HEALTH CARE SECTOR
STANDARD OPERATING PROCEDURE
for
Gender-Based Violence

Ministry of Health and Social Security
Ministry of Social Development and Housing
Health Care Sector Standard Operating Procedures
For
Gender-Based Violence

Developed by
Ministry of Health and Social Security
and
Ministry of Social Development and Housing

Supported by
Supported by Pan-American Health Organisation (PAHO)
and
United Nations Trust Fund to End Violence against Women (UNTF)

Approved by Cabinet
2014
Background and Summary

BACKGROUND

The Health Care Sector Standard Operating Procedures (SOP) for Gender-Based Violence was developed by the Ministry of Social Development and Housing in partnership with the Ministry of Health. Financial support was provided by the Pan American Health Organisation (PAHO) and United Nations Trust Fund to End Violence against Women (UNTF).

In drafting the SOP consideration has been given to the local laws, legal procedures, the Domestic Violence and Sexual Abuse Protocol, as well as World Health Organisation Standards. It consists of specific procedures and agreements among health care providers and some first responders to clarify and systematize the internal procedures in the Health Care Sector and to establish links with other agencies and stakeholders.

The draft was discussed by the health care professionals, members of the Royal Grenada Police Force (RGPF), social service providers from the Ministry of Social Development and Non-Governmental Organisations to respond to the Grenada context.

The development of this SOP is historic and ground breaking because it is the first recorded effort in Grenada to provide Standard Operating Procedures for the Health Care Professionals to deal with Gender-Based Violence.

These Standard Operating Procedures were approved by the Cabinet of Grenada on May 19, 2014 for implementation in the health care system throughout Grenada, Carriacou and Petite Martinique.

SUMMARY

**Purpose of the Standard Operating Procedures (SOPs):** The goal of the SOP is to improve the quality and consistency of services to victims of Gender Based Violence.

**Synopsis of Gender-Based Violence:** definitions of Domestic Violence and Sexual Violence are provided, in accordance with the Domestic Violence Act (2010) and the Criminal Code amendments (2012).

**Services provided by the Ministry of Social Development:** The SOP lists the services of the Ministry as direct social and psychosocial services to victims, economic support, and programming.

**Guiding Principles:** The guiding principles are:

1. Everyone has the right to live free from violence and abuse.
2. Domestic violence and sexual abuse are crimes that pose a serious health threat, undermining psychological and physical well-being.
3. The health and welfare of the victims take precedence over the collection of evidence.
4. Domestic violence and sexual abuse should be viewed as potentially life-threatening regardless of the severity of the present injury.
5. Everyone has the right to non-judgmental health and support services, and resources.
6. The response to domestic violence and sexual abuse must not re-victimize the patient/patient.
7. All interventions and care must be provided that facilitate the victim’s ability to exercise her/his own choice and enable her/him to be a full participant in the process.
8. Education and support should be provided in a way that will facilitate empowerment of the patients/victims.
9. All health care and support staff are responsible for ensuring that victims of domestic violence and sexual abuse receive high quality and compassionate care.
10. Health care providers should be appropriately trained and skilled in managing adults and children who have experienced GBV.
11. Confidentiality is a safety issue, and should be ensured to the extent of the law and health sector policies.
12. Health care providers are committed to working within an inter-sectored, collaborative framework to meet the needs of victims of GBV.

General Procedures for Health Care Staff in the Care and Management of Victims of Domestic Violence and Sexual Abuse: details are given for five aspects of care:

I. Universal screening identification
II. Assessment and Intervention, including examination when disclosure of abuse occurs, or when abuse is suspected but not disclosed
III. Documentation and Reporting
IV. Safety assessment and planning
V. Referral to other Support Service Providers

Medical Examination for Victims of Domestic Violence and Sexual Abuse
Clear guidelines are provided for five main steps in the examination process:

I. Step 1 includes preparing the patient for the examination, including guidelines on informed Consent and Confidentiality
II. Step 2 involves taking the Victim’s History
III. Step 3 is performing the actual examination, and includes obtaining laboratory tests at different stages: Prior to the examination; Physical examination, and Ano-Genital examination. It identifies special considerations that must be given to elderly women, children, men, and the mentally incapable (Patients with disabilities).
IV. Step 4: Prescribing Treatment for Victims of Domestic Violence and Sexual Abuse, with details on General Treatment, Wound care, Preventing Tetanus, Providing Psychological Counselling and Treatment, as well as preventing Pregnancy, Sexually Transmitted Infections, HIV transmission, HTLV-I, and Hepatitis B.
V. Step 5: Follow-up care for adult and child victims, with special notes relating to victims of sexual abuse.

Medico-legal Evidence Procurement and Storage Procedures
This section provides guidance on chain of custody in Grenada, photographing evidence, and sample collection and storage, such that the results can be considered valid by the Court.

Self-care for the Health Care Provider
This section recognises and gives guidance on personal safety and self-care.

Recommendations on training service providers and monitoring the use of the SOP are given.

APPENDICES
There are ten appendices which provide a Quick Reference Guide for Health Care Providers, various forms for recording information, sketches for Body Mapping, and contact information for stakeholder entities.
**Table of Contents**

Table of Contents ........................................................................................................................................................ i

Introduction ................................................................................................................................................................1

Purpose of the Standard Operating Procedures (SOPs) .............................................................................................1

Synopsis of Gender-Based Violence ...........................................................................................................................2

Definition of Domestic Violence .....................................................................................................................................2

Definition of Sexual Violence .....................................................................................................................................3

Services Provided by the Ministry of Social Development .........................................................................................3

Guiding Principles .......................................................................................................................................................4

General Procedures for Health care Staff in the Care and Management of Victims of Domestic Violence and Sexual Abuse .............................................................................................................5

  I. Universal Screening and Identification ...........................................................................................................5

  II. Assessment and Intervention Guidelines .......................................................................................................7

    When disclosure of abuse occurs: ......................................................................................................................7

    When abuse is suspected but not disclosed: .....................................................................................................8

  III. Documentation ...........................................................................................................................................9

    Documenting GBV: ...........................................................................................................................................9

    Reporting GBV ..............................................................................................................................................10

  IV. Safety Assessment and Planning ............................................................................................................. 11

    Conducting the Safety Assessment ................................................................................................................. 11

  V. Referral to Other Support Service Providers ............................................................................................... 13

Medical Examination for Victims of Domestic Violence and Sexual Abuse ............................................................ 14

  Step 1: Prepare patient for the examination ........................................................................................................ 14

    Informed Consent and Confidentiality ............................................................................................................. 15

  Step 2: Take Victim’s History ............................................................................................................................... 17

  Step 3: Perform examination and obtain laboratory tests .................................................................................. 18

    Prior to the examination: .................................................................................................................................. 18

    Physical examination ....................................................................................................................................... 19

    Ano-Genital examination ................................................................................................................................. 20

    Special Considerations ..................................................................................................................................... 22

    Elderly women: ................................................................................................................................................ 22

    Children: .......................................................................................................................................................... 23

    Men: ................................................................................................................................................................ 24

    Mentally Incapable (Patients with disabilities) ............................................................................................... 25

    Laboratory testing for victims of sexual abuse ............................................................................................... 25

  Step 4: Prescribing Treatment for Victims of Domestic Violence and Sexual Abuse .......................................... 26
General Treatment .......................................................................................................................................... 26
Wound care ..................................................................................................................................................... 26
Preventing Tetanus .......................................................................................................................................... 26
Providing Psychological Counseling and Treatment ....................................................................................... 27
Preventing Pregnancy ...................................................................................................................................... 28
Preventing Sexually Transmitted Infections ................................................................................................... 29
Preventing HIV transmission ........................................................................................................................... 30
Preventing HTLV-I ............................................................................................................................................ 31
Preventing Hepatitis B ..................................................................................................................................... 32
Step 5: Follow-up care ......................................................................................................................................... 32
At follow-up (for all victims): ........................................................................................................................... 32
For victims of sexual abuse: ............................................................................................................................. 33
Medico-legal Evidence Procurement and Storage Procedures ........................................................................ 33
Chain of Custody in Grenada ............................................................................................................................ 34
Photographing Evidence: .................................................................................................................................. 35
Sample Collection and Storage ........................................................................................................................... 35
Self-care for the Health Care Provider ............................................................................................................. 37
Personal Safety .................................................................................................................................................... 37
Self-care ............................................................................................................................................................... 37
Recommendations ............................................................................................................................................... 38
Monitoring .......................................................................................................................................................... 38
References ........................................................................................................................................................... 40
APPENDICES ...................................................................................................................................................... 41
APPENDIX A: Signature Page for Participating Actors ..................................................................................... 41
APPENDIX B: Quick Reference Guide for Health Care Providers ...................................................................... 42
APPENDIX C: ‘Top-to-Toe’ Examination ......................................................................................................... 45
APPENDIX D: Body Mapping ............................................................................................................................ 47
APPENDIX E: Domestic Violence and Sexual Abuse Health Care Provider Response Flowchart .................. 49
APPENDIX F: Medical Informed Consent/Assent Form for Domestic Violence and Sexual Abuse ............... 50
APPENDIX G: Confidentiality Agreement for Domestic Violence and Sexual Abuse Medical Services ........ 51
APPENDIX H: Domestic Violence and Sexual Abuse Medical Documentation Form ..................................... 52
APPENDIX I: Domestic Violence and Sexual Abuse Safety Assessment Form .............................................. 58
APPENDIX J: Mandatory Reporting Form ....................................................................................................... 59
Introduction

Grenada recognizes gender-based violence as a social and public health issue which has serious implications for women, children, and men. Although Grenada is unable to produce comprehensive national data on the prevalence of domestic violence and sexual abuse, the limited and fragmented empirical data from various stakeholders forcefully demonstrates a concern, especially for women.

The health care community is in a unique position to identify and respond to domestic violence and sexual abuse. Medical intervention is particularly important in domestic violence and sexual abuse cases, because it is often the first point of contact with the system for most victims. Health care providers have a responsibility to identify and respond effectively to domestic violence and sexual abuse, as well as, to take steps to prevent further abuse. It is important that health care professionals have the knowledge and tools necessary to identify and intervene appropriately in cases of abuse. However, interventions must be sensitive to differences of culture, class, ability, and psychiatric history.

This Standard operating procedures (SOPs) document will inform and guide health care providers in their work with persons who experience gender-based violence (GBV) in their lives.

Purpose of the Standard Operating Procedures (SOPs)

Standard operating procedures are specific procedures and agreements among organisations that reflect the plan of action and the individual organisations roles and responsibilities. As such, SOPs are companion documents that support the GBV plan of action, the National Domestic Violence and Sexual Abuse Protocols (individual Protocols for adults and children). Other related documents include: WHO’s Guidelines for medico-legal care of victims of sexual violence (2003) and AIDS Support and Technical Assistance Resources (AIDSTAR) document, The Clinical Management of Children and Adolescents Who Have Experienced Sexual Violence: Technical Considerations for PEPFAR Programs (Day and Pierce-Weeks, 2013).

This Health sector SOP is developed to clarify and systematize the internal procedures in the Health Care Sector, and the link with other agencies and stakeholders to improve the quality and consistency of services to victims of GBV. The processes described below, guides the clear delineation of specific roles and responsibilities for GBV prevention and response including victim consent and permission for screening and information sharing, incident documentation, specimen collection and analysis, treatment and referral systems, monitoring and training. However, there is a need for some additional systems, resources and training to address limitations within the health sector and existing GBV response network to adequately implement these procedures.

The terms victim and patient are used interchangeably to refer to all persons (girls, women, boys and men) who have or are suspected to have experienced an incidence of GBV. Moreover, when victims interface with the health system they are referred to as patients, to highlight the health care provider’s main priority of attending to their health needs above all.
Synopsis of Gender-Based Violence

GBV is the physical, emotional, psychological and other related forms of abuse, including all violations of a sexual nature, discrimination and the exploitation of the socially constructed vulnerabilities of victims, based on sex or gender, which occur in both the private and public spaces of society. Domestic violence and sexual abuse/violence are the forms of GBV addressed.

Both males and females are victims of various forms of GBV in Grenada. However, females are affected by the problem disproportionately as a result of historic, cultural and institutionalized gender inequality, built on the traditional patriarchal systems of governance and dominance, and societal norms of male power and control.

