This focuses on important elements to consider upon arrival at the facility and while conducting the actual assessment. The QA visit should always begin with an introductory meeting with facility leadership and staff to give an overview of the assessment.

Elements of the QA assessment:

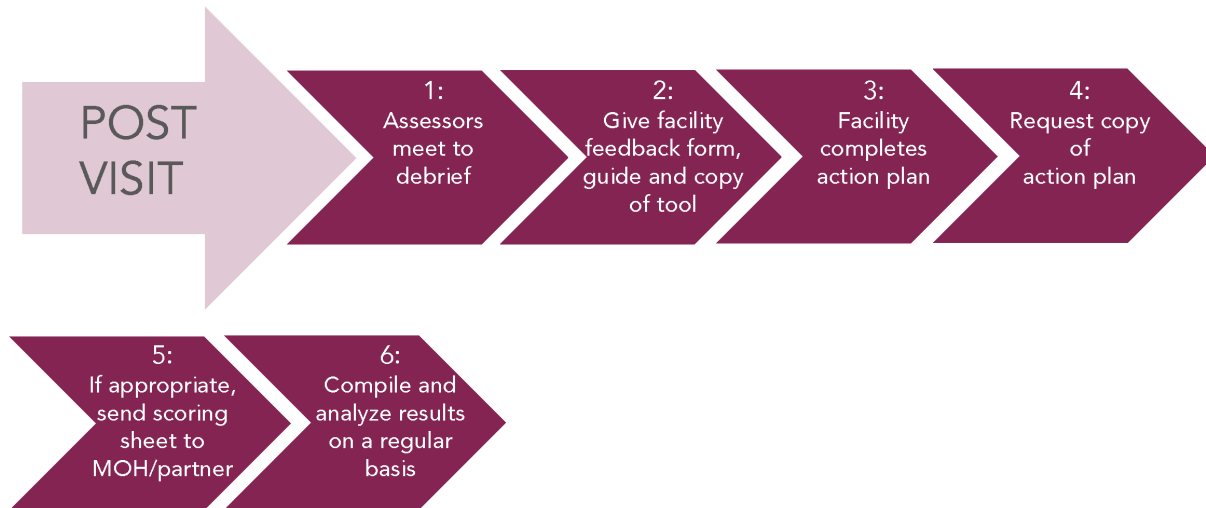
1. Conduct introductory meeting.
2. Introduce assessors and explain the reason for the assessment (drawing on language from the introduction above), and thank the facility’s QA team for their time and participation.

3. Explain that the first QA assessment can be used as a baseline assessment and then subsequent assessments with the same tool can be a continuous measurement of progress and to inform managerial decisions and reinforce momentum for change. Achieving and making sustained progress on these targets has an important motivating effect for those involved in the improvement process.
4. Read the Information Script on GBV QA Assessment Visit (Appendix V) to service delivery site staff and facility leadership to ensure they understand the purpose of the visit (preferably during the introductory meeting, but certainly prior to conducting the assessments). Make sure to sign the form and request storage with the official assessment files.
5. Explain that the assessment will last approximately 3-4 hours (2-3 for the Minimum Version) and includes time to meet with site-level management, and, if possible, a debrief to share preliminary results at the end of the visit.
6. If the facility manager has not already assembled a team of post-GBV care providers to participate, work with her or him to identify the staff that typically carries out post-GBV care to participate in the visit.
7. Ask for a brief tour/walk-through of the facility as someone seeking post-GBV care might experience it. It is helpful to conduct this tour prior to asking questions while reviewing the standards as you will be able to answer many questions during this walk-through.
8. Consider asking the facility QA team the following two questions as the first step to starting the conversation (and be sure to record their answers on the final page of the Scoring Feedback Form):
 - a. **What are your facility's greatest strengths/ what are you most proud of regarding this facility's provision of post-GBV care?**
 - b. **What are your biggest gaps, challenges and needs related to post-GBV care service delivery?**
9. Conduct assessment using either the full or minimum care version of the GBV QA Tool as appropriate for the facility, remembering to:
 - c. Ask clarifying questions to individuals responsible for these areas if needed;
 - d. Probe to get the precise information, do not assume responses;
 - e. Ask the person to show documents, equipment, or materials as appropriate; and
 - f. Be objective and respectful during the assessment.
10. Use the Chart Review Form (Appendix VIII) for the records review to assess four patients' records for completeness. Make a note on the form if any fields are incomplete.

