Ministry of Health
Vanuatu Government

Standard Operation Procedures

Clinical Management of Rape Sexual Violence and Gender-based Violence

Spotlight Initiative
To eliminate violence against women and girls

Table of Contents

Foreword

I am happy to launch this first ever Standard Operating Procedure (SOP) for the clinical management of Sexual and Gender-based Violence (SGBV) that will apply to all health facilities in Vanuatu. This is the first SOP developed by the Ministry of Health as a guide to ensure proper processes and documentation are followed in response to SGBV. The SOP contributes to the overall vision of the Ministry of Health, "A healthy, prosperous and sustainable Vanuatu in which all people, especially women, children, young people, people with disability and other vulnerable groups, and those living in rural areas, enjoy a high quality of physical, mental, spiritual and social well-being through equitable access to affordable and quality health care".

The SOP presents clear procedures, roles and responsibilities for healthcare providers in all health care facilities in Vanuatu for the clinical management of rape, sexual violence, and gender-based violence (adult and child). It is important that all health care workers understand their responsibilities and roles to play in the care of survivors of sexual and gender-based violence. The community will benefit from health care services available at all health facilities to manage and assess gender-based violence and sexual assaults, to ensure that survivors' health needs are met in the care, treatment and referral to social support services.

The SGBV SOP provides guidance on processes and procedures for the survivor's pathway to ensure they receive the appropriate care they need during and after clinical examination and assessment. This will allow other referral services outside of health to continue to support and follow up on survivors for the support they need. The SOP provides guidance and direction to health professionals to implement procedures and a step by step response to survivors of SGBV.

The Health Facility Readiness and Service Availability report in December 2020 showed that 0% of facilities are able to provide minimum services for gender-based violence (GBV) that meet global standards (54% of facilities reported offering at least one GBV service).

I believe that with that with the provincial rollout of training in SGBV for health care providers on the SOP, Vanuatu will have 100% SGBV services available in all health facilities. The SOP comes as the Health Sector's response to the wider Multi-Service Delivery Protocols that will be established by the Ministry of Justice, through the Department of Women's Affairs.

I encourage all health facilities to use this SOP as guidance and tool to provide appropriate health services for survivors of sexual and gender based violence problems referred to the Ministry of Health in Vanuatu.

Dr Samuel T Posikai

DIRECTOR GENERAL OF HEALTH (Acting)

This document is the internal Standard Operating Procedure of the Ministry of Health covering the topic of clinical management of rape, sexual violence, and gender-based violence (adult and child).

Staff shall not make significant deviations from this policy without the prior approval of the Director General of Health.

Signed this _____day of _____, 2021.

Acknowledgement

The Ministry of Health acknowledges with gratitude the great contributions and support of the following individuals and organizations during the development of the Standard Operating Procedures (SOP) for the Clinical Management of Rape Sexual Violence and Gender Based Violence.

1. Technical Assistance – Professor Anna Whelan
2. UNFPA office SRH Specialist – Ms Emily Deed
3. UN Women – Mrs Betty Toa
4. Family Protection Unit – Kathleen Alick & Jacky Lui
5. Director Vanuatu Women Center – Ms Vola Matas
6. Vanuatu Family Health Association – Ms Gerol Mana Sakita
7. Ministry of Health:
   - Director General of Health – Mr Russel Tamata
   - Director Public Health – Mr Len Tarivonda
   - Head of Accident and Emergency Department – Dr Vincent Atua
   - Head of Mental Health and Psychosocial Services – Dr Jimmy Obed
   - Head of Obstetrics and Gynae - Dr. Tonny John Harry
   - Senior Consultant OBGYN – Dr Boniface Damutalau
   - Consultant OBGYN – Dr Margaret T Lehi
   - Medical Superintendent NPH – Dr Andy Ilo
   - PH Manager Shefa – Mr Obed Manwo
   - PH Manager Penama – Mr Markson Tabi
   - Nursing Manager Norsup Hospital – Mrs Annie Taissets
   - RMNCAH Lead Tafea – Leina Ruth Moise
   - Nurse in Charge FP Clinic VCH – Hariette Obed
   - RMNCAH Lead Sanma – Susan Wokeke
   - Acting Nursing Manager NPH – Jenny Daniel
   - National RMNCAH Coordinator – Mr Sam Mahit
   - National Consultant – Leipakoa Matariki
8. UNFPA Office support – Ms Florence Karu

We acknowledge the funding support from the European Union (EU) Spotlight Initiative for the technical assistance and activity implementation facilitated through UNFPA. This has successfully completed the development of the Standard Operating Procedures (SOP) for Clinical Management of Rape Sexual Violence and Gender Based Violence in Vanuatu.

This document will not have been possible without all your technical support and invaluable contribution.

Dr Samuel Tapo Posikai
Acting Director General
Ministry of Health

Acronyms

CMR	Clinical Management of Rape
CPO	Child Protection Officer
DHS	Demographic Health Survey
DV	Domestic Violence
DVU	Domestic Violence Unit
DWA	Department of Women's Affairs
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
EHR	Electronic Health Records
EVAW	Elimination of Violence Against Women
FHSS	Family Health and Safety Study
GBV	Gender-based Violence
GBViE	Gender-based Violence in Emergencies
HCW/HCW	Health Care Worker/Health Care Professional
HIMS	Health Information management system
IPV	Intimate partner violence
MICS	Multi-Indicator Cluster Survey
MJCS	Ministry of Justice and Community Services
MOH	Ministry of Health
MWCSD	Ministry of Women, Community and Social Development
Ob/Gyn	Obstetrician/Gynaecologist
PEP	Post Exposure Prophylaxis
PFA	Psychological First Aid
PICTs	Pacific Island Countries and Territories
PTSD	Post-traumatic Stress Disorder
RDH	Rural District Hospitals
RHC	Rural Health Center
RTS	Rape Trauma Syndrome
SGBV	Sexual and Gender-based Violence
SOP	Standard Operating Procedure/s
STIs	Sexually Transmitted Infections
SV	Sexual Violence
VWC	Vanuatu Women Center

1. Introduction

Gender-based violence (GBV), sexual violence (SV) including intimate partner violence (IPV) have devastating effects on the lives of women and girls globally as well as in Vanuatu. As with other Pacific Island countries and territories (PICTs), GBV is a major concern to communities and governments, with multi-sectoral action required to prevent, treat and deal with GBV. Many women experience violence throughout their lives - as girls, while dating, in married life, including during pregnancy. The effects are inter-generational. It is recognized that men and boys suffer the effects of GBV and SV too.

Vanuatu has one of the highest prevalence rates of violence against women and girls, and the highest prevalence of sexual abuse of girls under 15 years in the Pacific and globally[1]. The latest GBV Survey by the Vanuatu Women's Centre in Partnership with the Vanuatu National Statistics Office was carried out in May 2011. This survey found that 60% of women who have ever been in a relationship have experienced either physical and/or sexual violence by a husband or intimate partner in their lifetime; more than 2 in 3 (68%) experienced emotional violence.[2] Intimate Partner Violence (IPV) occurs in all provinces and islands, and across all age groups, education and socio-economic levels and religions. Rates are higher in rural areas (63%) than in urban areas (50%). For most women who experienced physical or sexual violence, it occurs frequently, is often severe, including being punched, dragged, kicked, beaten up, choked, burned or hit with a weapon; for 42% of women who experienced physical violence, it was followed by rape. A Demographic Health Survey (DHS) with Multi-Indicator Cluster Survey (MICS) including GBV is planned for 2022.

While women have equal rights under Vanuatu law, cultural practices characterized by male dominance impact on women and girls being under-represented in education and on most community and national-level decision-making bodies. Attitudes which espouse inequality, combined with limited opportunities for women to gain employment or engage in the market economy, disempower them socially, economically and within relationships, and these contribute to their vulnerability to sexual violence. Children, people with disabilities and people expressing diverse sexual orientation and gender identity expression (SOGIE) are also vulnerable to heightened levels of violence.

1 Gender-based violence: An analysis on PNG, Vanuatu and Solomon Islands. https://www.imr.ptc.ac.fj/.../2019/01/Gender-Based-Violence-Analysis.pdf

2 Vanuatu Women's Centre & Vanuatu Statistics Office (May 2011), Vanuatu National Survey on Women's Lives and Family Relationships. Graph Pg 56 . Retrieved: https://www.researchgate.net/publication/304742327

There is no one single overarching policy solely dedicated to gender-based violence (GBV), however there are laws and policies that are relevant to the prevention of and response to GBV in Vanuatu. The passing of the Family Protection Act (FPA) 2008 by Parliament marked Vanuatu's commitment to end violence against women and girls. The Family Protection Act 2008 states that a police officer, may apply for a Protection Order, in the case where a complainant (or survivor) does not. The Act criminalizes domestic violence and obligates police and the law to formally act on complaints within 48 hours[3]. The Public Prosecutor's Office and Family Protection Unit of the Vanuatu Police Force have internal 'no drop' policies to ensure domestic and sexual violence cases are brought to trial (and not withdrawn)[4], however the extent to which they proceed through the courts is subject to the complainant's willingness to appear and provide evidence; the long wait for such cases to reach trial, and pressure from families and communities commonly influence complainants not to testify in Vanuatu's courts[5].

Vanuatu experiences many climate-induced emergencies and natural disasters, including six severe tropical cyclones between 2015 and 2020 (STC Pam, Winston, Donna, Gita, Harold, Yasa) and the 2017 eruption of Manaro Voui Volcano on Ambae Island that resulted in mass evacuation of Ambae's 11,000 residents[6]. During such emergencies the risk of violence, exploitation and abuse is heightened. In addition, restrictions put in place to manage COVID-19 may have major consequences for the provision of, and access to, essential health services for GBV at a time when there is increased need for GBV services, including to meet heightened mental health and psychosocial needs. Health service providers should be trained on the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) in crisis situations which includes the prevention and response to GBV and sexual violence as well as well as The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming which promotes the safety and wellbeing of women and children in emergencies and practical guidance on how to mitigate and prevent GBViE and facilitate access to multi-sector services for survivors (Annex 8).