Definition of Domestic Violence

Domestic violence is defined in the Domestic Violence Act (2010) as:

“Any controlling or abusive behavior that harms the health, safety or well-being of a person or any child and includes the following:

- Physical abuse or threats of physical abuse;
- Sexual abuse or threats of sexual abuse;
- Emotional, verbal, or psychological abuse;
- Economic abuse;
- Intimidation;
- Harassment;
- Stalking;
- Damage to, or destruction of property; or
- Entry into the applicant’s residence without consent, where the parties do not share the same residence.”

The Domestic Violence Act (2010) protects anyone who has or had a domestic relationship. Domestic violence can be committed at any place, including the home, workplace, school, church, or in any other private or public place, once the victim and the perpetrator are in a domestic relationship.

Under this SOP, domestic violence related primarily to violence arising between current or former intimate partners as described in the Domestic Violence Act (2010) in its definition of “domestic relationship” parts (a),(b), (c), (e), and (f). This includes women and men who:

- are or were married to each other;
- are or were living together as partners now, though not legally married;
- are the parents of a child;
- had parental responsibility for a child;
- are or were engaged;
- are or were in a visiting relationship; and
- are or were in a dating relationship, whether an actual relationship or a perceived relationship.

For the purposes of clarity, while the Domestic Violence Act (2010) offers protection for the victims, the Criminal Code Cap 1 (1990 and its Amendments 2012) address the criminal components of domestic violence aimed at punishing the offender. Criminal acts for which the offender or perpetrator can be charged include, but are not limited to: causing harm, causing wound, causing grievous harm, causing maim or dangerous harm,
Definition of Sexual Violence

Sexual violence is sexual conduct that abuses, humiliates, degrades or otherwise violates the sexual and physical integrity of a person. The Protocol explains that it includes sexual contact with a person who does not consent or cannot give consent, or where sexual activity is coerced.

Some of the main forms of sexual violence defined in the Criminal Code Cap 1 (1990) and its Amendments (2012) are:

- rape (including marital rape);
- sexual assault;
- indecent assault;
- inducing sexual intercourse by force, duress, etc.;
- sexual intercourse with a person under sixteen years of age;
- sexual intercourse with an imbecile;
- incest;
- sexual intercourse with a step-child, foster child, adopted child, ward or dependent;
- permitting or aiding in the defilement of a young female or male;
- procuration, unlawful taking or detaining of a person to have sexual intercourse, or unlawful detention of a person with intent to have sexual intercourse; and
- trading in prostitution.

Sexual violence can occur between persons who are strangers, or who are in any kind of relationship. It can be committed at any place, including the home, workplace, school, church, or in any other private or public place.

Services Provided by the Ministry of Social Development

The Ministry of Social Development, as the lead agency to facilitate development of these SOPs provides different levels of services to victims identified as:

- Direct social and psychological services to victims;
- Economic support to victims and their families; and
- Programming for victims, witnesses, perpetrators, and others affected by GBV.

Together with partners and stakeholders, a full range of services can be made available. The Ministry is committed to further facilitate the development of the multi-sector approach to addressing GBV, in particular the health, law enforcement, justice and social services sectors.
Guiding Principles

13. Everyone has the right to live free from violence and abuse.

14. Domestic violence and sexual abuse are crimes that pose a serious health threat, undermining psychological and physical well-being.

15. The health and welfare of the victims take precedence over the collection of evidence.

16. Domestic violence and sexual abuse should be viewed as potentially life-threatening regardless of the severity of the present injury.

17. Everyone has the right to non-judgmental health and support services, and resources.

18. The response to domestic violence and sexual abuse must not re-victimize the patient/patient.

19. All interventions and care must be provided that facilitate the victim’s ability to exercise her/his own choice and enable her/him to be a full participant in the process.

20. Education and support should be provided in a way that will facilitate empowerment of the patients/victims.

21. All health care and support staff are responsible for ensuring that victims of domestic violence and sexual abuse receive high quality and compassionate care.

22. Health care providers should be appropriately trained and skilled in managing adults and children who have experienced GBV.

23. Confidentiality is a safety issue, and should be ensured to the extent of the law and health sector policies.

24. Health care providers are committed to working within an inter-sectored, collaborative framework to meet the needs of victims of GBV.
General Procedures for Health care Staff in the Care and Management of Victims of Domestic Violence and Sexual Abuse

The main priority when caring for victims of domestic violence and sexual abuse is their health and welfare (Day & Pierce-Weeks, 2013). Health providers will be negligent if they fail to first and foremost attend to these needs of the victim.

Not all victims of GBV come forward to report domestic violence or sexual abuse, others seek help immediately, while others still may delay help-seeking for later. However, it is important to note that victims can choose to disclose domestic violence and/or sexual abuse at anytime to a health provider or other support service providers.

In some instance, paramedics and health facility staff, including administrative staff may suspect the occurrence of GBV, even when the patient has not disclosed such. Health providers should therefore become comfortable with various ways of asking patients about GBV as well as become familiar with ways of providing appropriate interventions and support.

There are five aspects of care that should be provided to survivors of domestic violence and sexual abuse:

1. Universal screening/identification
2. Assessment/examination
3. Documentation
4. Safety Planning
5. Referral

I. Universal Screening and Identification

Universal screening and identification for GBV applies to all health workers, including administrative staff and first responders, such as paramedics. The following should be observed during screening and identification:

- Paramedics, nurses, receptionists, and clerical staff MUST alert the provider responsible for the patient’s care if they suspect GBV or if the patient has disclosed experiencing form(s) of GBV.

- If the occurrence of GBV is disclosed, acknowledge the disclosure and reassure the patient that the health care provider is in a position to offer assistance.

- GBV screening should be a routine procedure during medical history taking, whereby ALL patients are discreetly screened for GBV.
DO NOT screen for abuse with the partner or other family members present. Security Personnel should be on standby to assist with the removal of difficult persons or alleged perpetrators.

ALWAYS document the patient’s responses to the screening interview using the Domestic Violence and Sexual Abuse Documentation Form (see Appendix G, page 43). Be sensitive to the fact that patients may refuse to give information about the abuse or refuse to receive intervention or referral information. Document this refusal in the patient’s chart.

Adhere to hospital and professional standards regarding confidentiality.

If the patient discloses abuse, proceed to guidelines for Assessment and Intervention (see page 7).

**Tips for Conducting GBV Patient Screening**

- Provide a safe, confidential, and supportive environment within which to screen for GBV.
- Nurses or physicians should be discreet during the course of the patient’s assessment and treatment, and interview the patient in a direct, but non-threatening and empathetic manner. Example questions could be:
  
  - “All information disclosed is confidential and we ask all of our patients this question: Are you in a relationship with someone who threatens to or has hurt you in any way?”
  
  - “I noticed you have a number of bruises. Could you tell me how they happened? Did someone hit you?”
  
  - “You seem frightened of your partner. Has your partner ever hit you or hurt you in any way?”
  
  - “You mentioned your partner uses drugs/alcohol. How does your partner act when drinking or on drugs?”
  
  - “Your partner seems very concerned and anxious. Was he responsible for your injuries?”
  
  - “You are not alone, you are not to blame, and there is help available; you do not deserve to be treated this way.”

- Build trust and support:
  - Focusing your attention on the patient
  - Avoid doing paperwork or other tasks during your time with the patient
  - Assure patient that all information disclosed is confidential. It is mandatory to report the incident to the police if the person is less than 18yrs, elderly, or mentally impaired, or if the incident involved a gunshot wound, knife wound, or other serious bodily injury, or sexual assault (see Confidentiality, page 15).
II. **Assessment and Intervention Guidelines**

*When disclosure of abuse occurs:*

- The health facility should be a safe, private, and supportive environment for the victim.
- Cases involving sexual assault should be prioritized and victims should not be required to endure long waiting periods before receiving medical attention.
- Alert security if alleged perpetrator is present and becomes violent or disruptive.
- Acknowledge the disclosure and affirm clearly that domestic violence is wrong. Reassure the patient that she/he is doing the right thing by talking with you.
- Attend to the victim’s immediate medical needs, and perform Medical Examination (See Step 3: Perform the Medical Examination section, pg. 13).
- Preserve and document physical evidence (See Medico-legal Evidence Procurement and Storage page 28; see Documentation guidelines, page 9).
- Pursue a treatment plan that integrates diagnostic lab work and X-rays as required; treat physical injuries and emotional trauma. Specialized treatment should be given to victims that have been sexually assaulted. (See Step 4: Prescribing Treatment for Domestic Violence and Sexual Abuse Victims, page 22).
- Review the information with the patient to ensure understanding.
- Maintain confidentiality. Be sure that partners, family members, friends or other health workers unrelated to the case DO NOT have access to patient’s medical treatment or records without the patient’s consent. (see Confidentiality, page 15)
- Inform the patient of his/her rights and options:
  - Everyone has the right to live free of abuse.
  - The patient is not to blame for the abuse
  - Domestic Violence is a crime
  - Everyone has the right to stay in a safe place.
  - A patient who is being abused has the right to file a report with the police.
  - The patient can get a Protection Order against the perpetrator
- If the police have not accompanied the victim, ask the victim whether they object to having their injuries reported to the police. If patient does not object, inform the police. **NOTE: It is required by law and/or health policy that GBV be reported to the police if the victim is:**
  - under the age of 18; or
  - 18 years of age or older and has received a gunshot wound, a knife wound, or other serious bodily injury. Serious bodily injury means any harm to the body which causes or could cause severe, permanent or protracted loss of, or impairment to the health or function of any part of the body.
  - Mentally incapable (refers to imbeciles, or other persons with developmental and or other disabilities that render them unable to provide informed consent)
  - an elderly person (refers generally to persons aged 60 years and over)
Refer to the Gender Violence Unit social worker for safety assessment, or conduct the safety assessment in the absence of a social worker (see page 11 for guidelines).

**Physical Indicators for Possible Sexual Abuse in Children**

- Pregnancy in a child unable to legally consent to sexual activity
- STI in a child beyond the perinatal acquisition period
- Pain, sores, bleeding, injury, and discharge from the genitalia of a prepubescent child
- Disclosure of sexual violence or exploitation by a child or adolescent

Children who experience sexual violence and exploitation may also be exposed to other forms of violence (emotional, physical, neglect, etc.) in the family or the environment. It is important that providers be aware of this and screen for other forms of violence during the examination.

Source: Day & Pierce-Weeks, 2013

**When abuse is suspected but not disclosed:**

- Provide further opportunity for disclosure
  - Continue with gentle but direct questioning.
    - For example: “I’m concerned about how you got these injuries. Did someone do this to you?”
    - “We often see injuries or symptoms like yours when a patient has been hurt by her/his partner. Has this happened to you?”
  - Be attentive to patient’s responses to additional questioning, for example, if the patient is becoming angry, hostile, or non-communicative, do not pursue further questioning.

- If patient continues to deny abuse, record in chart that the “*patient’s explanation of injuries is inconsistent with physical findings*”.

- Review the information with the patient to ensure understanding and determine with the patient whether it is safe for the patient to take written materials home.

- Refer patient to the appropriate services, such as the Gender-Based Violence Unit, Legal Aid and Counseling Clinic (LACC), Child Protection Authority, or Grenada National Organization of Women (GNOW), etc.
III. **Documentation**

Documentation is important for future medical and legal assessments, and health workers have a professional obligation to record the details of any consultation with a patient.

Proper medical documentation is beneficial for use in a court of law as evidence against the perpetrator(s), and/or if the patient is pursuing legal custody and access issue related to children.

Documenting that a patient is a victim of GBV will alert other health care providers who later attend the patient to this fact, and will assist them in providing appropriate and sympathetic follow-up care (WHO, 2003).

Documentation can provide administrators and policy-makers with an estimate of the incidence and prevalence of sexual violence that can be used to guide decisions about allocating resources (WHO, 2003).

The Domestic Violence and Sexual Abuse Documentation Form serves as written disclosure of abuse on the patient’s medical chart as well as guides medical professionals on obtaining necessary information. The health provider/health facility should have adequate number of copies of this form, easily accessible during consultation, including in Rape Kits.

**Documenting GBV:**

- Be objective, accurate, and pay attention to details said, done, and observed; this is essential to avoid misinterpretation.

- Notes should reflect what was said (by the patient, in his/her own words), and seen and done by the health worker.

- Record the injuries on a body map; precise recording of injuries is imperative for legal purposes. Include bruises, scratches, restraint marks, cuts, shearing, etc.

- Record any inconsistencies between patient’s explanation of how injury was sustained and medical findings.

- Provide the patient with the option of having injuries photographed as supplementary documentation; inform patient that this could be used as a visual reminder for health providers if he/she decides to take legal action in the future. Follow procedures for photographing patient injuries in the Medico-legal Evidence Procurement and Storage Procedures section.
Review documentation with the patient to ensure the accuracy of the information recorded.