11. Thank the facility QA team for their time and ask them if there is anything else they would like to share.

Step 5. Site Visit Debrief Meeting

Figure 3: Post Visit



1. If possible, immediately after the assessment, the assessors should meet to debrief and compare scores, come to a consensus on any unclear items. They should transfer results into the scoring form and conduct a debrief with the facility staff to review the results of the assessment by section. The debrief should highlight strengths the assessors observed during the assessments.
2. The assessor should give the facility staff the completed and consolidated Feedback Scoring Form, the Facilitation Guide, a blank copy of the tool (for further assessments conducted by the facility independently), and a blank copy of the action plan.
 - a. If time does not permit a full debrief using the consolidated scoring form, the assessors should conduct a **partial debrief** and provide high-level feedback on critical areas of strengths and weaknesses. In the case of the partial debrief, the assessors should complete the debrief the following day, and provide the final consolidated Scoring Feedback Form, the Facilitation Guide, and blank copy of the tool (that they can use for subsequent assessments) to the facility within 3 days.
 - b. Regardless of a complete or partial debrief, the assessors must notify the facility of any significant concerns or ethical violations observed during the visit, for example, privacy/confidentiality issues within the clinic, or evidence that a clinic staff member is not respecting the rights and dignity of the survivor.
 - c. Assessor should note that the questions and responses can sometimes be difficult to score, and individual assessors may have reached different conclusions. It is important to

come to a consensus and complete the scoring sheet together, using the scoring instructions provided below.

3. The facility should complete the action plan (see guidance below and a template in Appendix VI) in order to address the weaknesses.
 - a. Request that the facility share the completed action plan and the results of any subsequent assessments using the tool with you and the MOH/implementing partner
4. If appropriate, send the completed scoring sheet to the MOH/implementing partner.
5. The assessor and/or facility QA team should compile and analyze results on a regular basis (quarterly or bi-annually) from the reviews to present to relevant stakeholders to show which facilities are succeeding and which need greater support, and to share any trends in key areas of quality improvement across districts or regions. For example, the facility may score low on provider-client communication, indicating that further training is needed in this area.

Step 6: Post QA Action Plan

1. The implementation of the tool will lead to the identification of performance gaps that need to be reduced or eliminated in post-GBV care service delivery. Based on the results of the assessment and the feedback provided by the assessment team, facility managers and providers can then analyze the causes of the gaps and identify and implement appropriate measures to address them. Gaps might include lack of knowledge and skills, inadequate enabling environment (including infrastructure, resources and policies), and/or lack of motivation to make changes.
2. After every QA assessment, the facility staff should develop an action plan to address challenges identified through the assessment. These plans can be relatively simple and brief (see Appendix VI: Sample Action Plan), and should clearly outline gaps and their causes that need to be eliminated, the specific intervention to be conducted, the person(s) in charge, the deadline for the task, and any potential support that may be needed. The blank sample action plan should be given to the facility QA team/staff to complete and utilize.
The Action Plans should be shared with the assessor within 2 weeks of the facility visit.

Using the Tool

Description of the Tool

This GBV QA Tool is designed to objectively establish a desired level of performance, and determine what is considered high quality provision of post-GBV care. The tool contains standards that are organized into different sections by area of service delivery (e.g., facility readiness, clinical care).

Verification criteria are listed in a column directly next to each of the standards, and indicate what must be in place for each standard to be considered “achieved”. Verification criteria that are marked with a + symbol are considered to be aspirational measures of high quality care. There is a **minimum care version** of the tool that does not include these aspirational standards because they are challenging to achieve in very resource-poor settings. Facilities in more resource-constrained settings or facilities just starting to set up new services should be assessed using the minimum care version of the tool, which does not include + aspirational standards.

Many of the standards in the tool can be verified by doing a facility tour PRIOR to beginning the conversation (see Element 7 of Step 4 above). The assessor should familiarize her/himself with the whole tool before conducting the assessment to locate the standards that can be answered by observation during the facility tour.





Means of Verification

Means of Verification:

In the Means of Verification column of the tool, one or more of the following methods is suggested to help assessors know how to collect/verify the information needed to score each criterion. It may not be possible to use all the suggested methods for each verification criterion. The assessor should use her/his best judgement:

- **D:** Direct observation of physical facilities and administrative or clinic processes. **This does not include the observation of provider/patient interactions or exams, due to concerns around privacy and ethics.**
- **I:** Interview with providers or facility managers (the assessor asks questions and probes when necessary to determine if the procedure is performed or the item exists as described in the standards).
- **R:** Review of clinical and administrative records, guidelines, protocols and documents.

Each verification criterion lists whom to ask about achievement of these standards. Most verification criteria list multiple types of individuals within the facility to ask for verification. At a minimum, assessors will need to ask a team of at least two sources for corroboration, whenever possible. Specific instructions are included in the accompanying Facilitation Guide, which includes icons that specify whom to interview:

Doctor/Nurse/Midwife 	Social Worker/Counselor/Psychologist 
Facility Manager/GBV Services Supervisor 	Police ⁶ 

Some standards may be difficult to discuss. For these standards, *prompts with suggested language are included in italic font*. Some standards have supplemental information, or refer to another standard in the tool. For these standards, **(INSTRUCTIONS ARE INCLUDED IN BOLD CAPS AND PARENTHESES)**.