1.1. Purpose of the document

This Standard Operating Procedure (SOP) presents clear procedures, roles, and responsibilities for healthcare providers in primary, secondary and tertiary level healthcare facilities in Vanuatu. The SOP for sexual and gender-based violence (SGBV) has been developed to eliminate the practices that deprive GBV victims (children and adults) of their right to receive comprehensive care and which may seriously limit their access to psychosocial and legal assistance. Currently there is a process underway to develop a national Multisectoral Service Delivery Protocol for SGBV in Vanuatu, and this MOH GBV SOP will need to be reviewed to ensure alignment.

3 Republic of Vanuatu, 2009; *Family Protection Act No. 28 of 2008;* Port Vila, Republic of Vanuatu.
4 Human Rights Council, 2013; *National Report submitted in accordance with paragraph 5 of the annex to Human Rights Council Resolution 16/21: Vanuatu;* New York, United Nations General Assembly.
5 Vanuatu Women's Centre (2011), National survey Ibid
6 See Vanuatu National Disaster Management Office reports https://ndmo.gov.vu/resources/downloads/category/67-reports

The relationship and referral systems between the Police Family Protection Unit (FPU) and Ministry of Health (MOH) is critical to effectively respond to the physical, legal, and psychosocial needs of victims of crime. Both Ministries must be aware of their individual departmental responsibilities, as well as shared expectations in providing this care. For example:

- Adult victims of crime may present to Police to report an incident, and in such circumstances, officers may need to refer the victim to MOH facilities for medical examination and treatment.
- Individuals may present at MOH facilities, and in seeking medical help, may be identified as victims of crime, requiring referral to Police Family Protection Unit (FPU).
- Child victims may not have the agency to report abuse, and service providers from Police and MOH need to be alert to detecting such cases.

This document seeks to clarify the referral processes between these two departments for improved responses to victims/survivors. In addition to MOH and Police, there are other key stakeholders including the Department of Women's Affairs (DWA) and non-government organizations, such as Vanuatu Women's Centre (VWC) involved in supporting survivors of GBV and child abuse in particular the Ministry of Justice and Community Services (MJCS) Child Desk, that will be included in the SOP to ensure clear referral pathways.

The table below provides a brief description of the responsibilities and documentation required by each of the key stakeholder groups (Police and MOH), the details of which will be discussed in further detail in subsequent sections of this document.

	Service location	Responsibilities	Documentation
Ministry of Health	Vila Central Hospital Health Centers	• Identification of victims (including determining age of child) • Medical assistance and first-line support (PFA, LIVES) • Evidence collection and documentation • Immediate safety planning • Referrals to VWC (women and children) • Report preparation for court matters • Information sharing with partner departments and organizations	• Medical History and Examination form • Safety Planning Template • Mandatory reporting to Police with consent of survivor • Child referral to the MJCS Child Desk or VWC • Referrals (see list) • Medical records

	Service location	Responsibilities	Documentation
Police Family Protection Unit	Central Police Station Community Police Posts	• Identification of victims • Detain suspect/perpetrator for 24 hours • Interviewing victims (for child with the support of Child Protection Officer and safe adult) • Gathering and recording evidence • Statements from witnesses • Immediate safety planning including taking victim for Interim Protection Order if needed • Report preparation for court matters • Refer to MJCS Child Desk for cases involving children immediately • Refer to MOH for health needs • Refer to VWC for temporary shelter, if needed, for both children and adults • Court attendance	• Referrals (including to MOH, VWC) • Police record of incident requiring medical assessment • Safety Planning Template • History of victim (including previous experiences as a victim)

1.2. Role and Mandate of the Health Sector

Specifically for the health sector, this Standard Operating Procedure (SOP) identifies the mandate, role and flow of services offered as:

The mandate of the Ministry of Health (MOH) is to provide health services, create an enabling environment, regulate and set standards and policy for health service delivery. This is done through an integrated approach in the provision of curative and rehabilitative services.

The role of the health sector in prevention and response to GBV/SV is:

- Developing national policies, guidelines, standards, protocols and training curricula for SGBV service delivery, based on latest WHO Guidance.
- Capacity building of health service personnel through training and mentorship on clinical management of SGBV.
- Providing supportive supervision through the national and provincial health providers to ensure quality service delivery on SGBV.
- Providing services to SGBV survivors.
- Referring child survivors of SV/GBV/abuse to Vanuatu Women Center.

This SOP is in line with the MOH Reproductive, Maternal, Neonatal, Child and Adolescent (RMNCAH) policy and will need to align with the Multisectoral Service Delivery Protocol being developed for responding to cases of SGBV and to be included in the MOH workplan.

1.3. Objectives for GBV/SV Standard Operating Procedure

The objective for the SOP is to guide and give direction to the staff working in the Ministry of Health. The SOP outlines the procedures for a competent, step-by-step response to survivors of SV and GBV to ensure a quality standard of healthcare. Procedures for supporting both adult and child (female and male) victim-survivors are indicated in this SOP noting that children require a unique and tailored procedure due to young people's specific needs and vulnerabilities (see Annex 6).

The SOP:

- outlines the **minimum** requirements for health staff capacity development, health facilities, equipment and referrals
- describes **referral pathways.**

These SOPs are applicable to all levels of the health service: the main referral hospitals: Vila Central Hospital (VCH) on Efate and Northern Provincial Hospital on Santo, 33 health centers, 97 Dispensaries including four (4) provincial hospitals : Lenakel Hospital on Tanna, Lolowai Hospital on Ambae, Norsup Hospital on Malekula and Torba Hospital on Vanua Lava.

Of note is that some health centres may not have comprehensive care for sexual assault.

The Ministry of Health (MOH) acknowledges its significant role in eliminating GBV and Sexual Violence. These Standard Operation Procedures (SOP) clarify accountabilities and responsibilities for ensuring the best possible response to survivors of SGBV and SV. Essentially staff of the MOH are responsible to:

• Do no harm • Identify violence • Respond empathically • Provide clinical care	• Refer as needed • Documentation with confidentiality • Medico-legal evidence • Advocate as community role models

To ensure a competent response, adequate and relevant **training for all front-line staff will be provided to health care professionals (HCWs). The SOP is the foundation of the training and will be supported by relevant training material.**

This SOP may be used both in non-emergency and emergency settings, however, special considerations will need to be considered for each context to ensure the safety of survivors as well as the appropriateness, relevance and quality of interventions as per the current national GBV Multisectoral Service Delivery Protocol (forthcoming 2022).

1.4. Core Concepts and General Guiding Principles

The SOP highlights that all health staff who have direct contact with survivors will be familiar with and apply the guiding principles for **Survivor-Centered Care** and response, that is, respect for **human rights** and support for **gender equality.**

The health sector, as part of the overall multi-sectoral process, agree to extend the fullest cooperation and assistance to each other in preventing and responding to GBV, as well as adhere to the following set of guiding principles:

- Ensure the **safety** of the victim/survivor and his/ her family at all times.
- Respect the **confidentiality** of the affected person(s) and their families at all times
- **Respect** the wishes, rights, and dignity of the victim(s)/ survivor(s) when making any decision on the most appropriate course of action to prevent or respond to an SGBV incident, while also bearing in mind the safety of the wider community as well as the individual concerned.
- Ensure **non-discrimination** in the provision of services.
- Apply the above principles to **children,** including their right to participate in decisions that will affect them. If a decision is taken on behalf of the child, the **best interests of the child** shall be the overriding principle and appropriate procedures should be followed. Special procedures for working with direct and indirect child survivors are described in Annex 6.

In practice, this means while examining the patient, asking questions, collecting evidence, documenting or referring the case:

- make the **safety** of the victim/survivor and her family members your top priority
- respect the **confidentiality** of the victim and her family at all times
- **respect** the choices, decisions and dignity of GBV victims; however, in the case of children, prioritize the best interests of the child, choosing the course of action that is most effective in protecting the child's rights to safety and ongoing development (See Annex 6 for further details)
- while referring your patient to other facilities always remember that GBV victims have very limited opportunities for visiting various locations (lack of money, time and freedom to travel); try to offer the most efficient route (minimize the number of contacts and do as much as possible on the first contact) and give very clear directions
- while sharing information about a 'GBV/SV case' with other agencies or service providers obtain the consent of the victim and follow the procedure that protects the confidentiality of the victim
- all written information about the patients subjected to GBV/SV must be maintained in secure, locked files
- put your best effort into conducting examination/interview in **private** settings whenever it is possible and ensure it does not threaten the security of your patient
- Ensure that you treat all GBV/SV victims **equally** regardless of religion, ethnicity, gender, sexual orientation, gender expression, social status or people with disabilities.

2. Human Resources

The care for women, girls, men and boys experiencing GBV and SV/IPV/Domestic Violence (DV) should, as much as possible be integrated into existing health services. Health staff will **promote recovery and healing** from trauma and be aware of their responsibilities.

In line with the Do No Harm principle, management are to ensure that health staff or first line responders have undergone a background check to mitigate risk of adult child survivors of GBV/SV, who are already in a vulnerable situation, are not placed at additional risk of abuse/harm.

Adequate, trained and skilled human resources at all levels in the MOH are critical to provide essential minimum health care services for survivors of violence including clinical management of rape (CMR). According to WHO guidelines, with trained and resourced staff, the health service is:

- Able to identify survivors
- Manage urgent injuries and trauma
- Offer psychological first aid (PFA) and first-line support (LIVES)
- Complete history and physical examination with empathy
- Document safely and maintain confidentiality
- Provide treatment– including emergency contraception (EC), sexually transmitted infections (STIs) and post exposure prophylaxis (PEP) for HIV infections where indicated
- Ensure safety planning
- Safe referral competently.

2.1. Minimum staffing levels of Health staff trained in CMR at health facility level:

Community Health Centres (including remote island clinics)

All front-line staff to be trained in the SOPs–Medical Clinicians and Nurse Practitioners, Midwives, Registered Nurses, Nurse Aids.

At least one GBV focal point to be identified by Provincial Nurse Managers for each health centre.

Provincial and Referral Hospitals:

All front-line staff to be trained in the SOPs through regular training opportunities.