Ask the patient if there is any additional information that he/she would like to share.

For cases of domestic violence, inform the patient that a report can be filed with the Police, and the Police are mandated to bring charges against the perpetrator (Domestic Violence Protocol).

**Reporting GBV**

If the victim has reported the incident to the Police, and a Police Officer has accompanied the victim to visit the health facility, COMPLETE THE RGPF MEDICAL FORM FOR DOCUMENTING ASSAULT at the end of the medical examination, SIGN and RETURN the Form to the Police Officer present.

If the victim has reported the incident and has received the RGPG Medical Form, but during the visit to the health facility is unaccompanied by a Police Officer, the health care provider MUST COMPLETE AND SIGN the Form, store it safely and securely, contacting the relevant Police Station for collection by a designated Police Officer.

- The Police Officer collecting the Form should SIGN upon receipt of the Form. NB: Returning the form to the police is not a requisite for proceeding with a criminal case.

- The health care provider shall remind and encourage the victim to follow-up with the Police to complete the reporting process of the incident.

For victims who have not reported the incident to the Police at the time of visiting the health facility, but the case requires mandatory or other reporting, the correct authority should be called and a Mandatory Reporting Form (see Appendix x) should be completed and submitted.

- In the case of a minor, the health care provider is mandated to report the case to the Child Protection Authority (CPA) or the Police within 48 hours of initial reporting (Child Protection Act and Protocol). Initial reporting can be done via telephone, but will need to be followed-up by submission of the Mandatory Reporting Form to the Director of CPA.

- In the case of an adult, encourage reporting, but do not force reporting. The patient should be referred to the Legal Aid and Counseling Clinic (LACC) or the Gender-Based Violence Unit. In the case of mentally incapable and elderly persons, the health care provider is mandated to report to the Police, and follow up with official correspondence to the Gender Violence Unit in the Ministry of Social Development.
IV. Safety Assessment and Planning

Safety is sometimes an urgent short-term consequence of GBV. Ideally, the safety assessment and plan should be conducted by a social worker from the Gender-Based Violence Unit who is called to the health facility upon disclosure or suspected abuse, but this may not always be possible due to human resource shortages.

In the absence of a social worker, the health care provider will be expected to conduct this critical assessment of the safety needs of the victim and any children involved, providing appropriate referrals and follow-up when the need arises.

The severity of the current injuries or the abuse is not always an accurate predictor of future violence, and a Safety Assessment and Plan (see Appendix H, page 52) can help to better offer the appropriate support services to meet the needs of the victim.

A crucial component of developing a safety plan with the victim is to aid in empowering the victim and to help them take control of the situation. It is recommended that all health care providers familiarize themselves with emergency and non-emergency resources across sectors that address the short and long-term needs of GBV to provide adequate referral and follow-up care (See pages 13 & 28).

Health care providers should understand that leaving an abusive relationship is a process which may take years, just as the abuse may have taken place over a lengthy period of time.

Conducting the Safety Assessment

☐ Speak to victims about their immediate and future safety before he/she leaves the health facility.

☐ Ask/answer the following questions. A yes to one or more requires referral, exploration of patient options with provider, and development of a safety plan with the patient.
   - Has there been a history of abuse in the relationship?
   - Has the abuse increased in frequency/severity?
   - Did the abuse start or escalate during pregnancy?
   - Have the children ever been threatened or hurt? (Note: if this is a yes, it is mandated that the police and Child Protection Authority are informed)
   - Is the abuser presently in the home?
   - Does the patient perceive living arrangements unsafe to return?
   - Was there use of a weapon?
   - Is police intervention needed?
   - Is no one else aware of the abuse?
− Has the patient attempted suicide?
− Will the patient require medical treatment?
− Did he/she make a direct or indirect threat against you?

☐ Inform the victim of their legal rights, such as calling the Police (Domestic Violence Act 2010, Criminal code Amendments of 2012; Child Protection and Adoption Act 2010), and all their options. Note: The decision of how to handle the situation is ultimately that of the patient and the decision should be respected by the provider – unless the victim falls in to one of the special groups (i.e. under 18 years old, elderly and mentally incapable persons, or is 18 years or older and has received a gunshot wound, a knife wound, or other serious bodily injury).

☐ Refer the victim to appropriate services, such as the Gender-Based Violence Unit, Legal Aid and Counseling Clinic (LACC), Child protection Authority (CPA), or other sources, such as supportive family, friends to help ensure immediate safety.

☐ Explore how the victim will take children out of danger, especially in the middle of the night.

☐ Determine with the victim whether it is safe for him/her to take written materials home.
  • If it is safe to do so:
    − Provide the victim with brochures, pamphlets, and emergency numbers as well as safety plan information.
  • If it is unsafe to do so:
    − Discuss the information in the brochures, pamphlets, and ask the victim to memorize emergency numbers as well as safety plan information. Encourage the victim to discuss their safety plan with someone they trust who will help them cope with the situation.

☐ If the patient chooses to return and remain in the relationship, encourage the patient to develop an Emergency Escape Plan.

<table>
<thead>
<tr>
<th>Example of An Emergency Escape Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Put the following in a safe place)</strong></td>
</tr>
<tr>
<td>Small amount of money</td>
</tr>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>Keys</td>
</tr>
<tr>
<td>Child’s favorite toy or blanket</td>
</tr>
<tr>
<td>Your identification</td>
</tr>
<tr>
<td>Child’s identification</td>
</tr>
<tr>
<td>Bank book</td>
</tr>
<tr>
<td>Mortgage</td>
</tr>
</tbody>
</table>
V. **Referral to Other Support Service Providers**

The health provider is encouraged to bring together the following services in individual communities:

- Emergency medical
- Clinic
- Surgery
- Maternity
- Advocacy
- Counseling
- Criminal justice system
- Social welfare services including child protective services
- HIV/STI
- Community health
- Pharmacy
- Laboratory (testing and evidentiary)

- Victims with severe, life threatening conditions should immediately be referred for emergency treatment.

- All victims should be referred to for mental health counseling, irrespective of the severity of the event.

- Victims should be given both verbal and written referrals for the required support service, which will permit tracking and monitoring of referrals by a multi-sector Special Victims Unit.

- Sources of support for the victim, such as family or friends should also be referred for counseling.

- When required, health workers should provide a certificate of absenteeism from school or work, stating no-specific reasons for the absence.

SEE APPENDIX B, PAGE 39, FOR LIST OF RESOURCES THAT MAY BE USEFUL AND MADE AVAILABLE TO VICTIMS.
Medical Examination for Victims of Domestic Violence and Sexual Abuse

**Step 1: Prepare patient for the examination**

- Introduce yourself.
- Ensure trained person or health care worker of the same sex accompanies the patient throughout the examination, but limit the number of persons allowed in the examination.
  - When necessary, include Police Officer of same sex as the victim or non-offending parent, guardian or caregiver
- Explain what is going to happen during each step of the examination, why it is important, and how it will influence the care you are going to give. Explain their options giving sufficient information, allowing for informed choice about their care.
- Reassure the patient that he/she is in control of the pace, timing, and components of the examination.
- Address issues of confidentiality.
  - For adult victims: Reassure patient that the findings will be kept confidential unless he/she decides to pursue legal action, or if serious bodily injury is sustained.
  - For special groups (children, the elderly and mentally incapable persons): Inform the patient, guardian, or caregiver that the incident must be reported to police.
- Ask the patient, parent, guardian or caregiver if he/she understands and has any questions.
- When the patient is alone, ask if he/she would like a specific support person present.
- Obtain Consent and/or Assent to conduct medical examination and permission to proceed with examination (see Informed Consent Procedures, Page 16; Informed Consent Form, page 43).
  - DO NOT force or pressure the victim to do anything against his/her will.
  - Explain that he/she can refuse steps at any time during the process of the examination.
  - For adult victims:
    - Review and obtain oral and written consent of the adult victim prior to conducting the examination.
  - For special groups (children, elderly, and mentally incapable person):
    - Review and obtain oral and written consent from the non-offending parent, guardian, or caregiver, plus the consent/assent of special victim as appropriate (see Consent/Assent requirement, page 15).

Note: If parent or guardian refuses to provide consent, contact Child Protection Authority as a proxy to provide consent for the medical examination of the child.

- Conduct the examination as soon as possible following the incident and/or arrival to the health facility.
Informed Consent and Confidentiality

It is important that providers recognize consent as a process that continues throughout medico-legal examination and treatment. Although it almost always involves a formal signed document, consent may be withdrawn at any time. In some cases, however, consent can be problematic, especially when the best interests of the child conflict with the child and/or caregiver’s immediate concerns about giving consent. In cases where a caregiver refuses or is unable to give consent for the medical evaluation of a child, even after the need for the examination has been explained, the Child Protection Authority may need to be called in to waive the caregiver’s custodial rights over the child for the purpose of facilitating the medical evaluation (WHO, 2003).

Confidentiality is an important part in developing trust in a relationship. In cases of domestic violence and sexual abuse, confidentiality is not only a privacy issue but also a safety issue.

Codes of practice require all professionals to consider carefully their legal and ethical duties as they apply to patient confidentiality. The patient need to understand that health care professional may have a legal and professional obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent (WHO, 2003).

The issue of confidentiality should be discussed with the patient to ensure awareness of its meaning in the context of health care provision and the relevant laws, protocols, and operations procedures.

- Inform the patient of standards of practice regarding confidentiality related to GBV
  - Public sector Secrecy Act
  - Doctor-patient confidentiality (information shared on a need to know basis, to ONLY service providers directly involved in the case)
  - Mandatory reporting
  - Closed-Door (In-camera) sessions of GBV cases in the judicial system

- DO NOT force or pressure the patient to do anything against his/her will.
  - Explain that he/she can refuse steps at any time during the process of the examination.
  - For adult survivors:
    - Review and obtain oral and written consent of the adult survivor prior to conducting the examination.
  - For special groups (children, elderly and mentally incapable persons):
    - Review and obtain oral and written consent from the non-offending parent/guardian/caregiver, plus;
    - Obtain assent if pre-pubescent child;
– Obtain consent and assent if adolescent;
– Obtain consent/assent from elderly and mentally incapable victim based on capacity to provide informed consent (See Informed Consent Form, page 43).

☐ A child patient brought into the health facility against his/her wishes should not be examined without the patient's consent.

☐ Victims’ files and alleged perpetrator information should be securely stored (e.g. locked cabinet, password protected database) and handled ONLY by service providers directly involved in the case.

☐ Use professional judgment in terms of timing and delivery of information in keeping with the spirit of this standard operating procedure.

☐ Service providers should sign a confidentiality agreement outlining the boundaries of confidentiality and situations in which it may be breached.

☐ Healthcare providers may maintain confidentiality, even as to the child’s parent or guardian, unless failing to inform the parent or guardian would jeopardize the child’s health.

### TIPS FOR TALKING ABOUT CONFIDENTIALITY

- Reassure the patient that your conversation will not be discussed with the patient’s partner, nor will it be discussed with any other member of the family, without the patient’s consent.

- If the patient voices concern about the documentation, inform the patient of the benefits of full documentation (See Documenting procedures, page 9).

- Inform the patient about the mandatory reporting of child abuse (persons under age 18), suspected child abuse, or in any case of a gunshot wound, knife wound or other serious bodily injury.

### Informed Consent/Assent Guidelines

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Child</th>
<th>Caregiver</th>
<th>If No Caregiver or Not in Child’s Best Interest</th>
<th>Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Informed consent</td>
<td>Informed consent</td>
<td>Other trusted adult’s or case-worker’s informed consent</td>
<td>Written consent</td>
</tr>
<tr>
<td>6-11</td>
<td>Informed consent</td>
<td>Informed consent</td>
<td>Other trusted adult’s or case worker’s informed consent</td>
<td>Oral assent, Written consent</td>
</tr>
<tr>
<td>12-14</td>
<td>Informed consent</td>
<td>Informed consent</td>
<td>Other trusted adults’ or child's</td>
<td>Oral assent,</td>
</tr>
</tbody>
</table>
**Step 2: Take Victim’s History**

- If interview is conducted in the treatment room, cover the medical instruments until they are needed.

- Review any documents brought by the victim (e.g. RGPF Medical Form for Reporting Sexual Assault).

- Document victim’s history using the Domestic Violence and Sexual abuse Documentation Form. Record:
  - Name, address, sex, date of birth, date and time of examination, and name and function of any staff or support persons present during the interview and examination
  - Sequence of events
  - Time and place of incident
  - Nature of abuse and number of persons involved
  - Parts of the body damaged and the use of any weapons or objects.
  - Whether the victim was accompanied by police to the health care center; if not, follow procedure to determine police involvement.