Scoring Instructions:





1. Do not leave any verification criteria blank on the tool. Mark each criterion individually as **"YES"** or **"NO"**. Mark **"YES"** if the procedure, documentation, item, etc. exist as described. Mark **"NO"** if the procedure, documentation, item, etc. do not exist as described.
2. Provide a short justification for any criteria marked **"NO"** by recording any gaps, issues, or missing items/elements of care in the comments column.
3. Some verification criteria may not be applicable. If so, the option to mark "N/A" will be clearly indicated directly below the standard category description **(IN BOLD CAPITAL LETTERS AND PARENTHESES.)** For these, write **"N/A"** in the comments box and include an explanation of why the verification criterion was not applicable.
4. After the assessment, transfer the information collected in this document onto the Scoring Feedback Form. Take care when transferring information from the tool to the Scoring Feedback Form to ensure no data or comments are lost.
5. On the Scoring Feedback Form, score the standard as **"YES"** if **all** of its verification criteria are met; for the full version of the tool, this includes achieving all of the blue plus "aspirational" criteria in addition to the standard criteria.

⁶ Police may not be present in all facilities. Assessors should not reach out to police outside of facilities; however, police can serve as sources of verification where readily available on-site.

6. Score the standard as a **"NO"** if **any** of its verification criteria are **not** met, and write in the Comments column what item was missing or not performed.
7. Verification criteria marked **"N/A"** are not factored into the score. (If **all** the other verification criteria in that standard are met except the one marked **"N/A"**, score the standard as a **"YES"**. If **any** of the other criteria in that standard are not met, score the standard as a **"NO"**. Do not count a standard as achieved if **all** the criteria are **"N/A"**.) **(EXAMPLES OF SCORED STANDARDS ARE IN THE FACILITATION GUIDE.)**
8. Do not give a partial score (e.g. 0.75) if only **some** of the verification criteria are met, to avoid confusion or calculation errors. These should be marked as a **"NO"**.
9. Count the number of standards scored as **"YES."** Enter this into the "# of Standards Achieved" row.
10. Take the "# of Standards Achieved", divide by 28⁷ (or the total number of standards minus any that were scored as **"N/A"**) and multiply by 100 to get the "% of Standards Achieved". This is the final assessment result; record it on the Scoring Feedback Form.
11. Record overall strengths and challenges at the bottom of the Scoring Feedback Form.

⁷ Divide by 24 for the Minimum Care Version

Table 1: Example of Part of a Scored Standard

QUALITY ASSURANCE STANDARDS	VERIFICATION CRITERIA	MEANS OF VERIFICATION	YES	NO	COMMENTS
AVAILABILITY AND APPROPRIATENESS OF SERVICES					
1. Facility offers GBV services that are accessible, available, affordable and appropriate	1.1 Facility offers essential GBV care 24 hours a day OR facility helps patients to access alternative facilities that provide essential care during off-hours	I 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	GBV survivors were required to pay fees for the examination and laboratory costs
	1.2 Facility offers GBV care without requiring GBV patients to report to the police	I, R 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	1.3 Facility keeps medico-legal forms on site (e.g. patients do not have to go to the police station to obtain forms) (ASK TO SEE THE FORM)	I, R 	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	1.4 Facility eliminates or reduces fees for GBV patients Prompt: Are there any services GBV patients must pay for?	I, D 	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

In Table 1 above,

1. The assessor interviewed the provider, who reported that the facility offers essential GBV care 24 hours a day, so this verification criteria was marked YES.
2. The GBV Officer reported that survivors are not required to report the assault to the police in order to receive care, and the assessor reviewed the GBV Registry to ensure there was no column or note indicating that a survivor was denied care due to failing to report the assault to the police. This verification criterion was marked YES.
3. The facility had medico-legal forms on site and showed the assessor the form, so this standard was marked YES.
4. The fees for GBV survivors were not eliminated or reduced. This verification criterion was marked NO, and the assessor recorded the comment, "GBV survivors were required to pay full fees for the examination and laboratory costs."
5. The assessor scored this standard with a zero (0) because the fourth verification criterion was not achieved.

Essential Furniture, Equipment, Supplies and Commodities

This information box contains the priority items that must be present to provide post-GBV care. The assessor should tick the checkboxes for items that are present, and make a notation in the Scoring Feedback Form of any missing items to ensure the facility knows to procure them. Verification criterion 3.5 (“Essential infrastructure, furniture, equipment, supplies, documents and commodities are available”) should be scored as YES if all the minimum items in the blue box **without** a + symbol are checked off.

Existence of any stock-outs (medicines or supplies) should be noted on the Scoring Feedback Form. If there are stock-outs, ask providers to explain why this happened (e.g., the facility did not place their order in a timely manner, or central pharmacy did not deliver).

Key Considerations

This section offers best practice guidance that goes into greater depth than is possible in the GBV QA Tool.