GBV/SV Focal Points:

1. Doctor OB-GYN, Midwife in Charge
2. Accident & Emergency Room Doctor, Head Nurse
3. Head Nurse Paediatrics
4. Mental Health: Psychiatrist, Nurse, Coordinator, Counsellor
5. Provincial Health staff
6. MCH/FP/STI Program Coordinators

Each GBV/SV Focal Point will be trained in these SOPs including:

- The application of the guiding principles
- Response to sexual violence
- Provision of clinical care, examination, assessment
- Provision of PFA according to first-line psychological support principles (LIVES)
- Collection of forensic evidence (depending on professional standards)
- Referral for further healthcare including to Ob/Gyn for genital-anal examination and to Mental health services for further psychosocial support
- Filling in and storing forms (electronic and printed as applicable)
- Coordination and interagency referral pathways with other sectors
- Prevention of GBV/SV in collaboration with other sectors

Responsibilities and Accountabilities at each level of care

Facility level	Minimum Standards for medical management of survivors	Reporting/ recording requirements for health facilities	Minimum capacity requirements at health facilities
Remote island dispensary (without a laboratory or doctor)	• Manage injuries as much as possible • Provide first-line support • Identify GBV/SV • Detailed history, general examination and documentation (**excluding** genital-anal examination) • Provide first dose of EC and STI treatment • Refer for detailed history, genital-anal examination and documentation • Refer women to VWC where present • Refer direct and indirect child survivors to MJCS Child Desk immediately for care and protection planning and VWC for temporary shelter, if needed	• Fill in Medical History and Examination Form and keep on file (safely locked if hard copy) • Refer to post rape care hospital or counseling if indicated and follow up	• Nurse Aid/ Nurse if trained • Consult/refer to Provincial Hospital or Ob/ Gyn in VCH, NPH • Refer for trauma counseling if needed [VCH & NPH or outreach]

Facility level	Minimum Standards for medical management of survivors	Reporting/ recording requirements for health facilities	Minimum capacity requirements at health facilities
Health Centre (no doctor) **Provincial Hospital (with doctor)**	• Manage injuries as much as possible • Provide first-line support • Identify GBV/SV • Detailed history, general examination and documentation (**including** genital-anal) • Provide first doses of EC and STI treatment (and PEP if indicated) • Refer women to VWC • Refer direct and indirect child survivors to MJCS Child Desk immediately for care and protection planning and VWC for temporary shelter, if needed	• Fill in Medical History and Examination Form • Maintain a GBV register • Referral form to post rape care facility at hospital or counseling where indicated • Follow up locally	• Nurse practitioner or Midwife • Consult/refer to Provincial Hospital or Ob/Gyn in VCH, NPH • Refer for trauma counseling if needed VCH & NPH or outreach
Referral Hospital facilities (where full post rape care facilities can be provided)	• Manage injuries • Detailed history, examination and documentation • Provide EC and STI prophylaxis/ treatment • Refer genital-anal examination to Ob/Gyn • Provide counseling for trauma, HIV testing and PEP adherence • Refer women to VWC • Refer direct and indirect child survivors to MJCS Child Desk immediately for care and protection planning and VWC for temporary shelter, if needed	• Fill in Medical Examination form and maintain GBV register • Maintain a GBV register • Ensure follow up management of survivors • Complete Forensic examination form for Police and possible legal case	• Medical doctor and nurse trained in clinical case management of rape • Ob/Gyn • Trained trauma counselor

3. Facility Minimum Standards

Access to health care services is essential. For many survivors of GBV and SV it is very difficult to open up about the violence they are experiencing and ask for help. It is therefore important that all HCW demonstrate to survivors that they are in the right place to receive friendly, competent and supportive care. See Annex 6 for child-centered approaches.

The **outpatient/clinic** area should have information material (posters, information pamphlets, contact numbers – calling cards) about GBV and SV. The posters should describe the type and quality of services that survivors are entitled to (see a survivor-centered approach and guiding principles). It is also important to state that violence will not be tolerated against health care staff.

The HCWs who do the triage and registering should be mindful of the **need to maintain confidentiality and privacy.** Survivors of violence should be prioritised and not be made to wait in public waiting rooms.

At the hospitals, survivors should be directed to the designated gynaecological room unless the patient is in a critical condition.

A **dedicated space** for survivors is critical for the provision of clinical management of rape (CMR). The dedicated space where survivors will be assessed must provide auditory and visual privacy. The space should be equipped in line with Psychological First Aid guidelines.

Outer islands and hospitals

- The MOH will refurbish existing facilities for privacy and provide equipment to provide adequate response where this is possible.

3.1. Health Centres and Hospitals

Each health facility will be equipped with a copy of the WHO Clinical Handbook on *Health care for women subjected to intimate partner violence or sexual violence* (2014), the GBV SOP, CMR kit including consumables and medication (including Emergency Contraception), printed forms including body charts and procedures for assessment and documentation and contact information for referrals. A checklist for basic equipment, supplies and medicines is provided (over page).

CMR KIT

Content for CMR Kit can be made up beforehand, or as required, in order to minimise disruption:

☐ Forensic ruler and tape measure	☐ Emergency Contraceptive Pill
☐ Gloves [STERILE]	☐ Hepatitis B test and vaccine
☐ Gown/Sheet	☐ Pregnancy Test
☐ Pads	☐ STI Pack
☐ Plastic/ metal speculums in sizes	☐ Tetox
☐ Swabs	☐ Lignocaine gel
☐ Syringe, needles	☐ Tdap
☐ Tray – Vaginal Examination	☐ Slides
☐ Tray– Suture	☐ HIV test and PEP if indicated

The GBV Focal Person is responsible for review and replenishment of items.

Checklist of equipment, medicines and other supplies for examination and care of women subjected to violence	
Examination equipment	**Medicines**
☐ examination couch (with curtains or screen if needed for privacy ☐ secure record storage cabinets ☐ light source (lamp or torch) ☐ speculum ☐ pregnancy testing kits ☐ rapid tests for HIV, syphilis ☐ urinanalysis kits ☐ test strips for vaginal infections ☐ forensic evidence collection kits (depending on forensic laboratory capability), including: • swabs & container for transporting swabs • microscope slides • blood tubes • urine specimen containers • sheets of paper (drop sheet) • paper bag • plastic bags for specimens • tweezers • scissors • comb ☐ digital camera to document injuries	☐ supplies for wound care ☐ analgesics ☐ anti-emetics ☐ emergency contraception ☐ antiretroviral drugs for post-exposure prophylaxis for HIV prevention ☐ drugs for treatment or prophylaxis for sexually transmitted infection ☐ hepatitis B vaccination ☐ tetanus toxoid **Administrative supplies** ☐ a protocol/SOP for care ☐ job aids (for example, flow charts, algorithms, pictograms) ☐ consent forms ☐ documentation forms (for example, medical intake forms, police forms for forensic evidence, medico-legal certificates) ☐ communication materials **Disposables** ☐ sheets, blankets and towels ☐ in case the women´s clothes are soiled or torn or taken for evidence collection ☐ sanitary pads

4. Identifying violence: Raise the subject

It is often challenging for HCW to ask about violence, even if they have concerns or suspicions.

Be alert and consider violence when...

- Physical injuries are repeated and not well explained
- Ongoing emotional health issues, such as stress, anxiety or depression
- Harmful behaviours such as self-harm or attempted suicide
- Repeated STIs
- Unwanted pregnancies
- Unexplained chronic pain or conditions
- Repeated health consultations with no clear diagnosis
- Missing appointments
- Partner intrusive during consultations

4.1. What do I do if I suspect violence?

- NEVER raise the issue of partner violence unless a woman is alone
- If you ask her about violence, do it gently with empathy and non-judgmentally
- Be supportive and do not blame her

**See Annex 6 for child-centered approaches.

Some examples of opening questions:

- *These questions are now a regular part of my consultations for female patients*
- *I now ask these questions routinely because I have found that many of my female patients live with violence at home.*
- *I am now going to ask a few questions about your relationship because in my experience many patients have found it useful to discuss aspects of their home life that may impact on their general wellbeing*

    - *"I have seen other women with problems like yours."*
    - *"Is everything okay at home?"*
    - *"Many women have problems with their husbands."*

Follow up with indirect questions

- *How is your relationship? or How much tension is there in your relationship?*
- *Sometimes people we care about hurt us. Has that happened to you?*
- *I have seen women with problems like yours who have been experiencing trouble at home.*

Simple and direct questions that you can start with (this shows her that you want to hear about her problems):

Depending on her answers, continue to ask questions and listen to her story. If she answers 'yes' to any of these questions, offer her first-line support (LIVES).

- *Are you afraid of your husband (or partner for all questions)?*
- *Has your husband or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?*
- *Does your husband or someone at home bully or insult you?*
- *Does your husband try to control you – e.g. by not letting you have money or leave the house?*
- *Has your husband forced you into sex or forced you to have any sexual contact that you did not want?*
- *Has your husband or anyone else at home threatened to kill you?*

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

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

**See Annex 6 for child-centered approaches.

5. Preparation for Clinical Care

It is important for HCWs to be aware that health problems may be caused or made worse by violence. Women subjected to violence, including sexual violence in relationships often seek health services for related emotional or physical conditions, including injuries. However, they may not tell the HCW about the violence due to shame or fear of being judged, or fear of their partner as well as their communities.

- Health care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by DV/IPV in order to improve diagnosis / identification and subsequent care[7].
- Asking women about violence must be linked to an effective response, which include a PFA and first-line supportive response, appropriate medical treatment and care and referral within the health system itself or externally.
- In Vanuatu, it is found that survivors come with/or are brought by their family to the dispensary, with the aim to seek justice. However, it is important that the focus for the HCW is on the survivor's needs. The HCW's role is to provide healthcare and support to the survivor, through survivor-centered care.
- All child survivors must be referred to Police, MJCS Child Desk immediately and to the Paediatric Department of the Ministry of Health.

Upon presentation of the survivor: **Assess for medical stability including vital signs and immediate risk (to survivor and/or staff at health facility).**

5.1. Health Centres and Hospitals:

If the survivor is found to be medically stable, bring the patient to the dedicated space.

- If not – refer accordingly. Note: Survivors of GBV/SV should be prioritized.
- Refer Survivors with special needs as necessary.
- Refer child survivors to highest level of care available.

Apply PFA using first line approach to support and **address survivors' emotional, physical, safety and support needs (Annex 1).**
Establish informed consent by explaining confidentiality, available services and options[8]

7 See pages 9-12 of the WHO/UNFPA Clinical Handbook for a list of clinical and other conditions associated with intimate partner violence.

8 A detailed documentation of the incident using a standardised format (report) may be beneficial to the survivor as she can request the report at a later point.