- In the case of sexual abuse, record:
  - How clothing was removed, if medication or drugs were used; how penetration occurred. For example, whether finger, penis, object was used; whether penetration was oral, vaginal, or anal; and whether ejaculation occurred.
  - Whether patient bathed, urinated, defecated, vomited, used vaginal douche or changed clothing before seeking medical care. This may affect medical evidence that can be collected.
  - Information on existing health problems, allergies, use of medication, and vaccination and HIV status.
  - Possible pregnancy; ask for details about contraceptive use and the date of last menstrual period.

- When recording alleged perpetrator’s name, document as “patient states....”

- Document your findings without stating conclusions about whether rape occurred.

- Refer to Medico-legal Evidence Procurement and Storage Procedures prior to examination to ensure proper materials are collected as to not subject patient to re-examination and possible further trauma.
### Step 3: Perform examination and obtain laboratory tests

Although there may be a desire to separate distinctly the medical from the forensic components of the examination, it cannot be done. The forensic or evidentiary components of the exam, if they are necessary, must be incorporated into all aspects of the medical care itself in order to provide seamless care. For this reason, providers must be prepared to incorporate all evidence collection into the physical examination as it proceeds. Of equal importance is conveying the fact that the provider is interested in the entire person, not just their genitalia.

### Prior to the examination:

- Make sure the equipment and supplies are prepared.
- Always look at the patient before you touch her and note her appearance and mental state.
- Take the patient’s vitals (heart rate, blood pressures, respiratory rate, and temperature).
- Initial assessment may reveal severe medical complications that need to be treated urgently and for which the patient will need to be admitted to the hospital. Such complications may include:
  - Extensive trauma (to ano-genital region, head, chest, or abdomen)
  - Asymmetric swelling of joints (septic arthritis)
− Neurological deficits
− Respiratory distress

☐ Record all findings on the standard Documentation Form (Appendix G, page 45) and on pictograms (see page 53).

**Physical examination**

☐ Never ask the patient to undress or uncover completely. Try to provide as much privacy as possible while undressing.

☐ Collect lab specimen and forensic evidence as you go along (see Laboratory Tests, page 21, and Medico-legal Evidence Procurement and Storage Procedures, page 29).

☐ If clothing is to be collected for evidence, the patient needs to undress over a white sheet or large piece of light paper provided in Rape Kit. Provide replacement clothing.

☐ Systematically conduct ‘top-to-toe’ examination of patient’s body (see Appendix C, page 40), and follow procedures for special groups, as necessary (see page 21).
  − Examine the upper half of the body first, then the lower half.
  − Start with hands and wrists before the head as this is more reassuring to the victim.
  − Do not forget to look in the eyes, nose, mouth, ears, and neck.
  − Check for signs of pregnancy
  − For victims who are children, take note of pubertal stage.

☐ Look for signs that are consistent with the victim’s story, such as bite or punch marks, marks of restraints, patches of hair missing, and torn eardrums (result of being slapped). If the victim reports being throttled, look in the eyes for petechial hemorrhages.

☐ In cases of sexual abuse, examine body area that came in contact with the surface in which the incident occurred to see if there are injuries.

☐ Note all findings carefully on pictograms, taking care to record:
  − Classification: i.e. abrasion, contusion, laceration, incised wound, gunshot.
  − Site: record anatomical position of wound
  − Size and depth: Measure dimension and depth of wounds
  − Shape: linear, curved, irregular
  − Surrounds: note condition of surrounding or nearby tissues (e.g. bruised, swollen)
  − Color: when describing bruises
  − Course: comment of apparent direction of force applied (i.e. in abrasions)
  − Contents: note any foreign materials in the wound (e.g. dirt, glass)
  − Age: comment on any evidence of healing injuries
  − Borders: Describe characteristics of the edges of wounds – may provide clue as to the weapon used

**IF SEXUAL ASSAULT HAS OCCURRED, PERFORM ANO-GENITAL EXAMINATION.**
Ano-Genital examination

□ Ensure female healthcare witness is present before proceeding to the exam if the victim is female, and or female Police Officer, if necessary.

□ Always tell him/her what you are going to do and ask his/her permission before you do it, including for children.

□ Assure the victim that he/she is in control and can ask questions or stop the examination at any time.

□ For the genital examination, systematically inspect the following sites in females and males for injuries:

<table>
<thead>
<tr>
<th>Sites of injuries in females</th>
<th>Sites of injuries in males</th>
</tr>
</thead>
<tbody>
<tr>
<td>• mons publis</td>
<td>• Prepuce of the glans</td>
</tr>
<tr>
<td>• inside of thighs</td>
<td>• Glans penis and frenulum</td>
</tr>
<tr>
<td>• posterior fourchette</td>
<td>• Urethral meatus</td>
</tr>
<tr>
<td>• perineum</td>
<td>• Penile shaft</td>
</tr>
<tr>
<td>• labia majora and minora</td>
<td>• Scrotum</td>
</tr>
<tr>
<td>• clitoris</td>
<td>• Testes</td>
</tr>
<tr>
<td>• urethra</td>
<td>• Inguinal region</td>
</tr>
<tr>
<td>• introitus</td>
<td>• Perineum</td>
</tr>
<tr>
<td>• hymen and hymenal remnants*</td>
<td></td>
</tr>
</tbody>
</table>

* Hymenal tears are more common in children and adolescents.

□ Record:
  – Any scars or markings, e.g. from previous childbirth.
  – Genital injury, such as bruises, scratches, abrasions, tears (often on the posterior fourchette).
  – Signs of infection, such as ulcers, vaginal discharge, or warts.

□ If collecting sample for DNA analysis, take swabs from around the anus and perineum before the vulva, in order to avoid contamination.
  – If possible, illuminate the pudendum with an ultraviolet light (prosthetic secretions are fluorescent when dry).

□ Before the anal examination, note shape and dilatations of the anus.
  – Note any fissures around the anus, the presence of fecal matter on the perianal skin, and bleeding from rectal tears. If indicated by history, collect sample from the rectum.

□ If there has been vaginal penetration, conduct a pelvic exam for adults and post-pubescent girls. Generally, no speculum or digital examination should be used for pre-pubescent girls.
  – Before inserting speculum, ensure there is adequate light. State that you are about to touch a warm, water-moistened speculum on the inner thigh of the patient. Then proceed to state that you will be inserting the speculum into the vagina.
– Gently insert the warm, water/saline-moistened (non-lubricated) speculum to inspect the posterior fornix, vaginal mucosa, and cervix, noting any trauma, bleeding, or signs of infection. Note: if the victim is a child or in any other extreme cases, a general anesthetic may be required.
– Take swabs and collect vaginal secretions.
– If indicated by the history or examination, perform a bimanual examination and palpate the cervix, uterus, and adnexa looking for signs of abdominal trauma, pregnancy, or infection.
– If indicated, do a rectovaginal examination and inspect the rectal area for trauma, recto-vaginal tears, fistulas, bleeding or discharge. Note the sphincter tone. If there is bleeding, pain, or suspected presence of a foreign object, refer the patient to the hospital.

☐ Take samples according to the Medico-legal Evidence Procurement and Storage Procedures (page 29).

**Indicators for Internal Speculum Exam in Pre-Pubescent Girls**

- Bleeding from the vagina orifice
- Suggestion that a foreign body may be present in the vagina
- External genital injury requiring surgical repair

**IT IS ENTIRELY POSSIBLE TO HAVE A NORMAL PELVIC EXAM IN A SEXUALLY ASSAULTED WOMAN IF SHE IS NORMALLY SEXUALLY ACTIVE, AS THE VAGINA WILL ACCOMMODATE TO THE PENILE PENETRATION. YOU MUST BE ABLE TO EXPLAIN THIS IF CALLED TO COURT.**
Special Considerations

Elderly women:

Although there is no agreed upon chronological age to define ‘elderly’, many developing countries have accepted age 65, and the United Nations uses age 60+ to define the older population (WHO, 2013). However, in many instances, the age at which a person becomes eligible for statutory and occupational retirement pension is has become the default definition. Taking this into consideration, 60 years will be used to define elderly in the SOPs. However, this definition should be used along with change in capabilities of the older person (i.e. invalid status, senility and change in physical characteristics) to determine reporting, as persons below age 60 may have diminished capacity warranting protection.

Caretakers, including family members, may sexually assault older dependents, and the perpetrator may bring the victim to the health facility for care and treatment. Additionally, some older victims may be reluctant to report the crime or seek treatment because they fear the loss of independence.

Physical conditions common in the elderly coupled with the emotional impact of the assault may make the patient appear confused. Additionally, elderly women who have been raped vaginally are at increased risk for vaginal tears and injury, and transmission of STIs and HIV. Post-menopausal women have reduced vaginal lubrication and a thinner more friable vaginal wall due to decreased estrogen.

- Use a thin speculum for the genital examination;
- If the only reason for the examination is to collect evidence or screen for STIs, consider inserting swabs only without using a speculum to avoid further trauma. If there are external tears in the introitus, consider internal injuries as well;
- Conduct safety assessment, and involve adult protective services if necessary; and
- Refer the elderly patient for counseling to meet their emotional needs. This may enhance your ability to provide more effective care and treatment.

**NOTE: THE RECOVERY PROCESS FOR OLDER VICTIMS TENDS TO BE LONGER THAN FOR YOUNGER VICTIMS**
Children:

The Convention on the Rights of the Child defines a 'child' as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger. However, there are developmental differences among ages in this categorization, making younger children different from older children (e.g. pre-pubertal vs. pubertal), and older children different from adults (e.g. 18 year old vs. a 21 year old). Children achieve different developmental milestones at vary ages, including cognitive abilities, which affect their behavior and decision making capacity.

Health care providers must make preparations to respond thoroughly and compassionately to children, who have experienced sexually violence and exploitation. They need to be aware of the signs and symptoms that suggest the possibility that sexual violence and exploitation has occurred. Signs and symptoms typically fall into physical or behavioral categories, but no one sign or symptom should be used in isolation to suggest that sexual violence and exploitation has occurred.

Ideally, medico-legal evaluation should be performed by a health care worker with developmentally appropriate communication skills, trained and skilled in the clinical care of children who have experienced sexual violence and exploitation, and have the necessary equipment and supplies to provide treatment.

The primary objective in evaluating children and adolescents who have experienced sexual violence and exploitation is to provide compassionate, developmentally appropriate care and appropriate treatment.

In cases of sexual assault or rape:

- Ask girls whether they have started menstruating, if so they may be at risk of pregnancy.

- Small children can be examined on the mother's lap. Older children should be offered the choice of where they would like to be examined.

- Do not carry out a digital examination. Look for vaginal discharge. In pre-pubescent girls, vaginal specimens can be collected with a dry sterile cotton swab.

- Do not use a speculum on pre-pubescent girls; it is extremely painful and may cause injury.

- A speculum may only be used when a penetration vaginal injury is suspected. In this case, a speculum may be used with administration of anesthesia.

- In boys, check for injuries to the frenulum of the prepuce and for anal or urethral discharge; take swabs if indicated.
All children should have an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position as assailants often use it.

**Men:**

Commonly experienced forms of sexual violence among men include: receptive anal intercourse, forced masturbation or the perpetrator, receptive oral sex, forced masturbation of the victim. Some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, and may not want to disclose the assault to the health care provider.

Furthermore, male victims may be less likely than females to seek and receive support from family members and friends, as well as from counseling services. Men’s ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.

Do not assume the sexual orientation of the patient regardless of the gender of the attacker.

Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus, and anus. Note if the victim has been circumcised.

- Look for hyperemia, swelling, testicular torsion (medical emergency), bruising, anal tears, etc.

If urine contains large amounts of blood, check for penile and urethral trauma.

- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.

If relevant, collect material from the anus for direct examination for sperm under a microscope.
Mentally Incapable (Patients with disabilities)

Some patients may have several disabilities, including physical, mental or sensory disabilities, or a combination of disabilities. Disabilities may include: mental retardation, mental illness, developmental disabilities, traumatic brain injury, neurodegenerative conditions such as Alzheimer’s disease, or stroke. Note that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment).

Evidence in other contexts indicates that the risk of criminal victimization, including sexual assault for people with disabilities, appears to be much higher than for people without disabilities.

Furthermore, people with disabilities are often victimized repeatedly by the same offender. Caretakers, family members, or friends may be responsible for the sexual assault. However, the person with the disability may not be aware that a crime has been committed against her/him.