Guidance on PEP and EC Dosage

For standards 14 and 15, if no current national guidelines or policies specify the type and dosage of emergency contraception (EC) or HIV post-exposure prophylaxis (PEP), the following are recommended by WHO (2013) to be given within 72 hours for PEP, and 120 hours (5 days) for EC. **Prior, outdated guidance recommended that EC be given within 72 hours, but this should be updated, although the efficacy of EC is highest the sooner it is taken after the incident.**

Types and dosage of emergency contraception

- **Levonorgestrel** taken as a single dose (1.5 mg) or alternatively, levonorgestrel taken in 2 doses (0.75 mg each, 12 hours apart)
- **Ulipristal** acetate taken as a single dose at 30 mg
- **The Yuzpe method** uses combined oral contraceptive pills. The pills are taken in 2 doses. Each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel). The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) and the second dose should be taken 12 hours later. If vomiting occurs within 2 hours of taking a dose, the dose should be repeated.
- **Copper-based intrauterine devices (IUDs/IUCDs)**—WHO recommends that a copper-bearing IUD, when used as an emergency contraceptive method, be inserted within 5 days of unprotected intercourse. This method is particularly appropriate for a woman who would like to start using a highly effective, long-acting and reversible contraceptive method.

Types and Dosage of HIV PEP⁸

* Adult and Adolescent ARVdrug dosages for use in PEP	
Generic name	Dose
Tenofovir (TDF)	300 mg once daily
Lamivudine (3TC)	150 mg twice daily or 300 mg once daily
Emtricitabine (FTC)	200 mg once daily
Lopinavir/ritonavir (LPV/r)	400 mg/100 mg twice daily or 800 mg/200 mg once daily ^a
Atazanavir/ritonavir (ATV/r)	300 mg +100 mg once daily
Raltegravir (RAL)	400 mg twice daily
Darunavir + ritonavir (DRV/r)	800 mg +100 mg once daily or 600 mg +100 mg twice daily
Efavirenz (EFV)	600 mg once daily

* Simplified dosing of child-friendly fixed-dose solid formulations of recommended preferred ARV drugs for post-exposure prophylaxis of HIV for twice-daily dosing among children														
Drug	Strength of tablets (mg)	Number of tablets by weight band morning (AM) and evening (PM)										Strength of adult tablet (mg)	Number of tablets by weight band	
		3.0–5.9 kg		6.0–9.9 kg		10.0–13.9 kg		14.0–19.9 kg		20.0–24.9 kg			AM	PM
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM		AM	PM
AZT/3TC	Tablet (dispersible) 60 mg/30 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	300/150	1	1

Simplified dosing of child-friendly solid and oral liquid formulations of recommended preferred ARV drugs for post-exposure prophylaxis of HIV for twice-daily dosing among children

Drug	Strength of tablets (mg) or oral liquid (mg/ml)	Number of tablets by weight band, morning (AM) and evening (PM)										Strength of adult tablet (mg)	Number of tablets by weight band	
		3.0–5.9 kg		6.0–9.9 kg		10.0–13.9 kg		14.0–19.9 kg		20.0–24.9 kg			AM	PM
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM		AM	PM

Solid formulations														
3TC	Tablet (dispersible) 30 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	150	1	1
AZT	Tablet (dispersible) 60 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	300	1	1
LPV/r	Tablet (heat stable) 100 mg/25 mg	–	–	–	–	2	1	2	2	2	2	100/25	3	3

Liquid formulations														
AZT	10 mg/ml	6 ml	6 ml	9 ml	9 ml	12 ml	12 ml	–	–	–	–	–	–	–
3TC	10 mg/ml	3 ml	3 ml	4 ml	4 ml	6 ml	6 ml	–	–	–	–	–	–	–
LPV/r*	80/20 mg/ml	1 ml	1 ml	1.5 ml	1.5 ml	2 ml	2 ml	2.5 ml	2.5 ml	3 ml	3 ml	–	–	–

*LPV/r syrup should not be used for premature babies or infants younger than 2 weeks of age. NVP should be used instead at the following dose: 5 ml twice daily (3.0–5.9 kg), 8 ml twice daily (6.0–9.9 kg) and 10 ml twice daily (10.0–13.9 kg) if syrup is available; 1 tablet twice daily (3.0–5.9 kg), 1.5 tablets twice daily (6.0–9.9 kg) and 2 tablets twice daily (10.0–13.9 kg) if dispersible 50-mg tablets are available.

⁸ Dosage tables from WHO, 2014. Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. December 2014 supplement to the 2013 consolidated ARV guidelines. http://www.who.int/hiv/pub/guidelines/arv2013/arvs2013supplement_dec2014/en/

^c Co-trimoxazole dosing for adults and adolescents: the recommended dose of co-trimoxazole is 960 mg daily (800 mg sulfamethoxazole + 160 mg trimethoprim, either as a 960-mg double-strength tablet or two 480-mg single-strength tablets)

^d Simplified dosing of co-trimoxazole prophylaxis for children

Drug	Strength of tablet or oral liquid (mg or mg/5 ml)	Number of tablets or ml by weight band once daily					
		3.0–5.9 kg	6.0–9.9 kg	10.0–13.9 kg	14.0–19.9 kg	20.0–24.9 kg	25.0–34.9 kg
Co-trimoxazole	Suspension 200/40 mg per 5 ml	2.5 ml	5 ml	5 ml	10 ml	10 ml	–
	Tablets (dispersible) 100/20 mg	1	2	2	4	4	–
	Tablets (scored) 400/80 mg	–	0.5	0.5	1	1	2
	Tablets (scored) 800/160 mg	–	–	–	0.5	0.5	1