Allow the survivor to tell her story, listen in a supportive, **non-judgmental manner because survivors may tell you the information you need without asking questions.** Many questions can make someone feel like they are being interrogated or are in trouble. Use LIVES approach (Annex 2).

LIVES	**Remember**
• **L**isten • **I**nquire about needs and concerns • **V**alidate • **E**nhance safety • **S**upport	• Forcing or pressuring the survivor to answer questions or hurrying through the procedure can re-traumatize the survivor. • Always present as calm and not rushed. • Let the survivor stay in control. • Avoid any distraction or interruptions.

Explain benefits of undertaking a comprehensive medical history and examination:

- For diagnostics and provision of adequate treatment
- To create a record of the incident that will be kept safe in a lockable filing cabinet or electronic system with copy provided to the survivor if she wishes
- To document the injuries in the event that survivor may decide to pursue criminal justice.

Explain that the survivor has the **right to decline examination/report** and **can stop the process** at any point. See Annex 6 for child-centered approaches.

Document the informed consent by the offering the survivor to sign on the first page of a **'CONSENT AND MEDICAL EXAMINATION FORM'** (Annex 4).

5.2. Additional care for physical health after sexual assault

Immediately refer patients with life-threatening or severe conditions for **emergency treatment.**

If the woman comes **within 5 days** after sexual assault, care involves 6 steps in addition to the LIVES steps in first-line response

First, *Listen, Inquire, Validate* (first-line support). Then:

1. Take a history and conduct the examination
2. Treat any physical injuries
3. Provide emergency contraception
4. Prevent sexually transmitted infections (STIs)
5. Prevent HIV
6. Plan for self-care

Then, **E**nhance Safety, arrange **S**upport (first-line response).

The **examination** and **care of physical and emotional health** should take place together.

6. Medical History

The medical and assault history should be taken at the pace of the survivor, allow sufficient time and be non-judgemental. **Family members should not be present unless it is concerning a child.** HCWs are to ensure that there is another safe adult present during the examination as well as allow the child to choose who is present in the room whenever possible.

The HCW should pay attention to auditory/visual privacy and confidentiality. See Annex 5 for Medical History and Examination Form

Components of Standardised Medical History

- Past health (general health, diagnosed illnesses, any operations, infectious diseases)?
- Immunisation status?
- Medications (including herbal and/or other potions)?
- Allergies?

Components of Standardised Obstetric- Gynaecological History

- First day of last menstrual period?
- Any pregnancies? If so, how many? Dates?
- Any complications during delivery?
- Pelvic surgery?
- Contraception? What type?
- Last consensual intercourse?

Assess mental health status

Women experiencing violence should be assessed for mental health problems (symptoms of acute stress/Post-Traumatic Stress Disorder (PTSD), depression, alcohol and drug use problems, suicidality or self-harm) and be treated accordingly, using the mhGAP intervention guide which covers WHO evidence-based clinical protocols for mental health problems. Mental health care should be delivered by health service providers with an understanding of violence against women and children.

If at risk – refer according to Vanuatu mental health policy.

7. Information about the assault

Ask the survivor to tell the story of the incident; however, minimize the need for the child to repeatedly describe the incident, as this can be re-traumatizing (see Annex 6 for child-centered approaches). Note time and place for the assault. Utilize Psychological First Aid/LIVES strategies during the interview (Annex 1 and 2). Be compassionate and non-judgmental. Review any documentation from police and/or community services.

Purpose of the interview

- Detect and treat all acute injuries.
- Assess the risk of adverse consequences such as pregnancy and STIs/HIV.
- Guide relevant specimen collection - in most cases this is limited to a swab for confirming presence of spermatozoa.
- Documentation of the incident (the history should be precise, accurate, without unnecessary information that may result in discrepancies with police reports).
- Guide the forensic examination – to document visible injuries and mental state.

Good practice for interviewing survivors about the incidence

- Use the survivors' own words, at the survivors' own pace.
- If the survivor uses expressions such as 'sexual assault', 'rape' or other concepts it may be useful to clarify what the survivor mean.
- Articulate the survivors' strengths, for example 'despite everything you have made it here'.
- Ensure confidentiality (the interview should take place away from family).
- Minimize the number of times the survivor is asked to retell her/his story.
- Pay attention to information that is needed for medical care e.g.
  - penetration, oral, vaginal, anal by offender's penis, fingers or objects
  - forced oral contact of victim's mouth with offender's face, body or genital-anal area
  - ejaculation in victim's vagina, anus or elsewhere on body, or at the scene.

Consideration for Male Survivors (Men and Boys)

- Men and boys are often less likely to disclose.
- May be targeted in order to destroy their masculine identity.
- Men and boys are vulnerable in prisons.
- May be forced to witness or participate in sexual violence against others.
- The same procedures for obtaining consent, taking a history, conducting the physical examination (although the genital examination will be different) and ordering diagnostic laboratory tests should be followed for men and boys.
- Men and boys may be extra sensitive to touch.

8. 'Top-to-toe' Examination

The examination may be undertaken for urgent triage by nurses/midwives/nurse practitioners in community health centres and by medical doctors, nurse practitioners and midwives in the Provincial and Referral Hospitals.

8.1. Good practice for top-to-toe examination

- Ask gender preference for assessing healthcare provider. If not possible, a chaperone should accompany the HCW if the survivor prefers.
- Verbally confirm that the survivor is giving consent for each step of the examination. Allow withdrawal of consent.
- Assist survivor to maintain dignity, provide a sheet or gown.
- Practice universal precautions.
- Collection of specimens (swab for semen) during the course of the examination.
- Be systematic (head to toe; genital-anal by Ob/Gyn).
- Document everything thoroughly (pictograms).

Step 1

- General appearance and demeanour.
- If appropriate, start with the survivor's hands; this will reassure the survivor (note that male survivors may be extra sensitive to touch).
- 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.

Step 2

- Inspect the forearms for defence injuries. Defensive injuries include bruising, abrasions, lacerations or incised wounds.
- 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.
- Survivors who have been restrained by hands often display fingertip bruising on the upper arms.

Note that when clothing has been pulled, red linear petechial bruising can sometimes be seen.

Step 4

- Inspect the face.
- 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. Look for broken or missing teeth as a result of violence.
- Petechiae on the hard/ soft palate may indicate asphyxiation (penetration).
- Check for a torn frenulum and broken teeth. Collect an oral swab, if indicated.

Step 5

- Inspect the ears.
- Inspect 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 for rapture, bleeding /hematoma.

Step 6

- Gentle palpation of the scalp may reveal tenderness/swelling, suggestive of haematomas

Step 7

- The neck area is of great forensic interest as 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.

Step 8

- The breasts and trunk should be examined with as much dignity and privacy as possible.
- Start with the back. It is possible to expose only the area that is being examined.
- The shoulders should be viewed separately.
- Subtle bruising and more obvious bruising may be seen in a variety of places on the back.
- 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

- Abdominal examination, look for bruising, abrasions, lacerations and trace evidence.
- Abdominal palpation should be performed to exclude any internal trauma or to detect pregnancy.
- If she has a missed period or irregular menstrual cycle offer pregnancy test to determine any pre-existing pregnancy.

Step 10

- Legs to be examined in turn, commencing with the front of the legs.
- Inner thighs are often the target of fingertip bruising or blunt trauma (for example 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 survivor being forced to the ground).
- Feet may show evidence of abrasions or lacerations.
- Important to inspect the ankles (and wrists) for signs of restraint with ligatures.
- The soles of the feet should also be examined for abrasions, punctures (which may corroborate survivor's story.)

Step 11

- Examine the back of the legs with the survivor standing.
- The buttocks can be inspected with the survivor standing.
- Alternatively, the survivor 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 survivor is unsteady on her feet for any reason, but does not afford such a good view of the area.

8.2. Document

Use a standardised Medical History and Examination Form (see Annex 5)

- Any use of condoms and/or lubricant.
- Subsequent activities by the patient that may alter evidence, for example, bathing, douching, wiping, the use of tampons and changes of clothing.
- Details of any symptoms that have developed since the assault must be recorded; these may include:
  - genital bleeding, discharge, itching, sores or pain,
  - urinary symptoms,
  - anal pain or bleeding,
  - abdominal pain.

9. Genital-Anal Examination (Annex 5)

Referral to Hospital – speculum examination should be undertaken by specialist/attending Obstetrician/Gynaecologist. Give options for preferred sex of HCW/HCW if possible – otherwise provide chaperone.

Consider language – adjust for cultural and age preferences. For example:

- *'I'm now going to have a careful look at your private parts/where babies come from/....'.*
- *'I'm going to touch you [here] in order to look a bit more carefully'*
- *'Please tell me if anything feels tender/is hurting'*

9.1. Good Practice

- Establish verbal consent for each step.
- Position survivor to lie on her back with her knees drawn up, heels together and legs gently flopped apart, i.e. in the lithotomy position.
- Provide gown/sheet for dignity.
- Provide same sex chaperone (may not be appropriate for male survivors – ask for individual preference!)
- Know your limits: Do not pursue examination (e.g. speculum) if too painful for the survivor. Refer to higher level care.
- Be knowledgeable of the expected lack of visual signs of sexual assault and natural variations of the hymen.
- Be openminded. Survivors include women, men, girls and boys.
- Ensure adequate lighting.

Step 1 - Female

- Examine external areas of the genital region and anus, note any markings on the thighs and buttocks.
- Inspect the mons pubis.
- The vaginal vestibule should be examined paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum.
- A swab of the external genitalia should be taken before speculum examination is attempted.
- A gentle stretch at the posterior fourchette area may reveal abrasions that are otherwise difficult to see, particularly if they are hidden within slight swelling or within the folds of the mucosal tissue.
- Gently pulling the labia (towards the examiner) will improve visualization of the hymen. Asking the patient to bear down may assist the visualizing of the introitus.

Step 1 - Male

- For male survivors undertake careful examination of the penis and scrotum

Step 2 -Female

- If any bright blood is present, it should be gently swabbed in order to establish its origin, i.e. whether it is vulva or from higher in the vagina.

Step 3

- Speculum exam can be undertaken at the Hospitals and health centres, by trained staff.
- Nurses in health centres may consult with Ob/Gyn on the need for procedure.