A patient may want a caretaker, friend or family member with her/him in the exam room to assist with communication. This assistance may influence patient responses, so care must be taken to prevent this from occurring. Be aware that patients with cognitive disabilities may be easily distracted and have difficulty focusing.

- Make every effort to accommodate patient needs.
- Ideally, assistance in communicating with the patient, especially for patients with hearing and speech impairments should come from someone not associated with the patient.
- Be aware that patients with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions:
  - Conduct the exam in an area that is void of bright lights and loud noises;
  - Speak to patients in a clear and calm voice, and ask very specific and concrete questions; and
  - Be exact when explaining what will happen during the exam process and why.

Laboratory testing for victims of sexual abuse

The type of specimens collected and laboratory tests conducted should be decided on a case-by-case basis. These diagnostic health tests and forensic tests are critical for health care follow-up and criminal investigations. The following are some recommended tests that should be conducted for victims of sexual abuse.

- Pregnancy test for women and girls
- Regardless if sodomy disclosed, rectal swab for all, plus vaginal swab for women and girls
□ Slide for sperm
□ Oral, cervical, and rectal Chlamydia
□ Oral, cervical, and rectal N. Gonorrhea
□ HIV infection
□ HTLV-1, Syphilis, and Hepatitis B
□ Additional toxicology testing (i.e. cocaine, marijuana, opiates, morphine, benzodiazapines, etc) can be obtained if indicated.

Step 4: Prescribing Treatment for Victims of Domestic Violence and Sexual Abuse

General Treatment
The basic components of providing treatment include:
- Wound Care
- Preventing Tetanus
- Providing mental health treatment and counseling

In cases of sexual assault, treatment includes:
- Preventing Pregnancy
- Preventing Sexually transmitted infections
- Preventing HIV transmission
- Preventing Hepatitis B transmission
- Preventing psychological complications (e.g. suicide, depression)

Wound care
- Debride dead or damaged tissue
- Clean lacerations and abrasion.
- Decide if wounds need suturing.
- Suture clean wounds within 24 hours, but exceptions may be made beyond 24 hours depending on the wound (e.g. facial wound); after this time they will have to heal by second intention or delayed primary suture.
- If there are major contaminated wound, swab wound for culture and sensitivity; consider giving appropriate antibiotics and pain medication.

Preventing Tetanus
- If there are breaks in the skin or mucosa, tetanus prophylaxis should be given unless the victim has been fully immunized.
- Decide whether to administer tetanus toxoid and antitetanus immunoglobulin, if available.
If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.

Advise victims to complete the vaccination schedule (2nd dose at 4-6 weeks, 3rd dose at 6 months)

**Providing Psychological Counseling and Treatment**

Psycho-social support is an essential component of medical care for victims of domestic violence and sexual abuse. Victims may experience strong emotions as a result of the violent incident experienced, but it will go away over time as the emotion decreases.

Men are particularly reluctant to go for counseling, but have the same needs as women.

All patients should be provided a referral for psychological support, even if the patient chooses not to pursue treatment (victim may benefit from counseling at a later time and it is necessary that he/she have this information readily available).

If the victim has symptoms of panic or anxiety (such as dizziness, shortness of breath, palpitations, and choking sensations that cannot be medically explained), explain that these sensations are common in people who are very scared after having gone through a frightening experience and that they are not due to disease or injury.

Discuss the types of counseling options that are available to the victim (e.g. individual, family, group, formal, informal support group).

Provide medication only in exceptional cases when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours.

Only when the victim’s physical state is unstable and is disrupting his/her every day functioning, should he/she be provided with one tablet of 5-10 mg of diazepam to be taken at bedtime, for a maximum of 3 days.

- If the initial counseling and treatment is provided by a medical doctor, the victim should be referred to a trained mental health professional for reassessment the next day. *If no such professional is available*, and if the severe symptoms continue, the treatment may be continued for a few days, ensuring daily assessments.

**Tips for encouraging counseling among male survivors of GBV**

- Explain that counseling and social support will help to facilitate recovery;
- Listen carefully to the history of the event, ask about his concerns and address them appropriately;
- Explain to him that he did not deserve to be sexually violated;
- Reinforce that the assault was not his fault; and
- Stress that sexual violence is an issue of power and control. *(Source: WHO, 2003)*
Preventing Pregnancy

□ Emergency contraceptive pill (ECP) should be provided to all female victims of sexual assault.

□ If the female victim of unprotected rape, including children, is being seen within less than 120 hours (5 days) of the incident, ECP must be provided, except with the informed refusal of the victim.
   – Women should be offered objective counseling on this method as to reach an informed decision.
   – If ECP is given after 72 hours, inform the patient that there is no guarantee that pregnancy will be prevented due to the efficacy of the pill beyond this period.
   – Progesterone only pills are the recommended ECP regimen. They are more effective than the combine estrogen-progesterone regimen and have fewer side effects.

□ There is no known contraindication to giving ECPs at the same time as antibiotics and post exposure prophylaxis (PEP) for HIV; however, the doses should be spread out and taken with food to reduce side-effects, such as nausea.

□ If the patient, including adolescents, wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her and prescribe this to start on the first day of her next period or refer her to another clinician that can prescribe contraceptives (e.g. nearest public health facility, personal family physician, Grenada Planned Parenthood Association).

□ If the patient is seen within 5 days of sexual assault occurring, and pregnancy is detected by the health care provider, make it clear to the woman or girl that the pregnancy cannot be the result of the rape.

□ A therapeutic abortion should be provided as an option for pregnancies resulting from sexual assault, if it is determined necessary to preserve the physical or mental health of the woman or girl, as well as, to save her life.
   – An evaluation of the patient MUST be conducted to determine the impact of the pregnancy on the physical and mental health of the patient, as well as risks to her life
   – Health care providers MUST NOT conduct a therapeutic abortion without the informed consent of the pregnant victim.
   – Section 250 of the criminal code protects the health care provider in these circumstances as it states, “Any act which is done, in good faith and without negligence, for the purpose of medical or surgical treatment of a pregnant woman is justifiable, although it causes or is intended to cause abortion or miscarriage, or premature delivery, or the death of the child.”

□ In cases involving children, parental consent is not needed to provide ECP, contraception to prevent future pregnancies, and therapeutic abortion. In cases where parent(s) wishes are in opposition to the child’s wishes, CPA should be contacted.

<table>
<thead>
<tr>
<th>Pregnancy Prophylaxis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard</strong></td>
</tr>
</tbody>
</table>
Alternative

- 100 mcg ethinyl estradiol + 1.5 mg levonorgestrel (1 pill 12 hours apart)

Effectiveness is 57%.

Notes: Prophylaxis is not needed if victim has IUD, tubal ligation, is taking and compliant with oral or vaginal contraceptive, or is menopausal. Repeat dose if victim vomits within 1 hour of taking ECP.

EMERGENCY CONTRACEPTIVE PILLS CANNOT PREVENT PREGNANCY RESULTING FROM SEXUAL ACTS THAT TAKE PLACE AFTER THE TREATMENT.

Preventing Sexually Transmitted Infections:

- Victims of rape should be given antibiotics to treat gonorrhea and other STIs endemic to Grenada. See table below for treatment regimens.

- WARNING: women who are pregnant should not take certain antibiotics, therefore, modify the treatment accordingly.

- Administer the shortest courses of prophylaxis available.

<table>
<thead>
<tr>
<th>STI Prophylaxis in Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
</tr>
<tr>
<td>N. Gonorrhea</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Chlamydia in pregnant</td>
</tr>
<tr>
<td>women</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>Syphilis in patient</td>
</tr>
<tr>
<td>allergic to penicillin</td>
</tr>
<tr>
<td>Trichomoniasis</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

STI Prophylaxis for children and adolescents
<table>
<thead>
<tr>
<th>Disease</th>
<th>Standard</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>N. Gonorrhea</td>
<td><strong>Ceftriaxone</strong>: single 125 mg intramuscular injection</td>
<td><strong>Spectinomycin</strong>: one 40mg/kg intramuscular injection (max 2g)</td>
</tr>
<tr>
<td>Chlamydia</td>
<td><strong>Azithromycin</strong>: 20mg/kg single oral dose</td>
<td><strong>Erythromycin</strong>: 500 mg/kg divided into 4 doses per day for 7 days</td>
</tr>
<tr>
<td>Chlamydia</td>
<td><strong>Erythromycin</strong>: 500 mg orally, 4X per day for 7 days</td>
<td><strong>Azithromycin</strong>: 1g orally, single dose</td>
</tr>
<tr>
<td>&gt;45kg but &lt;12 years old</td>
<td><strong>Erythromycin</strong>: 500 mg orally, 4X per day for 7 days</td>
<td><strong>Azithromycin</strong>: 1g orally, single dose</td>
</tr>
<tr>
<td>Syphilis</td>
<td><strong>Benzathine</strong>: 50,000 IU/kg single intramuscular injection (max 2.4 million IU)</td>
<td>Allergic to penicillin: <strong>Erythromycin</strong>: 50mg/kg (max 2g) orally, divided into 4 doses for 14 days.</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td><strong>Metronidazole</strong>: 5mg/kg orally, 3X per day for 7 days.</td>
<td></td>
</tr>
</tbody>
</table>

**Preventing HIV transmission**

Risk of HIV transmission increases if: there was more than one assailant, if the victim has torn or damaged skin, if the perpetrator is known to be HIV-positive, or an injecting drug user. Post Exposure Prophylaxis (HIV PEP) following sexual assault is not simple or straightforward. However, if patients meet the criteria for non-occupational exposure to HIV PEP, they can be provided with PEP that usually consists of 2 or 3 antiretroviral drugs. See table below for treatment regimes.

- If the status of the alleged perpetrator(s) is not known, assume they are HIV-positive.
- Provide PEP to patient, including children according to your assessment of risk of exposure (i.e. whether there was penetration, number of attackers, injuries sustained, etc.).
  - If risk for HIV is low, PEP treatment is not recommended unless there are compelling circumstances, such as strong patient desire for PEP after informed consent.
  - For children, parental consent is not required to provided HIV test or PEP. If parent(s) wishes are in opposition to that of the child victim, contact CPA.
  - Health care providers who find this morally objectionable are obligated to refer the patient to another health care provider within the same or different facility who can provide these services in a timely manner.
- If PEP is unavailable in your setting, refer victim immediately (within 72 hours of rape) to where it can be supplied.
  - However, the patient should still have HIV testing at the initial visit, with follow up testing at 6 weeks, 3months, and 6 months from the time of assault.
- If the victim presents after 72 hours, provide information on voluntary counseling and testing services (VCT) available (e.g. STI Clinic Day in Community Health Services facilities, GPPA, NIDCU).
- Victims who attend the emergency department should be referred to the National Infectious Disease Control Unit (NIDCU) for HIV counseling and testing.
- Testing should be done in the emergency department ONLY if the patient has an identified physician to whom the results will be sent and with whom that patient will have a scheduled appointment to discuss the results and arrange further follow-up testing.
- Victims, who attend Community Health Services on non-STI Clinic Days, should be referred to the STI Clinic Day, NIDCU, or GPPA for VCT.

☐ Children and adolescents should not be denied VCT for HIV in the absence of parental consent, including when they may have entered into a sexual relationship they consider consensual.

☐ The patient should be willing to continue 28 days of uninterrupted PEP therapy.

<table>
<thead>
<tr>
<th>HIV</th>
<th>Adults and adolescents &gt;40kg</th>
<th>Children (28 day regimen)</th>
</tr>
</thead>
</table>
| **Combivir** | (zidovudine/AZT 300mg and lamivudine 150 mg) 1X per day for 3 months | <2yrs or 5-9kg: zidovudine syrup (7.5 ml 2X/day) + lamivudine syrup (2.5ml 2X/day)  
10-19kg: zidovudine (100mg capsule 3X/day) + lamivudine (150mg, ½ tablet 2X/day)  
20-39kg: zidovudine (two 100mg capsules 2X/day) + lamivudine (150mg tablet 2X/day) |

**Preventing HTLV-I**

Risk of HTLV-I transmission increases if: there was more than one assailant, if the victim has torn or damaged skin, if the perpetrator is known to be HTLV-I positive, or an injecting drug user.

Soon after infection with HTLV-I the body will respond by producing antibodies to fight the infection. HTLV-I antibodies, which are produced only in response to HTLV-I infection and not to any other infection, can easily be detected in the laboratory but only if the specific test is done. HTLV-I causes a lifelong infection and the presence of these antibodies is proof of infection.