Guidance on Assent and Consent for Children and Adolescents

Standard 10 focuses on child and adolescent survivors. However, the GBV QA Tool is not intended to be a comprehensive guide to the care for children and adolescents who have experienced violence, which is complex. For more comprehensive information providers should refer to PEPFAR’s The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence and the forthcoming WHO Guidelines on Clinical Care for Children and Adolescents Who Have Suffered Sexual Violence (anticipated in November, 2018). This QA tool covers the most basic elements of care for minors because a large majority of survivors seen in GBV facilities are children and adolescents.

It is important for the health care provider to obtain a patient’s consent or assent to care. Since the age of consent for HIV testing or for medical examination varies by country, it is imperative that providers are aware of and understand the national laws regarding consent. If no national guidance is available, Table 4 below can offer best practice guidance.

A child who is of the age of **consent** (which varies by country) should sign or give verbal permission for all treatment, including the medical forensic examination. If the child is below the age of consent:

- a. The health care provider must obtain consent from either the parent/guardian or caregiver (recognizing that the parent, guardian or caregiver may also be the perpetrator, in which case another trusted companion should be identified, if possible) AND
- b. The health care provider should obtain assent to care **from the child** provided the child is old enough to understand what is going on. The child should never be forced to undergo the medical or forensic examination unless it is necessary for medical care (e.g. if internal bleeding is suspected).

Health care providers need to know the following about children’s legal rights in decision-making:

- The person(s) responsible for providing permission (informed consent) for care and treatment of a child in the local context;

- The age at which a child is able to independently consent to care and treatment in the local context;
- The mechanisms for third-party individuals to provide consent if caregivers or parents are not available, or if a caregiver or parent is the suspected perpetrator.

Table 4: Informed Consent/Assent Guidelines (8)⁹

Age Group	Child	Caregiver	If no caregiver, if parent/caregiver is perpetrator or if not in child's best Interest	Means of Obtaining Consent
0-5	-	Informed consent	Other trusted adult's or case worker's informed consent	Oral or written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, oral or written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight and may allow a child to self-consent	Oral or written assent or consent
15-18	Informed consent	Obtain informed consent only with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Oral or written consent

Guidance on Eligibility of Facility to Conduct GBV Enquiry

The WHO has laid out minimum criteria that must be met in order for a provider to conduct GBV clinical enquiry:¹⁰

- A protocol or standing operating procedure exists
- A questionnaire with standard questions where providers can document responses exists
- Facility has ability to provide first-line support¹¹
- Providers have received training on how to ask about GBV
- A private setting exists, and confidentiality ensured
- A system for referrals in place

⁹ This table is taken from the IRC/UNICEF 2012 Caring for Child Survivors of Sexual Abuse Guidelines for health and psychosocial service providers in humanitarian settings. However, the Means have been updated to reflect the context in which these standards may be applied, in which patients or caregivers may not be literate.

¹⁰ In this tool, *routine screening* refers to systematically asking all patients— regardless of whether or not they report or show symptoms of GBV— about experiences of violence or abuse. This includes screening ONLY certain groups of patients OR ALL patients at SPECIFIC entry points (e.g., antenatal care, HIV Testing and Counseling).

¹¹ The WHO defines "first-line support" using the acronym "**LIVES**": **L**istening, **I**nquiring, **V**alidating, **E**nsuring safety, and **S**upport through referrals. (WHO, 2014, Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. p. 13 http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf)

If any of these minimum requirements is missing, GBV services are considered inadequate for routine or universal ‘screening’ or enquiry. The rationale is that in settings with limited resources and referral options, the high burden of routine or universal screening could overstretch providers and cause difficulty for women who face repeated enquiry (i.e., are retelling their stories over and over) without any action being taken. WHO also acknowledges that it could “easily become a tick-box exercise carried out without due consideration, or undertaken in an ineffectual way... [In settings where minimum criteria are not met] it is preferable to focus on enhancing providers’ ability to respond adequately to those who do disclose violence, show signs and symptoms associated with violence, or are suffering from severe forms of abuse.”¹²

Guidance on the Forensic Evidence Section of the Tool

Forensics is a new area for many countries, and some may lack the systems, policies, infrastructure and training to conduct forensic examination and evidence collection. Carrying out a full forensic exam requires specialized skills and certification, including performing a sufficient number of examinations under supervision. However, all providers, trained or not, can document basic forensic evidence such as injuries in a comprehensive and detailed manner that can be useful for criminal prosecution. The standards in this section, starting on p.23, pertain to forensic examination beyond documentation of basic evidence, and only to facilities where providers have received training in forensics. The standards in this section are therefore all considered aspirational and are marked with a + symbol. The GBV QA Tool contains a list of minimum criteria that must be met in order to conduct forensic examination and evidence collection. This list was generated through consultation with international GBV experts and will evolve as countries’ forensics capacity evolves, and deserves further exploration:

- Provider has received specific training¹³ in forensics.
- Facility has a functional supervision system for providers that includes hands-on preceptorship immediately following training.
- Country’s medical and legal systems have written guidelines or an agreement in place that establishes procedures for cooperation.
- There is an established system to maintain the chain of custody for evidence.