- Speculum exam is indicated if there is significant vaginal or uterine pain post assault, vaginal bleeding or suspicion of a foreign body in the vagina.
- For assaults that occurred more than 24 hours but less than 96 hours (approximately) prior to the physical examination, a speculum examination should be performed in order to collect an endocervical canal swab (for semen).
- If a speculum examination is not conducted (e.g. because of patient refusal) it may still be possible to collect a blind vaginal swab.
- Use of a transparent plastic speculum is especially helpful for visualizing the vaginal walls. A speculum examination allows the examiner to inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising.
- The speculum examination may be particularly difficult for the patient, as it may remind her of the assault. Therefore, it should be introduced gently and its importance explained carefully.

Step 4 Female/Male

- Visual anal examination is usually easier with the patient in left lateral position.
- Respectful covering of the thighs and vulva with a gown or sheet during this procedure can help prevent a feeling of exposure.
- The uppermost buttock needs to be lifted to view the anus. This should be explained. The patient can hold the buttock up, if he/she is comfortable and able to do so.
- Gentle pressure at the anal verge may reveal bruises, lacerations and abrasions.
- Digital rectal examinations are ONLY recommended if there is a reason to suspect that a foreign object has been inserted in the anal canal; this will only be undertaken by a Doctor.
- Rectal examination ONLY if medically indicated: In the digital rectal examination, the examining finger should be placed on the perianal tissues to allow relaxation of the natural contraction response of the sphincter. Once relaxation is sensed then insertion can take place; this will only be undertaken by a Doctor.

Step 5 Female/Male

- In cases of anal bleeding, severe anal pain post-assault, or if the presence of a foreign body in the rectum is suspected, proctoscopy may be needed. This shall be undertaken by a Specialist Doctor/OB/GYN/attending physician.

Injuries

Lack of visible genital injury does NOT disprove a claim of an alleged sexual assault

Female genital-anal injuries related to penetration

- Posterior fourchette,
- Labia minora and majora
- Hymen and the perianal folds are the most likely sites for injury
- Abrasions, bruises and lacerations are the most common forms of injury

Male genital-anal injuries related to sexual violence

- Anal sphincter tears
- Fistulas
- Genital torture, mutilation
- A survivor who complains of involuntary leaking of faeces or urine should be referred to a surgeon
- Penile/testicular/anal/rectal pain
- HIV/AIDS or other sexually transmitted infections
- Abscesses
- Reproductive issues
- Sexual dysfunction

10. Treatment/ prescriptions

10.1. Emergency contraception[9]

Offer **emergency contraception** to survivors of sexual assault presenting within 5 days of sexual assault, ideally as soon as possible after the assault, to maximize effectiveness (up to 72 hours).

Offer EC to any woman who has been sexually assaulted along with counseling so that she can make an informed decision.

Facts about emergency contraception pills

2 kinds of pills are commonly used for EC:

- **Levonorgestrel-only** Works better and causes less nausea and vomiting than combined. Preferred dosage: 1.5 mg levonorgestrel in a single dose.
- **Combined estrogen-progestogen** Use if levonorgestrel-only pills not available
- 0.03 mg EE + 0.15 mg LNG formulation such as in **Microgynon** – give 4 tablets immediately and 4 tablets 12 hours after.

Women of childbearing age can take EC pills. There is no need to screen for health conditions or test for pregnancy.

Women of childbearing age can take EC pills, antibiotics for STIs and PEP for HIV prevention at the same time without harm. EC and antibiotics can be taken at different times and along with food to reduce nausea.

Emergency contraception counseling points

A woman who has been sexually assaulted is likely to worry if she will get pregnant. To reassure her, explain emergency contraception. Also, you can ask her if she has been using an effective contraceptive method such as pills, injectables, implants, IUD, or female sterilization. If so, it is not likely she will get pregnant. Also, if her last menstrual period began within 7 days before the attack, she is not likely to get pregnant. In any case, she can take EC if she wishes.

9 WHO Clinical Handbook for full details, pages 49-51

Use of emergency contraception is a personal choice that only she, the woman herself, can make. In the case of female child sexual abuse, the best interests of the child prevail and should be assessed/ determined in close consultation with Child Protection Officers (MJCS Child Desk).

Tell her:

- Emergency contraception can help her to avoid pregnancy, but it is not 100% effective.
- EC pills work mainly by stopping release of the egg.
- EC pills will not cause abortion.
- EC pills will not prevent pregnancy the next time she has sex.
- EC pills are not meant for regular use in place of a more effective, continuing contraceptive method.

She does not need to have a pregnancy test before taking EC pills. If she is already pregnant, EC pills will not harm the pregnancy. However, a pregnancy test may identify if she is pregnant already, and she can have one if she wishes.

Instructions

- She should ***take the EC pills as soon as possible.*** She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes.
- EC pills may cause nausea and vomiting. If she vomits within 2 hours after taking EC pills, she should return for another dose as soon as possible. If she is taking combined pills for EC, she can take medicine (meclazine hydrochloride) 30 minutes to 1 hour before the EC pills to reduce nausea.
- She may have spotting or bleeding a few days after taking EC pills.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. EC pills will not work, but they will not harm the pregnancy.
- She should return if her next menstrual period is more than 1 week late. Safe abortion could be offered where it is within the law.

Emergency copper IUD

- Also can be used for EC up to 5 days after unprotected intercourse.
- More effective than EC pills.
- The higher risk of STIs following rape should be considered if using a copper IUD.
- Good choice for very effective long-acting contraception if a woman is interested in the IUD and could be referred for it immediately.

Post-exposure prophylaxis for sexually transmitted infections[10]

Women and child (female or male) survivors of sexual assault should be offered prophylaxis for the most common sexually transmitted infections and hepatitis B vaccine following national guidance.

HIV post-exposure prophylaxis

The prevalence of HIV is very low in Vanuatu, however clinicians may offer a test for HIV and hepatitis and consider offering HIV post-exposure prophylaxis (PEP[11]) for survivors presenting within 72 hours of a sexual assault, if there are concerns about HIV status of perpetrator. Use shared decision-making with the survivor, to determine whether HIV PEP is appropriate and follow national guidelines for prophylaxis.

10 WHO Clinical handbook for further details, section 2.3, pages 52-54
11 WHO Clinical Handbook for further details, section 2.4, pages 55-57

11. Forensic evidence

The primary objective of the examination is to determine the appropriate clinical care for the survivor. Forensic evidence may be documented during the examination to help the survivor pursue legal redress.

In Vanuatu the main forensic evidence is the survivor's recount of the incident(s) and the carefully recorded findings from the medical examination.

- It is very important that the incident is documented in the words used by the survivor.
- The medical examination should be documented using exact medical terminology, be thorough and scientific (use measuring instruments) to document injuries.

Swabs can be collected and analysed under microscope for semen. No other forensic material is to be collected if there is no capacity to analyse. Please refer to Annex 6 for child-centered approaches to gathering forensic evidence.

11.1. Good Practice

- The survivor may choose not to have evidence collected. Respect this choice
- Consider if timing is appropriate for doing a swab for semen (< 72 hours)
- HIV and STI screening are **not done** for forensic purposes
- Document injuries with appropriate medical language in the medical record
- Utilize the pictogram to note the location and size of the injuries

The medical record should be signed by the Doctor who is completing the examination.

- **Injury evidence:** Physical and/or genital trauma can be proof of force and should be documented and recorded on a pictogram, for example bruises on the back, patches of hair missing, lacerations on forearms from self-defence, torn eardrums from slapping, etc.
- **Sperm and seminal fluid:** If penetration took place in the vagina, anus, or oral cavity, look for the presence of sperm.
- **Blunt force injury often presents with contusions, abrasions, or lacerations.**

Terminology for documenting injuries

A **contusion** is an area of bleeding into skin or soft tissue as a result of rupture of blood vessels due to blunt force injury or pressure. The extent and severity of the contusion depends on the amount of force and the structure and vascularity of the injured tissue.

- The site of the contusion does not necessarily correspond with the impact point.
- Bleeding into soft tissue will follow fascial planes (i.e. battle sign, raccoon eyes).
- It can be difficult to see or demonstrate in dark-skinned individuals.

- If present, a contusion always indicates blunt force; however, blunt force may not always produce a contusion (i.e. severe internal abdominal damage following blunt force application, but with no external bruising.)

An **abrasion** is caused when the superficial (epithelial) layer of the skin is scraped away, destroyed, or detached due to contact of the skin with a rough surface, a sliding motion, and/or occasionally by compression or pressure.

A **laceration** is a tear in tissue caused by blunt force such that the tissue is crushed, stretched, sheared, or avulsed.

- They commonly occur over bony prominences.
- They are characterized by strands of 'bridging' tissue within the wound depths.

Sharp force injuries

- An **incised wound** may be superficial or deep.
- A **penetrating incised wound, or stab wound,** is produced by a pointed instrument in which the depth of penetration is greater than the length of the wound on the skin. There are no tissue bridges evident in these types of wounds.
- **Chop wounds** are perpetrated with a heavy instrument that has at least one cutting edge.

Use detailed, objective medical language in your description.

DO:	**DO NOT**
• Position/ location (document in clock format) • Negative findings (write intact or unremarkable) • Describe all wounds in detail: **T** – Tear/Laceration **E** – Ecchymosis[12] **A** – Abrasion **R** – Redness **S** - Swelling	• Use abbreviations • Draw lines – state "normal" or "not injured" • Leave empty spaced • Leave empty spaces

12 Discoloration of the skin resulting from bleeding underneath.

12. Safety Planning

A core aspect of CMR is to assist with the safety and security of the survivor. Safety planning is taking practical steps for identifying adult survivors in danger and implementing safety strategies before the violence escalates. **The violence often escalates when a survivor is seeking to leave the abuser.** The HCW assessing the survivor is responsible for discussing a plan to protect the survivor from further harm. For children, Child Protection Officers will assess the immediate risks and needs and will respond.

Assess survivor's safety.

- If it is not safe for the survivor to return home, work with her to identify a safe place that she can go to.
- Discuss strategies that may help prevent another assault.
- **Please consider:**
  - The violence may escalate as she has notified authorities about the violence.
  - Making a police report should be done with the consent of the survivor – especially as this may further increase her risk of violence.