(Taylor, 2006)

☐ If the status of the perpetrator(s) is not known, assume they are HTLV-I positive.

☐ The victim should be giving the HTLV-I specific blood test to determine infection.
If the blood test is conducted soon after the sexual assault occurred, a follow-up test should be repeated three months later. This is because HTLV-I antibodies may not yet be present in the body if the incident just occurred.

If HTLV-I is suspected in pregnant or breastfeeding victims, advise discourage victim from breastfeeding as the virus can be transmitted from mother to child this way.

Refer victim to the National Infectious Disease Control Unit (NIDCU), if necessary.

THERE IS CURRENTLY NO TREATMENT FOR HTLV-I

**Preventing Hepatitis B**

If rape occurred, the victim should receive hepatitis B vaccine within 14 days of the incident.

*If already vaccinated*, no additional doses of the hepatitis B vaccine need to be given. Prior HBV vaccination should be confirmed on vaccination card.

HBV may be given at the same time as the tetanus vaccine, and is safe for pregnant women and persons with chronic or previous HBV infection.

Give vaccine intramuscularly either in the deltoid (adults) or anterolateral thigh (infants and children). Do not administer into the buttock as it is less effective.

**THE USUAL VACCINATION SCHEDULE IS 0, 1, AND 6 MONTHS.**

**Step 5: Follow-up care**

All victims of domestic violence and sexual abuse should be given an appointment and encouraged to return to see the health care provider in 1-2 weeks and 6-9 weeks for a follow-up evaluation.

For adult, encourage the patient to return to the health facility at any time if he/she notices any clinical signs or symptoms of a disease or she recognizes signs or symptoms of pregnancy.

For children in protective care, encourage CPA to bring the child back to the health care provider for follow-up care and treatment, whether or not the child is still living at home or in the care of the state.

**At follow-up (for all victims):**
☐ All victims should be evaluated and treated for injuries obtained at the time of the incident and for any subsequent injuries.

☐ Evaluate psychological health and emotional status; refer or provide counselling and treatment as needed.

☐ Reiterate that abuse is a crime, that he/she is not alone, and that it was not his/her fault.

☐ Provide patient with list of community resources again, if necessary; refer to proper agencies.

☐ Give clear advice on additional follow-up care needed.

For victims of sexual abuse:

☐ Evaluate for pregnancy and provide counselling as needed.

☐ Check that the patient has taken full course of any medication given for STIs/HIV, and/or administer follow-up doses of treatment.

☐ If prophylactic antibiotics were not given, evaluate for STIs and provide advice on HIV and HTLV-1 testing; provide treatment and counselling as needed.

☐ If patient was given PEP for HIV, evaluate adherence and side effects of drug regimen.

**Medico-legal Evidence Procurement and Storage Procedures**

☐ The victim is the crime scene; collect everything.

☐ **Victim taking legal action:** if the victim has made the decision to take legal action against the perpetrator, evidence related to the assault should be collected and labeled to ensure that it can be used in a court of law.

☐ **Victim not taking legal action:** If the victim has not made a decision about taking legal action at the time, encourage the patient to allow the collection of forensic evidence which will be stored in the event that he/she chooses to take legal action at a later date.
**Chain of Custody in Grenada**

- **STEP 1:** Specimens are collected by Health Care Professional wearing gloves throughout the examination, and in the presence of a police officer, if necessary.

- **STEP 2:** All exhibit envelopes and packages should be sealed and labeled then returned to the Rape Kit/Evidence Box.
  - NEVER lick an envelope to seal it.
  - Close any bags/envelopes that are not self-sealing with tape (e.g. clothing collection bags). DO NOT use staples.
  - For Rape Kits, return used and unused component to the Rape Kit. If a particular collection is not made, indicate such by writing on the appropriate envelope and ALWAYS document the reason why the specimen is not collected.

- **STEP 3:** The Rape Kit/Exhibit Box is sealed by the health provider conducting the examination.

- **STEP 4:** The Rape Kit/Exhibit Box is given to the accompanying police officer who delivers the Kit to the laboratory.

- **STEP 5:** The seal on the Rape Kit/Exhibition Box is to be broken only by the laboratory technician who verifies and signs for the content of the Rape Kit/Exhibition Box. Doing otherwise will call into question the integrity of the specimens in the Kit/Box.

- **STEP 6:** Clothing collected as evidence is not included as part of the Rape Kit, and is collected and stored with the police rather than the hospital. Chain of custody outlined above MUST be followed for delivery to the designated Police storage facility and personnel.

- **STEP 7:** The Evidence MUST be signed in and out for every time the evidence moves (i.e. from the laboratory to the court, back to the laboratory) it must be signed in and out.
  - Limit the number of persons who handle the evidence to preserve the chain of custody.
  - If specimens are requested for use in court, a laboratory technician is required to accompany the specimens to maintain chain of custody. More often, laboratory reports on the results of the tests conducted are used in court.

- **STEP 8:** DNA testing, which is primarily conducted in Trinidad and Barbados, MUST be routinely conducted and chain of evidence must be followed.

---

*IF THERE IS A CONVICTION, THE COURT DECIDES WHAT HAPPENS TO THE EVIDENCE. IF NO PERPETRATOR IS CAUGHT, EVIDENCE IS KEPT IN POLICE CUSTODY. RAPE IS A FELONY, AND A PUBLIC PROSECUTOR IS ALWAYS INVOLVED.*
**Photographing Evidence:**

- Inform the patient of the legal benefits of photographing injuries (i.e. provides supplementary evidence to medical documentation), and OBTAIN CONSENT.

- If there is police involvement, a Police Photographer at the Police Station should photograph the evidence at the time the victim is reporting to the Police. If a Police Photographer is unavailable, the attending health provider at the health facility should photograph the victim’s injuries.

- If the police are not involved, follow the guidelines below for obtaining photographic evidence:
  - Obtain patient’s consent to take photographs of the injuries.
  - When photographing the injury, begin with an “orientation” photo; for example, the entire arm, leg, etc.;
  - Take two sets of photo for each injury.
  - Offer the patient a copy of the photos;
  - Keep the other set in the patient’s file; and
  - Sign each photo on the back including the patient’s name, date of birth, health facility name, and date. Photograph should also be signed by the victim.

**ALTHOUGH PHOTOGRAPHIC EVIDENCE TAKEN BY A HEALTH PROFESSIONAL IS NOT ADMISSABLE IN A COURT OF LAW, THE PHOTOGRAPH IS AN IMPORTANT AID TO REMIND THE HEALTH PROFESSIONAL AND VICTIM AS TO THE EXTENT OF THE INJURIES SUSTAINED BY THE VICTIM AT THE TIME OF THE INCIDENT.**

**Sample Collection and Storage**

Evidence collection begins with the Health Care Professional. Physical and/or genital trauma, as well as, torn or stained clothing may be useful to prove that physical force was used. Foreign materials found on the clothes, body or hair may corroborate the victim’s story.

DNA analysis can be done on material found on the survivor’s body or at the location of the assault, which may be soiled with blood, sperm, saliva or other biological material from the assailant, as well as on swab samples from bite marks, semen stains, and fingernail scrapings.

- Obtain consent prior to collecting any samples for the victim.
- Every sample obtained as MUST be LABELED, SEALED, SIGNED and handed over to the Police who then SIGNS UPON RECEIPT.
  - INJURY EVIDENCE: physical and/or genital trauma should be documented and recorded on pictograms (see page 53) and stored as part of the victim’s medical records.
  - CLOTHING: Torn or stained clothing should be collected. Use paper bag, NOT plastic to store clothing. If clothing evidence is wet and cannot be fully dried before packaging, report this to the police officer when evidence is picked up. If saturated, place in an open plastic bag inside the paper bag. Notify law enforcement of the wet articles.
  - If clothing cannot be collected (e.g. replacement clothing is not available) state the reason, and describe and record the condition of the clothing.
FOREIGN MATERIALS: Soil, grass, leaves, hairs, fingernail scrapings, etc may be found on clothes, body, or in hair.
- Foreign hairs should be collected by combing or gathering loose hairs.
- Foreign body specimens such as pubic hair, vaginal debris and finger nail scrapings should be collected in a plastic bag, sealed and handed over to the police if the victim wants to pursue the case.
- SPERM AND SEMINAL FLUID: swabs may be taken from the vagina, anus, or oral cavity. If penetration took place in these locations, look for the presence of sperm and for prostatic secretions.
  i. Vaginal swab should be conducted from posterior fornix.
  ii. Anal specimens should be collected using an anoscope.
- VICTIMS DNA: Blood from the victim should be collected to allow his/her DNA to be distinguished from any foreign DNA found on the victim’s body or location of the assault.
- Blood or urine may be collected for toxicology testing if the patient was drugged, or to determine whether the victim may have been drugged.

☐ Rape kit with the samples collected MUST be brought to the Laboratory within 48 hours of collection, where the contents of the kit are VERIFIED by the lab and SIGNED FOR by the same Laboratory technician.

☐ Ideally, the lab evaluates samples within 72 hours of collection, and stores samples at an appropriate temperature in incubator, refrigerator or freezer based on the types of samples. Sperms have been found in volunteers fully or fragmented up to 18 hours post rape but rarely after 72 hours.

☐ For lab tests that cannot be conducted in Grenada, the victim’s doctor may make a request for samples to be tested in Trinidad or Barbados.

☐ Hospital laboratory will store medical/forensic specimen until required for use as evidence.

**COMPLETED RAPE KIT MUST NEVER BE LEFT UNATTENDED.**
Self-care for the Health Care Provider

There are three components to self-care for the health care professional: personal safety, self-care, and setting realistic expectations for interventions.

It is crucial that attending health care providers be aware of personal safety issues when assisting victims of domestic violence.

It is important to acknowledge that providing support to victims of domestic violence often triggers personal feelings and attitudes about domestic violence. Common feelings range from disbelief to rage to helplessness to frustration. It is important to talk about these feelings with colleagues or your supervisor. Sometimes these reactions are in response to personal experiences of having lived with violence.

The following guidelines should be adhered to by all health care providers:

**Personal Safety**
- Do not confront perpetrator.
- Do not place yourself physically between arguing people.
- Police or security should be notified if the perpetrator, parent/guardian/caregiver in case of children, or other person(s) accompanying the victim becomes violent or disruptive.
- When the perpetrator is present in the room with you, position yourself so that a quick exit is possible, especially if you sense hostility.
- To avoid threats or harassment from perpetrator(s), health facility staff should never release over the telephone or in person, the home phone, address, or shift schedule of any staff members.

**Self-care**
- Health care workers MUST be counseled and/or debrief individually or in groups after being exposed to cases of GBV, to help maintain good mental health. Debriefing and problem-solving should be done regularly, and can be done through staff meetings with colleagues.
- Based on the extent of the situation and impact on the health care provider, crisis intervention may be used as a coping strategy.
- If you are living in an abusive situation, seek support from a trusted friend, colleague, family member or community agency (see Helpful Contact Information on page 39).
Recommendations

Based on the existing health care system, legislation and policies in Grenada at the time of developing this SOPs document, several recommendations are made in effort to ensure that the SOPs remain a useful working document that can keep up or anticipate the health services needs of victims of GBV, as well as the needs of the health care professionals who attend to their needs. Recommendations are made in the following areas:

Training

1. Health care providers should be provided with an initial orientation to GBV, including policies and legislation, and given an opportunity to further their education and training (e.g. short courses), and participate in quality control and peer review processes on the topic.

2. The continuous training of health care providers in routinely screening for GBV among different population groups, as well as training to meet the needs of specials groups during the medico-legal examination.

3. Whenever possible, training in the actual clinical environment should occur, utilizing providers experienced in the care of children and adolescents who have experienced sexual violence and exploitation.

4. Other sectors involved in the care and support of victims should also be invited to participate in training sessions with health care providers, to develop a more comprehensive understanding of the care and protection of victims of GBV.

5. Ensure that both male and female nurses and physicians are available whenever possible, and are encouraged to receive training in the care of victims who have experienced GBV, especially children experiencing sexual abuse.

6. Training should include correct and timely completion of the various Forms.

Monitoring

A GBV working group should be created to monitor GBV activities and intervention, including implementation of the SOPs.

Data on incidence of GBV and should be submitted by the various institutions/agencies (e.g. Gender-Based Violence Unit, Ministry of Health, Child Protection Authority, and the Royal Grenada Police Force) to the GBV working group for compilation of a monthly report containing non-identifying data on reported incidents, action taken, and outcomes across sectors.
The GBV working group should compare monthly GBV reports over time and discuss and analyse information about GBV incidents, general outcomes, security issues, referral and coordination issues, and other factors.