If any of these criteria is not met, the provider should not proceed. To do so, similar to the challenges described above in relation to routine clinical enquiry, could cause additional trauma to the patient with little or no benefit to her/him and no guarantee of justice. When in doubt, the overarching principle should be that the health and welfare of the survivor takes precedence over the collection of evidence.

¹² WHO 2013. Responding to intimate partner violence and sexual violence against women: Clinical and policy guidelines. p. 18 <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en>

¹³ Training can be pre-service or in-service (on-the-job)

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Appendix II. Sample Forms

There are a number of templates available that contain the necessary information that should be captured by providers and facilities. If the national forms do not capture all necessary items, suggest to the MOH that it update them according to the format and contents of the forms below:

Sample Consent Form

- USAID, 2013. The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. p.79 <https://aidsfree.usaid.gov/resources/prc-tech-considerations>
- WHO, 2003. Guidelines for Medico-Legal Care for Victims of Sexual Violence. P. 118. <http://apps.who.int/iris/bitstream/10665/42788/1/924154628X.pdf>

Sample Medico-Legal Form with pictograms/traumagrams

- USAID, 2013. The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. p. 93 <https://aidsfree.usaid.gov/resources/prc-tech-considerations>
- WHO, 2014. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. p.89 "Sample History and Examination Form" http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf

Job Aids

- USAID, 2013. The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs. p. 81, "Top to Toe Physical Examination," and "Medical Management of Child Sexual Violence and Exploitation," p. 87 <https://aidsfree.usaid.gov/resources/prc-tech-considerations>
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- WHO, 2014. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook. p.47 "Physical Exam Checklist" and p. 65 "Pathway for Initial Care After Sexual Assault." http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf

Client Exit Survey (Client Feedback Form)

- International Planned Parenthood Federation, 2004. Improving the Health Sector Response to Gender-Based Violence A Resource Manual for Health Care Professionals in Developing Countries. p. 207
https://www.ippfwhr.org/sites/default/files/GBV_cdbookletANDmanual_FA_FINAL.pdf

Appendix III. Confidentiality Agreement

Gender-Based-Violence Quality Assurance Site Assessment Confidentiality Agreement

To be signed once by all staff participating gender-based violence quality assurance (GBV QA) site assessments prior to implementation and should be stored by an agency point of contact responsible for personnel involved in these activities.

1. I will, to the extent allowable by law, maintain the confidentiality of any patient names or other patient identifiers, such as dates of birth, places of residence, and addresses, that I may see as part of the GBV QA Site assessment.
2. I will review patient registers and any other record with patient names or other patient identifiers in a private place, or in such a manner as will protect patient confidentiality.
3. I will not record any patient names or other patient identifiers.
4. I will discuss any questions that I have related to the review of patient records with other site visit staff only in a private place, or in such a manner as will protect patient confidentiality.
5. To the extent allowed by applicable law, I will not disclose the names or other personal identifiers of the staff of the site or Implementing Partner (IP) staff. In addition, I will only store site and IP identifiable information related to the GBV QA assessment in secure data management systems.
6. These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities created by existing statute or Executive order relating to (1) classified information, (2) communications to Congress, (3) the reporting to an Inspector General of a violation of any law, rule, or regulation, or mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety, or (4) any other whistleblower protection. The definitions, requirements, obligations, rights, sanctions, and liabilities created by controlling Executive orders and statutory provisions are incorporated into this agreement and are controlling.

Signature: _____

Date: _____

Appendix IV. Information Script on GBV QA Site Assessment

*To be read to site staff prior to each GBV QA assessment. *Note, if the visit is not being conducted on behalf of PEPFAR, adapt language as appropriate.*

We're here today on behalf of the United States President's Emergency Plan for AIDS Relief, or PEPFAR, to conduct an assessment of PEPFAR-supported GBV activities. We hope that this will increase the impact of PEPFAR programs on the individuals served in this facility. Because you work for an organization or site that receives PEPFAR support, we will be asking for your input on this assessment, as you can provide valuable information and insight into program procedures and challenges. We will be asking you questions using a standardized form for data collection. We hope that this information will help us to help you provide the best care possible to your community.

Your response to all questions is voluntary. We will not be collecting or disclosing the names or other personally identifiable information of patients, beneficiaries, or staff (for example, your name or job title will not be recorded or disclosed). We will not link anything we collect or record during this visit to any individual. All information we collect or record will be associated only with the site, organization, or implementing partner. We will be providing feedback on the findings of this visit to site and implementing partner staff after the visit.