12.1. Safety plan

Discuss the particular situation from a safety perspective, her needs and situation, exploring her options and resources. **It is important to find out if there is an immediate and likely risk of serious injury and increased levels of violence.**

Assess immediate risk of violence

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

Questions to help assess immediate risks

Women who answer "yes" to at least 3 of the following questions may be at especially high immediate risk of violence:

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

Safety planning

Even women who are not facing immediate serious risks could benefit from having a safety plan. Please consider the following questions:

Safety Planning	
Identifying danger	What are the warning signs? When do you take action? (see Cycle of Violence[13])
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, phone numbers, keys, money, clothes, or other things with you when you leave?
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get access to money in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

13 Violence often follows a repeating cycle within intimate relationship. First the tension builds up, and it reaches the peak resulting in a violent incident. This is followed by honeymoon phase where the perpetrator may feel ashamed, tries to justify the action and begs for forgiveness.

13. Reporting – Forms

- After obtaining consent (Annex 4), details about the alleged assault must be documented in specified forms (Annex 5).
- Forms should be signed by the HCW who undertook the assessment and the Medical Superintendent.
- Keep the paper forms in a secure location in a locked cabinet in the hospital (or with a code if using an electronic record in future) for confidentiality.

Good Practice

- Fill out all forms with the survivor still present.
- Validate the information documented by reading it back to the survivor.

14. Follow-up Care & Referrals

Referrals from other departments or NGOs:

- Minimize the number of times that the survivor is asked to repeat her story as this is retraumatizing for the survivor.
- Police/Referring Department should share the report/statement to prevent a situation where the survivors have to repeat her story.
- Treating Dr/HCW should review any information.

Once the assessment and medical examination is completed it is important to discuss with the survivor any findings and what the findings may mean.

14.1. Good Practice

- Give the patient ample opportunity to voice questions and concerns.
- Practice PFA according to the LIVES strategy and give reassurance.
- Teach survivor how to properly care for any injuries.
- Explain how injuries heal and describe the signs and symptoms of wound infection.
- Explain the importance of completing the course of any medications given.
- Discuss the side effects of any medications given.
- Explain the need to refrain from sexual intercourse until all treatments or prophylaxis for STIs have been completed and until his/her sexual partner has been treated for STIs, if necessary.
- Explain rape trauma syndrome (RTS) and the range of normal physical, psychological and behavioural responses (see below) that the survivor can expect to experience to both the survivor and (with survivor's permission) family members and/or significant others. Encourage the survivor to confide in and seek emotional support from a trusted friend or family member.
- Inform survivor of their legal rights and how to exercise those rights.
- Give survivor written documentation. Consult the survivor if it is safe to bring home the documents. Documents include:
  - any treatments received
  - tests performed
  - date and time to call for test results
  - meaning of test results
  - date and time of follow-up appointments
  - information regarding legal process.

- Emphasise the importance of follow-up examinations at two weeks, three months and six months.
- Tell the patient that she can telephone or come into the health care facility at any time if she has any further questions, complications related to the assault, or other medical problems.

14.2. Referral (see Annex 7)

Maintaining confidentiality when referring a patient within the health system is critical. It is important that the safety of the patient is carefully considered when referring to other agencies and departments. Annex 7 provides contact details of agencies for referral and women should be consulted about what would be appropriate referrals.

The Vanuatu Police Force set up a Family Protection Unit which works with community leaders, such as chiefs, pastors, women and youth leaders to work in educating communities and schools through awareness, radio talk back shows, brochures and posters. There is Family Protection Unit in Port Vila and Luganville, Santo Police stations; however police posts are available on other islands that also deal with domestic violence issues.

The Vanuatu Women Center assist women, children and minority groups in cases of SGBV. VWC provide victim support to all who come for assistance as well as education and awareness programs around the country about GBV, its impact and also legal implications and services available. VWC was founded by women's rights activist, Merilyn Tahi in 1992 in Port Vila, but now has five provincial branches in Lenakel- Tanna, Lakatoro- Malekula, Luganville- Santo, Lavatu- North Pentecost and Sola- Vanua Lava, as well as 36 island-based committees against violence. VWC also has an active national network of over 100 male advocates who work actively to promote human rights and prevent and address violence against women and children in their communities. The Vanuatu Women Centre also provides temporary short term safe accommodation for survivors.

Other NGOs provide services that health workers need to understand in order to refer appropriately.

The Ministry of Health and the Police Force should meet regularly to review practices and coordinate interventions.

14.3. GBV in emergencies (Annex 8)

During emergencies such as natural disasters (e.g., cyclones, tsunami, earthquake) and public health concerns (e.g., measles outbreak, COVID-19 pandemic) the risk of violence, exploitation and abuse is intensified, particularly for women and girls. National systems and social support networks may be overwhelmed as affected populations cope with the disruption in their lives. Pre-existing gender inequalities may become more evident. Women and adolescent girls are often at particular risk of sexual violence, exploitation and abuse, denial of resources and discriminating traditional practices. Men and boys may also be survivors and/or victims. Often during emergencies, an environment of impunity prevails and perpetrators are not held accountable. GBV has significant and long-lasting impacts on the health and psychological, social and economic wellbeing of survivors and their families, thus it is essential to establish a functioning GBV response mechanism in disaster preparedness, response, and recovery plans.

15. Health Information System

It is important to record the prevalence of GBV and SV seen by the Health Centers and the Hospital. Be mindful not to not break confidentiality. Work in currently ongoing to finalise what data to include as GBV administrative data and whether it can be electronic and able to be extracted from the Medical Examination Form.

Type of violence to be coded for follow up and data collection (GBV Administrative data) reporting:

- Physical
- Sexual
- Child abuse under 18 years of age
- If referred
- Follow-up
- Perpetrator

16. Glossary of Terms

Child	In accordance with the Convention on the Rights of the Child a "child" is defined as a person below the age of 18 years.
Gender[14]	Refers to the socially constructed characteristics of women and men–such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and work places. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion–all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.
Gender equality[15]	Refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration – recognizing the diversity of different groups of women and men. Gender equality is not a 'women's issue' but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development. Gender inequality therefore refers to the absence of such rights, responsibilities and opportunities.
Gender-based violence[16]	An umbrella term for any harmful act that is perpetrated against a person's will; it is based on socially ascribed (gender) differences between male and female. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.
Informed consent	This means explaining all aspects of the examination to the patient in a manner they can fully understand. Particular emphasis should be placed on the matter of the release of information to other parties, including the police and other parties. This is especially important in settings where there is a legal obligation to report an episode of violence (and hence details of the examination) to relevant authorities. It is crucial that patients and parent/caregivers understand the options open to them and are given sufficient information to enable them to make informed decisions about their care. This is a fundamental right of all patients but has particular relevance in this setting where patients may have been subjected to a personal and intrusive event against their will. It is also important to ensure that a patient has a sense of control returned to them when in medical care. Above all, the wishes of the patient must be respected (WHO 2003).

14 Gender Fact sheet N°403 August 2015 http://www.who.int/mediacentre/factsheets/fs403/en/ accessed 11, May 2017

15 Gender mainstreaming: strategy for promoting gender equality. Office of the Special Advisor on Gender Issues and Advancement of Women (OSAGI); 2001 (http://www.un.org/ womenwatch/osagi/pdf/factsheet1.pdf, accessed 11, May 2017)

16 Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery IASC Inter-Agency Standing Committee 2015(https://interagencystandingcommittee.org/working-group/documents-public/guidelines-integrating-gender-based-violence-interventions accessed 11 May 2017)

Perpetrator	A person who directly inflicts or supports violence or other abuse inflicted on another against her/his will.
Psychological first aid (PFA)	A set of skills that helps someone to provide basic stabilizing psychological support in the aftermath of a traumatic event.
Sexual Assault	The term sexual assault refers to sexual contact or behaviour that occurs without explicit consent of the victim. Some forms of sexual assault include: • Attempted rape • Fondling or unwanted sexual touching • Forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body • Penetration of the victim's body, also known as rape
Sexual Violence	Sexual violence is defined as: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation. Sexual violence includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus.
Survivor/ victim	Survivor/victim refers to people who have experienced/are affected by violence. The term survivor is usually preferred by those working on violence against women to emphasize that women affected by violence have agency and are not merely passive "victims" in the face of violence. The term victim is, however, used in criminal justice. For the purposes of this document, they are used interchangeably.

17. Language – Translation into Local Languages

It is important that all health staff are comfortable using explicit local words for relevant terminology associated with attending to survivors of GBV and SV. Some examples provided below.

Glossary	Translation
Anal	Rod blong sitsit
Breasts	Titi
Clitoris	No Bislama word
Confidentiality	Kipim I sikret
Hymen	No Bislama word
Informed consent	Explenesen I klia mo yu agri wetem
Labia	No Bislama word
Masturbation, touching sex organs	Pleple long hem wan o I askem yu blong pleplei wetem tabu part
Oral penetration by penis	Hemi pusum tabu part blong hem insaed long maot
Penetration of rectum by object	Hemi pusum wan narafala samting insaed lo rod blong sitsit
Penetration of rectum by penis/ finger	Hemi pusum tabu part blong hem or finger blong hem insaed lo rod blong sisit
Penetration of vagina by object	Hemi pusum wan narafala samting insaed lo tabu part
Penetration of vagina by penis/ finger	Hemi pusum tabu part blong hem or wan narafala samting or finger blong hem insaed lo tabu part
Penis	Pipe blo pispis (pispis)/tabu part
Rape	Hemi force blong mekem trabol/sex we yu no wantem
Scrotum	Basket blo bolbol
Sexual assault	Fasin blong fosem man/woman blong mekem sex or touchem tabu part blong man or woman
Testicle	Basket blo egg blong man
Vagina	Tabu part/rod blong pikinini

Annexes

Annex 1.
Psychological First Aid for Health Staff

PFA is a set of skills and knowledge that can be used to help people who are in distress AND as a way of helping people to feel calm and able to cope in a difficult situation. It can be used in many situations, not just in dealing with GBV.

PFA is simply:

- comforting someone (adults and/or children) in distress and helping them feel safe and calm
- assessing needs and concerns
- protecting people from further harm
- providing emotional support
- helping to address immediate basic needs, such as food and water, a blanket or a temporary place to stay
- helping people access information, services and social supports.