The data elements to be included in this report are:
- Number of incidents per 10,000 population in total and by type of incident (case definition)
- Number or percentage of incidents (by type of incident) by:
  i. Time of day (morning, afternoon, evening, night)
  ii. General location (keeping in mind that if location is too specific, it may identify a victim)
  iii. Victim age, marital status, other demographic information
  iv. Perpetrator relationship to victim
  v. Number of perpetrators
  vi. Perpetrator age, other demographic information
  vii. Services received, referrals made, actions pending
  viii. Outcomes

Qualitative information about GBV incidents should be reported, including results of focus group discussions, rumours of GBV incidents, community perceptions of risky areas or suspicious activities, and any issues that may be recognized or suspected.

There will be at least one outcome indicator for response and one indicator for prevention developed, shared, and monitored for each sector (at minimum, health, legal/justice, psychosocial, and safety/security) and each cross-cutting function (e.g., coordination).

The GBV coordinating agencies should produce a written report (at least bi-annually) based on the quantitative and qualitative data, that is shared with members of the GBV working groups and others (carefully consider ethical and safety implications when determining how widely to share this information). The report will identify issues, and actions undertaken to address these issues.

Data collection, analysis and information sharing resulting from monitoring will guide the continuous development of prevention and response actions.

Protocols for medication specified in this SOP will be updated or otherwise adjusted in accordance with developments in medicinal drugs and procedures as determined by the Ministry of Health.
References


APPENDICES

APPENDIX A: Signature Page for Participating Actors

All participating agencies and groups mentioned in the document demonstrate, with a signature, their commitment to the SOPs.

We, the undersigned, as representatives of our respective organizations, agree and commit to:

- abide by the procedures and guidelines contained in this document;
- fulfil our roles and responsibilities to prevent and respond to GBV;
- provide copies of this document to all incoming staff in our organizations with responsibilities for action to address GBV so that these procedures will continue beyond the contract term of any individual staff member;

List of all the organisations/groups who participated in the process of developing these SOPs.

<table>
<thead>
<tr>
<th>Organization or Group Name</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B: Quick Reference Guide for Health Care Providers

NOTE: This guide is a supplement to the standard operating procedure and only serves as a reminder. It is essential that all health care providers familiarize themselves with the details of the Standard Operating Procedure (SOP) to ensure a consistent and appropriate response.

Five Aspects of Care:

- Screening/identification—Example screening questions:
  - “I’m concerned about how you got these injuries. Did someone do this to you?”
  - “We often see injuries or symptoms like yours when a patient has been hurt by her/his partner. Has this happened to you?”

- Assessment/examination
  - Attend to immediate medical needs
  - Ask the patient whether they object to having their injuries reported to the police. If patient does not object, inform the police. **NOTE: It is required by law that the abuse be reported to the police if the patient is under 18 yrs or has obtained a gunshot wound, knife wound, or other serious bodily injury.**
  - Perform medical examination
  - Preserve physical evidence and document.
  - Pursue a treatment plan

- Documentation
  - Be objective and accurate. Use the patient’s own words when documenting.
  - Record the injuries on a body map. Include bruises, scratches, restraint marks, cuts, shearing, etc.
  - Record any inconsistencies between patient’s explanation of how injury was sustained and medical findings

- Safety Assessment and Planning
  - Assess safety
  - Provide assistance developing Emergency Escape Plan

- Referral
<table>
<thead>
<tr>
<th>DO</th>
<th>DO NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Ask all women about abuse/violence in routine assessment &amp; treatment</td>
<td>X DO NOT blame or shame the patient</td>
</tr>
<tr>
<td>✓ Interview the patient alone</td>
<td>X DO NOT minimize her experience</td>
</tr>
<tr>
<td>✓ Convey that you believe the patient</td>
<td>X DO NOT IGNORE the disclosure of abuse</td>
</tr>
<tr>
<td>✓ Convey an attitude of concern and respect</td>
<td>X DO NOT align yourself with the abuser</td>
</tr>
<tr>
<td>✓ Assure patient that the encounter is confidential</td>
<td>X DO NOT ask, “Why don’t you leave?”</td>
</tr>
<tr>
<td>✓ Let her know that abuse is a crime, that she is not alone, and that it is not her fault.</td>
<td>X DO NOT make decisions without the patient’s knowledge or consent.</td>
</tr>
<tr>
<td>✓ Assess immediate safety of patient and develop safety plan with the patient</td>
<td>X DO NOT express feelings of frustration or helplessness to the patient.</td>
</tr>
<tr>
<td>✓ Provide patient with list of community resources; refer to proper agencies</td>
<td>X DO NOT make excuses for the abuser (e.g. “Your partner is probably under a lot of stress”)</td>
</tr>
<tr>
<td>✓ Document information on patients charts and complete Documentation Form</td>
<td></td>
</tr>
</tbody>
</table>
Emergency and Community Resource Contact Information

RESOURCES GUIDE

GRANADA

- Emergency (911)
- RGFP Community Relations Department (440-3764)

Hospitals
- General Hospital (440-2051)
- Princess Alice Hospital (440-5400)
- Princess Royal Hospital (443-7400)
- Mt. Gay Mental Hospital (440-2485)
- St. Augustine Medical Hospital (440-6173)

Ministry of Social Development, Domestic Violence Unit
- St. George’s Main office, Ministerial Complex (440-2269; 440-7952)
- St. David Sub-Office, Petite Esperance (439-2269)
- St. Andrew Sub-Office, Grenville (438-2269)
- St. Patrick Sub-Office, Sauteurs (442-2269)
- St. John/St. Mark Sub-Office, Victoria (437-2269)

Child Protection Authority (435-0293)
Grenada National Organization of Women (GNOW) (440-6257)
Legal Aid & Counseling Clinic (LACC) (440-3788/85)
Grenada Community Development Agency (GRENCODA) (444-3480; 444-9490)
Psychological Services, St. George’s University (439-2277)
Grenada Planned Parenthood Association
  - St. George’s Clinic (440-3341)
  - Grenville Clinic (442-5442)
Ministry of Carriacou & Petit Martinique Affairs
  (443-7280)
Student Support Services, Ministry of Education
  (440-2737; 440-1335)
Grenada National Council for the Disabled (440-0112)

Health Centres
- The Esplanade, St. George (440-3371)
- Gouyave, St. John (444-8414)
- Grand Bras, St. Andrew (442-7623)
- Sauteurs, St. Patrick (442-9317)
- St. David (444-6249)
## APPENDIX C: ‘Top-to-Toe’ Examination

<table>
<thead>
<tr>
<th>STEP</th>
<th>Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>First note the patient’s general appearance and demeanour. Start with the patient’s hands; this will reassure the patient. Take the vital signs, i.e. pulse, blood pressure, respiration and temperature. Inspect both sides of both hands for injuries. Observe the wrists for signs of ligature marks. Trace evidence may need to be collected (some jurisdictions require fingernail scrapings).</td>
</tr>
</tbody>
</table>
| Step 2 | Inspect the forearms for defence injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body. Defensive injuries include bruising, abrasions, lacerations or incised wounds.  
In dark skinned people bruising can be difficult to see, and thus tenderness and swelling is of great significance. Any intravenous puncture sites should be noted. |
| Step 3 | The inner surfaces of the upper arms and the armpit or axilla need to be carefully observed for signs of bruising. Victims who have been restrained by hands often display fingertip bruising on the upper arms. Similarly, when clothing has been pulled, red linear petechial bruising can sometimes be seen. |
| Step 4 | Inspect the face. Black eyes can be subtle. Look in the nose for signs of bleeding. Gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising. The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa. Petechiae on the hard/soft palate may indicate penetration. Check for a torn frenulum and broken teeth. Collect an oral swab, if indicated. |
| Step 5 | Inspect the ears, not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp. Use an otoscope to inspect the eardrum. |
| Step 6 | Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of haematomas. Hair loss due to hair pulling during the assault may cause large amounts of loose hair to be collected in the gloved hands of the examiner; alternatively, a gentle combing may recover any loose hair. Electrostatic forces can, however, cause large amounts of loose hair to be retained in the head until the patient next takes a shower or bath. |
| Step 7 | The neck area is of great forensic interest. Bruising on the neck can indicate a life-threatening assault. Imprint bruising may be seen from necklaces and other items of jewellery on the ears and on the neck. Suction-type bruising from bites should be noted and swabbed for saliva before being touched. |
| Step 8 | The breasts and trunk should be examined with as much dignity and privacy as can be afforded. It is generally most convenient to start with the back. It is possible to expose only that area that is being examined; for example, the gown may be taken aside on the right side of the back and then the left side of the back. The shoulders should be separately viewed. Subtle bruising and more obvious bruising may be seen in a variety of places on the back. If the patient is able to sit up on the couch, the gown can be taken down to the upper breast level just exposing the upper chest on the right and left and then each breast can be examined in turn. Breasts are frequently a target of assault and are often bitten and so may reveal evidence of suction bruises or blunt trauma. If the breasts are not examined, the reasons for not doing so should be documented. |
| Step 9 | The patient can then be reclined for an abdominal examination, that is to say an inspection for |
| Step 10 | With the patient still in a reclined position, the legs can be examined in turn, commencing with the front of the legs. Inner thighs are often the target of fingertip bruising or blunt trauma (caused by knees). The pattern of bruising on the inner thighs is often symmetrical. There may be abrasions to the knee (as a consequence of the patient being forced to the ground); similarly, the feet may show evidence of abrasions or lacerations. It is important to inspect the ankles (and wrists) very closely for signs of restraint with ligatures. The soles of the feet should also be examined. |
| Step 11 | It is advisable, if possible, to ask the patient to stand for the inspection of the back of the legs. An inspection of the buttocks is also best achieved with the patient standing. Alternatively, the patient may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock. The latter method may be the only option if the patient is unsteady on her feet for any reason, but does not afford such a good view of the area. Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibres, grass, soil). |

Source: WHO, 2003
APPENDIX D: Body Mapping
APPENDIX E: Domestic Violence and Sexual Abuse Health Care Provider Response Flowchart

First Contact: Screen for Abuse

- No disclosure of abuse; strong suspicion of abuse
  - Provide further opportunity for disclosure
  - No Disclosure
  - Disclosure

- Abuse disclosed
  - Acknowledge the disclosure of abuse
  - Tend to the patient’s immediate needs
  - Discuss Police involvement **
  - Perform Medical Examination (ensure female support person present especially with victims of sexual abuse)
  - Documentation:
    - Be objective--use patient’s own words; record injuries on body map; record any inconsistencies between explanation and medical findings
  - Preserve physical evidence and document (e.g. photos, semen and hair samples, etc.)
  - Pursue appropriate treatments for the patient
  - Conduct safety assessment and planning
  - Provide written materials (if safe to bring them home) and referral

- No disclosure of abuse; no suspicion
  - Proceed with routine medical history

**Required by law to report abuse for patients under 18 and those persons who have obtained a gunshot wound, knife wound, or other serious bodily injury.

**For elderly and mentally incapable adults who are incompetent to provide informed consent, the Health sector policy encourages reporting of suspected or disclosed cases of domestic and sexual abuse to the police.
APPENDIX F: Medical Informed Consent/Assent Form for Domestic Violence and Sexual Abuse

NAME OF FACILITY: _____________________________________________

Note: After providing the relevant information to the patient, read the entire form to him/her (and parent or guardian for child patient). Explain that they can choose to refuse any (or none) of the items listed. For adult patient, obtain patient’s signature as well as that of a witness. For child patients or those who may be competent to fully give consent, obtain relevant assent/consent from patient, parent/guardian/caregiver, as well as that of a witness (see Table x, page x).

___________________________________________________ (Print health provider’s name) has explained to me the procedures of examination, evidence collection and release of findings to the police and/or the courts.

I, _____________________________________________ (print name of patient) understand that I can refuse any aspect of the examination I don’t wish to undergo.