The US Government (USG) will securely store the assessment visit data. In-country USG staff will use the data to improve the support that PEPFAR provides to sites and to organizations that support and guide the sites. Summary data by PEPFAR country or region as well as global summaries may be available in a format that will not identify your facility, community, or PEPFAR-supported entity. Site level data from military sites will not be publicly available.

If you would like a copy of this information form, please let us know.

Are there any questions?

Assessment Team Lead:

I have read this information form aloud and given a copy to those assisting with the site assessment visit.

Assessment Team Lead (print name): _____

Assessment Team Lead (signature): _____

Date: _____ Facility Name: _____

Appendix V. Sample Action Plan

It is essential for each facility to complete an action plan to address the gaps and challenges identified in the assessment. Each gap should have a specific action item to address it, a person responsible, the support needed, and a deadline.

It is important to understand that the process is usually initiated by a small group of committed persons because it is very infrequent to find widespread support for a new improvement initiative. It is, therefore, key to identify committed champions for the initiative and incorporate them in the initial improvement efforts.

In addressing the identified gaps and challenges through the assessment, the teams should remember that there are three main categories of gaps that need to be addressed:

1. **Internal Gaps** that do not require significant cause analysis because the solution is obvious and simple (e.g., designation of a person in charge of a task, minor purchases to replace broken pieces of equipment, minor relocation of supplies and equipment to make them more available at point of use)
2. **Resource Gaps** that are likely to be caused by factors that are under local/facility control and could be eliminated with the mobilization of local resources (e.g., modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, some types of training, implementation of some types of incentives)
3. **External Gaps** that are likely to be caused by factors that are outside local/facility control and that usually require the mobilization of significant external resources (e.g., changes in policies, salary increases, increases in the number of staff, provision of additional budgets, remodeling/construction)

The facility teams are encouraged to focus first on the gaps and the standards and interventions that are easy to achieve (the “low hanging fruit”) in order to achieve early results, create momentum for change, and gradually acquire change management skills to address more complex gaps.

Partial improvements can and should be rewarded during the process using a combination of measures including feedback and social recognition (e.g., ceremonies, symbolic rewards). The achievement of compliance with standards by the facility is acknowledged through a recognition mechanism that should involve institutional authorities and the community.

Gap/Challenge	Type of Gap			Action Item	Person Responsible	Support Needed	Deadline
	Internal	Resource	External				
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							

Appendix VI. Scoring Feedback Form

Facility Name _____

AVAILABILITY AND APPROPRIATENESS OF SERVICES				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
1. Facility offers GBV services that are accessible, available, affordable and appropriate	7			

FACILITY READINESS AND INFRASTRUCTURE				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
2. Facility has visible GBV information, education and communication (IEC) materials	1			
3. Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate GBV care	8			

IDENTIFICATION OF PATIENTS WHO HAVE EXPERIENCED OPV or SV				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
4. Facility has an appropriate system in place for providers to identify patients who have experienced GBV	4			
5. Provider asks about IPV or SV in an appropriate manner	5			

6. Provider assesses and addresses any risk of immediate violence or harm when IPV or SV is disclosed (i.e. safety planning)	3			
PATIENT-CENTERED CLINICAL CARE & COMMUNICATION				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
7. Provider obtains informed consent from adult patients and informed assent from patients who are minors	8			
8. Provider manages injuries appropriately	5			
9. Provider demonstrates knowledge of appropriate communication techniques to prevent further traumatization of patient	1			
10. If the patient is a child, provider takes special considerations, according to national guidelines	7			
11. Provider respects and maintains patient privacy and confidentiality	5			
12. Provider observes the following aspects of respectful care to prevent further traumatization of patient	5			
13. Provider conducts medical examination for genital and non-genital injuries	4			
14. For female sexual assault survivors, provider offers emergency contraception	4			
15. Provider offers HIV counseling, testing and HIV post-exposure prophylaxis (PEP) within 72 hours to sexual assault survivors	8			

16. Provider offers relevant medications and/or vaccinations for prevention and treatment of other sexually transmitted infections	3			
17. Providers offer mental health care to patients	3			

Standards 18 and 19 are not included in the Minimum Care Version of the Tool—please do not score the following two standards when using the Minimum Version.

FORENSIC EXAMINATION & HANDLING OF EVIDENCE				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
18. Provider conducts a medico-legal examination and collects forensic evidence according to national protocol if available	3			
19. Provider collects, stores and/or transports forensic evidence securely, according to national protocol	11			

REFERRAL SYSTEM & FOLLOW UP OF PATIENTS				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
20. Facility has a referral system in place to ensure patient is connected to all necessary services	6			
21. Provider offers the patient follow-up services	8			

TRAINING AND QUALITY IMPROVEMENT				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
22. All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of patients	1			
23. Facility has systems in place to ensure continuous quality improvement of post-GBV care services	5			

HEALTH CARE POLICY AND PROVISION				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
24. Facility has protocols in place to offer standardized post-GBV care according to national or WHO guidelines	2			

Standard 25 is not included in the Minimum Care Version of the Tool—please do not score the following standard when using the Minimum Version.