PFA is NOT

- something only professionals do
- professional counselling or therapy
- encouraging a detailed discussion of the event that has caused the distress
- asking someone to analyze what has happened to them
- pressuring someone for details on what happened
- pressuring people to share their feelings and reactions to an event.
- making decisions for someone about what to do next

Consider the below PFA steps along with supportive communication and actions when treating patients who are in distress - **Learn, Look, Listen, Link:**

Learn- asks what you know about the current conditions in your area of operation.

- Are people experiencing other stressful events like intimate partner violence or the death of a loved one? Which events? Are conditions safe or is the crisis ongoing?
- Who has been most affected by the conditions or is most vulnerable in the current crisis?
- What do you know about available services in your area and how to access them?

In PFA, learning is about getting to know the environment in which you work or reflecting on and analyzing the environment that you know well.

Look- guides you to observe individuals who have been affected by the crisis.

- Look at their appearance (weight, injuries, clothing, and hygiene) and behavior/body language (rate of breathing, pale or flushed skin, eye contact, slow or painful body movements, clenched hands, and facial expressions). Be aware of social norms.
- In particular, look for signs of distress like crying, anxiety, guilt, shame, irritability, anger, hyperventilating, shaking, nightmares, abnormal sleeplessness, loss of appetite, headaches, and stomach aches.
- Look for a safe physical and emotional place for those who are in distress to express their feelings.

Listen- connect and respond to what you have observed through active listening or communication skills.

- Ask the person in distress if you can help and move to a quiet space to protect their privacy. If the woman is with her partner, talk to her alone in case she is experiencing intimate partner violence (IPV). Prioritize her safety and security always.
- Offer basic immediate comforts like tissue, water, or a blanket.
- Put all of your focus on the person. Clear your mind of judgments and assumptions, especially in cases of gender-based violence.
- Don't rush to talk or start interviewing the person. Sit quietly with the person.
  - If you know the situation you can refer to it. For example, experiencing violence can be a terrifying and stressful experience. How are you coping?
  - If you don't know the situation, you can state your concerns and invite the person to tell you their needs. For example, I have seen you are not yourself, you look sad and worried. Is there something I can help with?
- Use appropriate body language (relaxed posture, lean in slightly, face the survivor, open arms, soft eye contact).
- Ask only necessary questions.
- Use "encouragers" like nodding your head, saying I see or go on.
- Use silence to allow the person space to think and talk.
- Use comforting statements like:
  - You are not alone. Other people have experienced this too.
  - You are doing your best. You had a terrible situation and you tried to make the best decision you could.
  - Many people who have this experience feel like you do. This is a common reaction to what happened.
- If listening to a GBV survivor, provide immediate emotional comfort. Tell the survivor it is not her fault. Believe her.
- Identify high-risk cases.

Link- respond to what you heard by providing relevant information, focusing on positive coping skills, addressing basic needs, helping people access services, and connecting people to loved ones and social support that fits their situation.

- Information tools- facts about the situation, rights, and safety. Give information that addresses common feelings that people might experience. Share information about what you can do to help.
- Coping tools- positive coping strategies, deep breathing, identifying a support system.
  - Positive coping strategies include something creative (sing, draw, sewing), physical (walk, exercise, stretch), social (tea with a friend, playing with children, attending virtual events), and relaxing (meditate, read, play).
  - Encourage people to use positive coping strategies while avoiding negative ones such as drinking alcohol, taking drugs, using violence, sleeping all day, neglecting personal hygiene.
- Basic needs and services tools- information about other relevant services that might be available, the national referral system, which offers the following direct services for survivors of GBV:
  - safety and security, including the Domestic Violence Interim Protection Order;
  - medical care, including clinical care for physical and sexual assault;
  - counselling and survivor advocacy;
  - shelter;
  - child protection
- Connecting people with others- community, friends, family, religious leaders, volunteers, recreational or educational groups, livelihood programs.
- Linking those in crisis to the appropriate tools can build their resilience to recover from negative events and resume normal life.

For more information about PFA refer to the following resources:

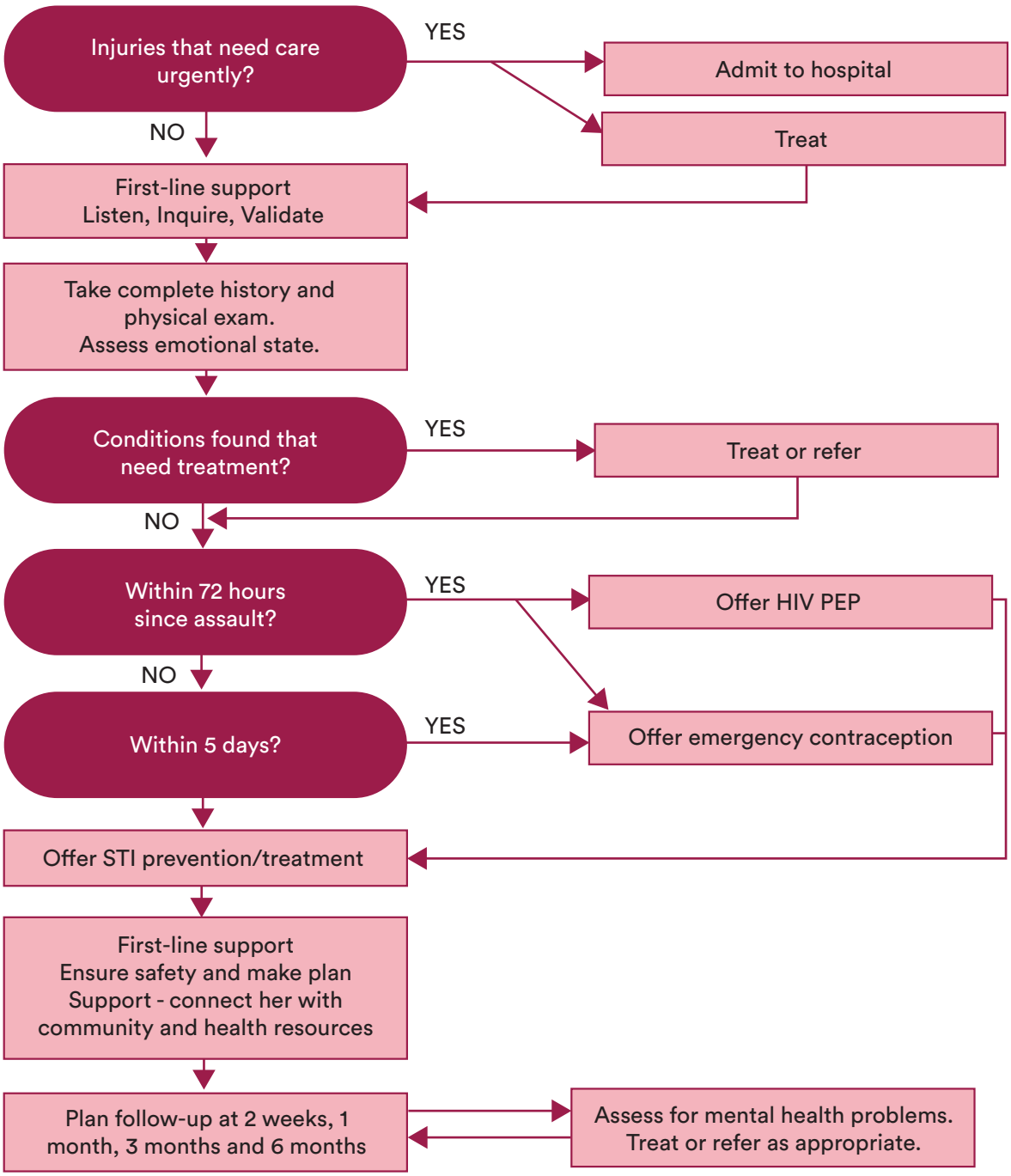
Psychological First Aid: Guide for Field Workers. 2011. WHO, *War Trauma Foundation and World Vision International* *http://www.who.int/mental_health/publications/guide_field_workers/en/*

WHO 2013 Psychological First aid: Facilitator's manual for orienting field workers.

Annex 2.
What is First-Line Support?
LIVES

	RAISE THE SUBJECT	Many women experience problems with their husband or partner, or someone else they live with
	USE DIRECT QUESTIONS	Are you afraid of your husband or partner? Has your husband or partner or someone else at home threatened to hurt you or physically harm you? Has your husband or partner forced you into sex or forced you to have sexual contact you did not concent to?
L	**LISTEN**	Make eye contact Reflect how she is feeling Respect her rights and dignity Be gentle Don't rush her
I	**INQUIRE**	Ask open-ended questions Ask for clarification or detail Reflect back her feelings Help her identify needs or concerns Summarize what she said
V	**VALIDATE**	It's not your fault. you are not to blame You are not alone Everybody deserves to feel safe at home i am concerned this may be affecting your health
E	**ENHANCE SAFETY**	Has physical violence increased over the past six months? Is he violently and constantly jealous of you? Has he ever beaten you when you were pregnant? Has he ever used or threatened you with a weapon? Do you believe he could kill you?
S	**SUPPORT**	Ask her "What would help the most if we could do it right away?" Help her to identify and consider her options Discuss her social support

Annex 3.
Pathway for Initial Care after Assault



Annex 4.
Consent

Name of facility _____

Note to the health worker:
After providing the relevant information to the patient, read the entire form to the patient (or his/her parent/guardian), explaining that she can choose to refuse any (or none) of the items listed. Obtain a signature, or a thumb print with signature of the witness.

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

	Yes	No
Conduct a medical examination	☐	☐
Conduct pelvic examination	☐	☐
Conduct evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided	☐	☐

I understand that I can refuse any aspect of the examination I don´t wish to undergo

Signature: _____

Date: _____

Witness: _____

Annex 5.
Medical History and Examination Form for Sexual Assault

CONFIDENTIAL **CODE: _____**

May I ask you some questions so that we can decide how to help you? I know that some things may be difficult to talk about. Please try to answer. But you do not have to answer if it is too difficult.

1. GENERAL INFORMATION

Family name	Given name	
Address		
Sex	Date of birth _____ / _____ / _____ DD MM YY	Age
Date and time of examination _____ / _____ / _____ ; _____ DD MM YY	In the presence of	

2. GENERAL MEDICAL INFORMATION

Existing health problems
Do you have any ongoing health problems? ☐ Yes ☐ No If "yes", what health problems?
Do you have any allergies? If so, to what?
Are you taking any medicines, herbs or potions?