I, _____________________________________________ (print name of patient) authorize the above-named facility to perform the following (tick the appropriate boxes):

<table>
<thead>
<tr>
<th>Check each that applies</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a medical examination to diagnose any medical problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct examination of the genitals, including pelvic examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conduct examination of the anus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect specimens in case of criminal investigation (such as collection of clothing, hair combing, scrapings or cuttings of fingernails, body fluid or blood samples)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide specimens, test results, and verbal or written report to the police or other investigators and/or the courts (limited to the results of this examination and any relevant follow-up care provided).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient’s Signature:                                                                                     _________________________________

Parent/guardian/caretaker’s signature:                                                                      _________________________________

Witness signature:                                                                                       _________________________________

Date:                                                                                                        _________________________________
APPENDIX G: Confidentiality Agreement for Domestic Violence and Sexual Abuse Medical Services

Formal Statement of Confidentiality

"I respect the concerns that you may have about the privacy of the material that you share with your health provider. This information will be held in strictest confidence and no health care provider or other support service provider (e.g. police, court, social services and counselors, etc) who are not directly involved in your care, has access to information about you. Nothing will be released to third parties without your signed consent, except where required by law or professional ethics. Health providers are required by law to report disclosed or suspected abuse for patients under 18 and those persons who have obtained a gunshot wound, knife wound, or other serious bodily injury. Health policy requires health providers to discuss concerns regarding all cases suspected or disclosed abuse to their District Medical Officer, who will be obligated to report it to the Domestic Violence Unit in the Ministry of Social Development, or the appropriate regulatory body. If the matter is taken to court, and I am summoned as a witness, I am obligated by law to disclose information relevant to your cause. Breaches of confidentiality beyond the limits of this agreement can be reported to the Ombudsman, and may result in disciplinary action taken against the health provider."

Health Provider signature:  _________________________________________________

Patient’s Signature:  _________________________________________________

Parent/guardian/caretaker’s signature:  _________________________________________________

Date:  _________________________________________________

PRINT APPENDICES F & G AS A DOUBLE-SIDED FORM
APPENDIX H: Domestic Violence and Sexual Abuse Medical Documentation Form

Name of Facility: _________________________________

General Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Date of Birth</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date/time of examination</th>
<th>In the presence of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Police involvement prior to arrival</th>
<th>Yes</th>
<th>No</th>
<th>Officer’s Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the cases of a child or persons with disability: include name of parent/guardian/caregiver and relationship to child

The Incident

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Time of incident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Full name of alleged perpetrator</th>
<th>Relationship of alleged perpetrator to victim (specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Description of incident (victim’s description, including what the victim did after the incident)

<table>
<thead>
<tr>
<th>Physical abuse</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Description and location on body</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Type (kicking, hitting, pushing, choking, burning, withholding food/medical attention, etc) | |
|------------------------------------------------------------------------------------------|
|                                                                                         |

<table>
<thead>
<tr>
<th>Use of restraints</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of weapons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual abuse</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
<th>Description and location (oral, vaginal, anal, other, type of object)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Type (forced/unwanted touching or sexual acts, forced prostitution, control over sexuality, etc.)

Penetration
Penis, finger, other (specify)

Ejaculation

Condom used

Emotional Abuse
Yes  No  Not sure  Description

Type (name calling, use of intimidation, yelling/shouting, homicidal threats, suicidal threats, restricting contact with family/friends, other (specify))

Economic Abuse
Yes  No  Not sure  Description

Type (withholding money, taking money, complete control of financial decisions, other (specify))

---

Medical History

Existing Health Problems

Social History

Allergies

Current medications

Menstrual/Obstetric History:

Contraception Use at time of event (check all that apply):

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>Implant</td>
</tr>
<tr>
<td>IUD</td>
<td>Condom</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Other</td>
</tr>
</tbody>
</table>

THE FOLLOWING TABLE SHOULD BE USED FOR VICTIMS OF SEXUAL ABUSE; IF THE NATURE OF THE ABUSE WAS NOT SEXUAL, SKIP TO THE MEDICAL EXAMINATION SECTION.

History of consenting intercourse (only if samples have been taken for DNA analysis)

Last consenting intercourse within a week prior to the assault

Date:

Name of individual:

Past History of Abuse:  (describe: When was the first time? How long has it been happening? Who did it? Number of perpetrators? Is the person still a threat? Also ask about bleeding from the vagina or the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, any other signs or symptoms – use appended blank sheet if necessary.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>After the incident, did the victim</td>
<td>Yes</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Vomit?</td>
<td></td>
</tr>
<tr>
<td>Urinate?</td>
<td></td>
</tr>
<tr>
<td>Defecate?</td>
<td></td>
</tr>
<tr>
<td>Brush Teeth?</td>
<td></td>
</tr>
<tr>
<td>Rinse mouth?</td>
<td></td>
</tr>
<tr>
<td>Change clothing?</td>
<td></td>
</tr>
<tr>
<td>Wash or bathe?</td>
<td></td>
</tr>
<tr>
<td>Use tampon or pad?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Vaccinated</th>
<th>Not Vaccinated</th>
<th>Unknown</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS status</td>
<td>Known</td>
<td></td>
<td>Unknown</td>
<td></td>
</tr>
</tbody>
</table>

**Medical Examination**

<table>
<thead>
<tr>
<th>Weight</th>
<th>Height</th>
<th>Blood Pressure</th>
<th>Temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse Rate</td>
<td>Respiratory Rate</td>
<td>Pubertal Stage (pre-pubertal, pubertal, mature)</td>
<td></td>
</tr>
</tbody>
</table>

Appearance (clothing, hair, obvious physical or mental disability)

Mental State (communicative/non-communicative, calm, agitated, fearful, withdrawn, apprehensive, crying, anxious, cooperative, minimizing illness/injury, depressed, suicidal ideations, etc.)

Physical Findings (indicate as accurately as possible ALL injuries sustained: systematically record type, shape, size, form, color, and exact location of all wounds, bruises, petechiae, marks, etc. Be descriptive, do not interpret the findings. Draw/record all injuries on attached body maps)
<table>
<thead>
<tr>
<th>Head and face</th>
<th>Mouth and nose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes and ears</td>
<td>Neck</td>
</tr>
<tr>
<td>Chest and breasts</td>
<td>Back</td>
</tr>
<tr>
<td>Abdomen</td>
<td>Buttocks</td>
</tr>
<tr>
<td>Arms and hands</td>
<td>Legs and feet</td>
</tr>
</tbody>
</table>

**Genital and Anal Examination**

<table>
<thead>
<tr>
<th>Vulva/scrotum</th>
<th>Introitus and hymen</th>
<th>Anus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vagina/penis</td>
<td>Cervix</td>
<td>Bimanual/rectovaginal exam</td>
</tr>
</tbody>
</table>

Position of patient (supine, prone, knee-chest, lateral, mother’s lap)

For genital examination  | For anal examination

**Investigations Done**

<table>
<thead>
<tr>
<th>Type and location</th>
<th>Examined/sent to laboratory</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Treatment Prescribed

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
<th>Type and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus prophylaxis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI prevention/treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-exposure prophylaxis for HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Counseling, Referrals, Follow-up

- Victim plans to report OR has already made report __Yes__ __No__
  (note: required by law to inform police in cases of children or serious bodily harm)

- Victim has a safe place to go __Yes__ __No__
  Has someone to accompany her/him __Yes__ __No__

#### Referrals made & Information provided/options discussed

- Social work consult
- Police
- Ministry of Social Development
- Legal Aid and Counseling Clinic
- Shelter
- Other (Specify) ___

- Affirmed patient is not to blame for the abuse
- Provided written materials on domestic violence and/or sexual abuse
- Provided emergency and other related phone numbers
- Contacted police if not done so at time of care
- Contacted family member or friend
- Contacted Ministry of Social Development
- Discussed securing personal documents in a safe place (e.g. passport(s), birth certificates(s), address book, health information, etc.)
- Other (specify) ___

### Follow-up required:

- ___

### Date of Next Visit:

- ___

### Name of Physician providing care: ________________________ Signature ________________________

### Name of Nurse providing care: ___________________________ Signature ___________________________
APPENDIX I: Domestic Violence and Sexual Abuse Safety Assessment Form

Name of Facility: _________________________________

Safety Assessment

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was there use or threat of a weapon?</td>
<td>Has there been a history of abuse in the relationship?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the abuse increased in frequency or severity?</td>
<td>Is the abuser presently in the home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you perceive your living arrangements unsafe to return?</td>
<td>Was police intervention needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you planned or attempted suicide?</td>
<td>Is anyone else aware of the abuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have the children ever been threatened or hurt? ** Verify law for elderly and persons with disability</td>
<td>Did the abuse start or escalate during pregnancy?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Safety Rating:
- If “yes” to any of the questions in column A, share concern with patient and assist in developing a safety plan (e.g. staying with family, friend, or shelter)
- If “yes” to any of the questions in column B, explore options, provide emergency numbers, referral, and written information.

**Where child abuse is disclosed, the health care provider is required by law to report the case to the police and/or the Child Protection Authority.

Name of Social Worker/Health Care Provider: ________________________________

Signature of Social Worker/Health Care Provider: ________________________________
**APPENDIX J: Mandatory Reporting Form**

**Written Confirmation of Mandatory Reporting for Sexual Violence: Medical Professional**  
*(for Children, the elderly, and persons mentally incapable of providing consent)*:

NOTE: Health care professionals engaged in examination, care and treatment of persons, are required by Law and/or Policy (section 27 of the Child Protection Act of 2010; Section 182 of the Criminal Code (Amendment) of 2012; National Child Abuse Protocol of 2011) to protect the above category of vulnerable persons, if they acquire information that causes them to reasonably suspect the person is in need of protection. Reporting to the appropriate authority should be done within 48 hours of the initial report to the health professional. Forms pertaining to (1) Children should be sent to the Director of Child Protection Authority; and (2) Other Persons should be sent to the Gender-Based Violence Unit.

**Name of Patient:** ____________________________________________________________

Sex: ___________________ Age: ___________________

Address: _____________________________________________________________________

Parent’s/Guardian/Caregiver’s Name: ____________________________________________

Address: _____________________________________________________________________

Nature of patient’s condition:

Evidence of previous suspected abuse(s):

Plan of action for patient upon leaving the health facility:

Remarks:

<table>
<thead>
<tr>
<th>Person presumed to have caused abuse:</th>
<th>____ Father  ____ Mother  ____ Stepfather  ____ Sibling  ____ Child  ____ Caregiver  Other: ________</th>
</tr>
</thead>
</table>

**PERSON MAKING REPORT**

<table>
<thead>
<tr>
<th>Type of health professional (e.g. Attending physician, Surgeon, Dentist, Nurse):</th>
</tr>
</thead>
</table>

Name: ________________________________________________

Medical Facility: ___________________________________

Address: _________________________________________

Date: _____________________________________________

Health Professional Signature: ________________________

ACKNOWLEDGEMENTS

The Ministry of Social Development and Housing and the Ministry of Health and Social Security acknowledge the work of the Division of Gender and Family Affairs, in particular, the Gender-Based Violence Unit, in leading the process of developing the SOP.

The Ministers and Permanent Secretaries of the Ministries express appreciation for the contributions of the persons, institutions and organizations involved in crafting and developing the Health Care Sector Standard Operating Procedures on Gender Based Violence.

Technical and Financial Support was received from Pan American Health Organisation (PAHO) and United Nations Trust Fund to End Violence against Women (UNTF). Special thanks to the PAHO Country Programme Specialist of Grenada for her support.

Thanks are extended to the persons who drafted the SOP: Ms Tamar Atzenhoefer, Intern, Master’s in Public Health, St George’s University, for the initial research and drafting; and Dr Tonia Frame, Public Health Consultant, for conducting consultations and training sessions and finalization of the SOP.

Technical and Administrative Staff of many Government Ministries and Departments, civil society organisations and faith-based Organisations participated in consultations, meetings, interviews and review sessions. Appreciation is expressed for their contribution, time and commitment to the process.

List of Agencies/Organisations that Participated in Consultations, Interviews and Review Sessions

Ministry of Health
  - Chief medical Officer
  - Chief Nursing Officer
  - Director of Hospital Services
  - Administrative Staff
  - Director of Accidents and Emergency Department, General Hospital
  - Hospital Administrator
  - Princess Alice Hospital Administrative Staff (Mirabeau)
  - Princess Royal Hospital Administrative Staff (Carriacou)
  - Director of Nursing Services
  - Community Nurses
  - District Medical Officers

Ministry of Social Development
  - Counselling Unit
- SEED Unit
- Division of Social Services
- Division of Gender and Family Affairs

Other Government Ministries, Departments and entities
- Office of the Prime Minister
- Ministry of Education
- Ministry of Legal Affairs
- Royal Grenada Police Force
- Central Statistical Office
- Child Protection Authority

Civil Society Organisations
- Legal Aid and Counselling Clinic
- Grenada National Organisation of Women
- Grenada National Coalition on the Rights of the Child
- Grenada Association of Professional Social Workers

Faith Based Organisations