OUTREACH				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
25. Facility integrates GBV awareness raising and referrals into other health programs and outreach activities	2			

REPORTING AND INFORMATION SYSTEMS				
QUALITY ASSURANCE STANDARDS	# of Criteria in Standard	# of Criteria Met	Standard Achieved (Y/N)	Comments (additional comments may be found on comment sheet)
26. Facility has intake forms, chart forms, or registers that collect information about a patient's experience of GBV and the post-GBV care s/he received	2			

Standard 27 is not included in the Minimum Care Version of the Tool—please do not score the following standard when using the Minimum Version.

27. There is an evaluation system in place to collect and analyze GBV program data	3			
28. GBV data are compiled and analyzed to understand trends, improve health services and systems	9			
TOTAL: 28 STANDARDS (24 FOR MINIMUM CARE VERSION)	133			

ASSESSMENT RESULT	
# of Standards Achieved	
# of Standards	28
% of Standards Achieved	

Strengths

Signed _____ Date _____
 (Assessment Team Lead)

Signed _____ Date _____
 (Facility Recipient)

Challenges

Appendix VII. Chart Review Form

To score verification criteria 13.1 in the GBV QA Tool on completeness of documentation:

1. Ask the health facility to share four patient forms or the GBV register and review them to see if they have a space to collect the items listed in the rows below. Ask the staff for clarifications when necessary, and assure them that no confidential client information will be captured. Take care to cover up the names on the files when reviewing and do not record or take pictures of any personal identifying information during the chart review.
2. Provide the following guidance to encourage a more random and diverse sample:
 - a. Refrain from pulling just the four most recent patients' files (i.e., try to pull records from the last several months to a year)
 - b. Include both sexual and physical violence case files
 - c. Include more than one provider's records (i.e., patient files do not all come from the same provider)
3. Review patient files/records one at a time for the list of items below.
4. If the forms/registers do not have a way to collect ALL of the items listed in the rows below, score as "NO" in the GBV Quality Assurance Tool and record any missing items in the comments section. It is likely that multiple forms will need to be consulted, as information may be spread out across different forms and registers.
5. Note whether or not the items in the rows below are collected in each of the patient files by circling a "Y" for yes or "N" for no. For some patient files, certain items may not be applicable. For these, circle "N/A" (e.g., a pregnancy risk assessment would not be conducted for a 5-year-old female sexual assault patient since she is pre-pubescent).
6. Was the facility able to provide at least four patient files? If not, score as "NO" but review the files they were able to produce. Note which items are missing or are not collected completely in the comments section of the GBV Quality Assurance Tool.

Item	1	2	3	4
1. Sex of patient	Y N	Y N	Y N	Y N
2. If patient identifies as a member of a key population (man who has sex with men, person who injects drugs, sex worker, transgender person, or prisoner)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
3. Sex of perpetrator(s)	Y N	Y N	Y N	Y N
4. Age of patient	Y N	Y N	Y N	Y N
5. Age of perpetrator(s) (if known)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
6. Number of perpetrators (if more than one)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
7. Relationship of the perpetrator(s) to the patient(if any)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
8. Time and date of assault/violence	Y N	Y N	Y N	Y N
9. Time and date of consultation	Y N	Y N	Y N	Y N
10. Type of violence/assault	Y N	Y N	Y N	Y N
11. Description of incident	Y N N/A	Y N	Y N	Y N
12. For sexual assault, whether or not a condom was used	Y N N/A	Y N N/A	Y N N/A	Y N N/A
13. For sexual assault, type of penetration (with penis, finger, object or mouth)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
14. For sexual assault, location of penetration (vaginal, oral, anal)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
15. Pregnancy risk assessment	Y N N/A	Y N N/A	Y N N/A	Y N N/A
16. HIV and STI risk assessment	Y N N/A	Y N N/A	Y N N/A	Y N N/A
17. History of consensual intercourse within 5 days of assault (if DNA samples collected)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
18. Documentation of the patient's injuries on a detailed diagram	Y N	Y N	Y N	Y N
19. Medications administered, offered, accepted and/or declined including PEP	Y N	Y N	Y N	Y N
20. Forensic evidence collected (if any; may be N/A)	Y N N/A	Y N N/A	Y N N/A	Y N N/A
21. Current GBV signs and symptoms (for a list, refer to p.10 of GBV QA Tool)	Y N	Y N	Y N	Y N

Item	1	2	3	4
22. Relevant medical history (e.g. pre-existing injuries, previous sexual assault, currently pregnant? HIV status?)	Y N	Y N	Y N	Y N
23. Vital signs	Y N	Y N	Y N	Y N
24. Referrals offered	Y N	Y N	Y N	Y N
25. From where a patient was referred (if anywhere)	Y N N/A	Y N N/A	Y N N/A	Y N N/A