Vaccination status
Have you been vaccinated for:
tetanus? ☐ Yes When? _____ / _____ / _____ DD MM YY
☐ No ☐ Does not know
hepatitis B? ☐ Yes ☐ No ☐ Does not know
HPV? ☐ Yes ☐ No ☐ Does not know
HIV/AIDS status
Have you had an HIV test? ☐ Yes When? _____ / _____ / _____ DD MM YY ☐ No
If" yes", may I ask the result? ☐ Negative ☐ Positive ☐ Not disclosed

3. DESCRIPTION OF INCIDENT

Date of incident: _____ / _____ / ____ DD MM YY	**Time of incident:**
Could you tell me what happened, please? Has something like this happened before? ☐ Yes ☐ No If "yes": When was that? _____ / _____ / ____ DD MM YY Was the same person responsible this time? ☐ Yes ☐ No	
Physical violence	**Describe type and location on body charts**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	
Drugs/alcohol involved	

In case of sexual assaut	Penetration	Yes	No	Not sure	Describe (oral, vaginal, anal)
	Penis	☐	☐	☐	
	Finger	☐	☐	☐	
	Other (describe):	☐	☐	☐	
	Ejaculation	☐	☐	☐	
	Condom used	☐	☐	☐	

Actions after assault		
After this happened did you	**Yes**	**No**
Vomit?	☐	☐
Urinate?	☐	☐
Defecate?	☐	☐
Brush your teeth?	☐	☐
Rinse your mouth?	☐	☐
Change your clothes?	☐	☐
Wash or bathe?	☐	☐
Use a tampon or pad?	☐	☐

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method?

☐ IUD ☐ Pill ☐ Injectable

☐ Sterilization ☐ Condom ☐ Other _____

Were you using this method when the incident happened? ☐ Yes ☐ No

Menstruation and pregnancy

When did your last menstrual bleeding start? ___ / ___ / _____ DD MM YY

Were you menstruating at the time of event? ☐ Yes ☐ No

Do you think you might be pregnant? ☐ Yes ☐ No

If "yes", number of weeks pregnant: ____ weeks

Have you ever been pregnant? ☐ Yes ☐ No

If "yes", how many times? _____ times

History of consenting intercourse (only if samples taken for DNA analysis in assault case)

When was the last time you had sex willingly? ____ / ___ / ____DD MM YY

Who was it? (for example, husband, boyfriend, stranger)

5. HEAD-TO-TOE PHYSICAL EXAMINATION

Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature)	
Pulse rate	Blood pressure	Respiratory rate	Temperature
Physical findings Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document type, size, colour, form and other particulars. Describe as completely and accurately as possible. Do not interpret the findings.			
Head and face		Mouth and nose	
Eyes and ears		Neck	
Chest		Back	
Abdomen		Buttocks	
Arms and hands		Legs and feet	

6. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	Introitus and hymen		Anus
Vagina / penis	Cervix	Bimanual / rectovaginal examination	Evidence of female genital mutilation? (where relevant) ☐ Yes ☐ No
Position of patient (supine, prone, knee–chest, lateral)			
For genital examination		For anal examination	

7. MENTAL STATE

Appearance	☐ casual dress, normal grooming and hygiene ☐ other (describe):	
Attitude	☐ calm and cooperative ☐ other (describe):	
Behavior	☐ no unusual movements or psychomotor changes ☐ other (describe):	
Speech	☐ normal rate/tone/volume without pressure ☐ other (describe)	
Affect	☐ reactive and mood congruent ☐ normal range ☐ labile tearful blunted	☐ depressed constricted flat ☐ other (describe):
Mood	☐ euthymic ☐ anxious ☐ irritable elevated	☐ depressed ☐ other (describe):
Thought Processes	☐ goal-directed and logical ☐ disorganized	☐ other (describe)
Throught Content	☐ delusions phobias ☐ obsessions/compulsions	☐ other (describe)
Perception	☐ no hallucinations or delusions during interview ☐ other (describe):	
Orientation	Oriented: ☐ time ☐ place ☐ person	☐ self ☐ other (describe):
Memory/Concentration	☐ short term intact ☐ long term intact ☐ distractable/inattentive	☐ other (describe):
Insight/Judgement	☐ good ☐ fair ☐ poor	

Acute stress/PTSD risk	Yes	No
Are you distressed by certain places, people, situations etc that remind you of the incident?	☐	☐
Are there bad thoughts or memories or dreams that keep coming back?	☐	☐
Are you seeing the event over and over in your mind?	☐	☐
Avoiding thoughts, feelings, or conversations about hte incident	☐	☐
Avoiding activities and places or people who remind you of it	☐	☐
Irritability or outbursts of anger	☐	☐
Reckless or self-destructive behavior	☐	☐
Problems concentrating	☐	☐
Feeling on guard	☐	☐
Easily startled	☐	☐
Problems sleeping	☐	☐
Self harm risk:		
Have you had thoughts about hurting yourself? ☐ Yes ☐ No		
Do you have any plans on when, where and how you intent to harm yourself?		
Do you have any history of self harm? If yet-when? What method? Premeditated? Intention?		
Risk of self harm ☐ Low ☐ Moderate ☐ High		
Agression/violence risk		
Has the individual made threats? Against whom?		
Is the patient hostile or angry? ☐ Yes ☐ No		
Does the individual carry any weapon? ☐ Yes ☐ No		
Thoughts of violence ☐ Yes ☐ No		
Risk of harm to others ☐ Low ☐ Moderate ☐ High		

8. INVESTIGATIONS DONE

Type and location	Examined / sent to laboratory	Result

9. EVIDENCE TAKEN

Type and location	Sent to / stored	Collected by / date

10. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and comments
STI prevention/treatment	☐	☐	
Emergency contraception	☐	☐	
Wound treatment	☐	☐	
Tetanus prophylaxis	☐	☐	
Hepatitis B vaccination	☐	☐	
Post-exposure prophylaxis for HIV	☐	☐	
Other	☐	☐	

11. COUNSELLING, REFERRALS, FOLLOW-UP

Client plans to report to police OR has already made report? ☐ Yes ☐ No	
Client has a safe place to go? ☐ Yes ☐ No	Has someone to accompany her/him? ☐ Yes ☐ No
Counselling provided:	
Referrals made (for example, housing, mental health care, support group): To: Purpose:	
Follow-up agreed with client? ☐ Yes ☐ No Date of next visit: _____ / _____ / _____ DD MM YY	

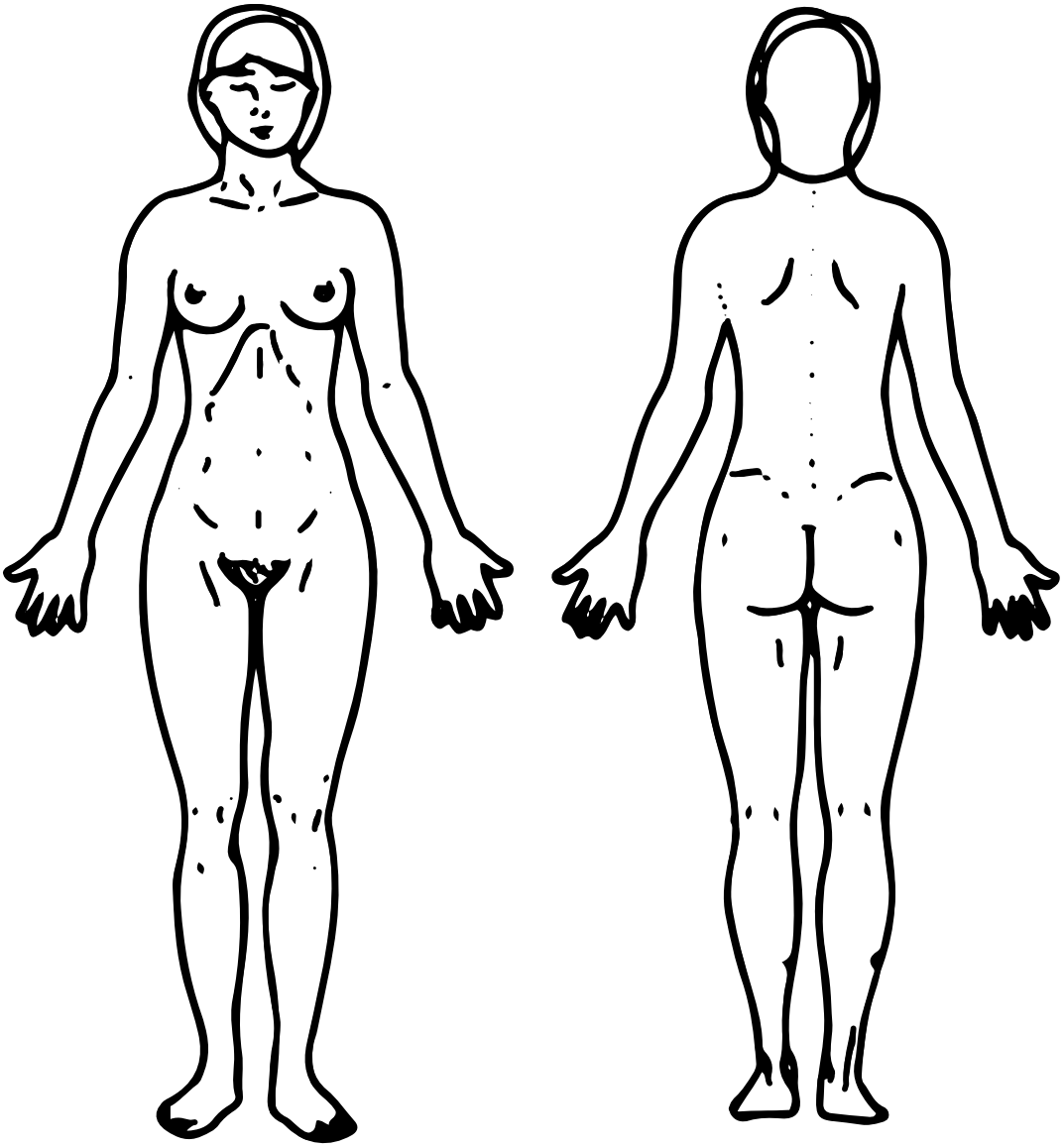
Name of health-care provider conducting the examination/interview:

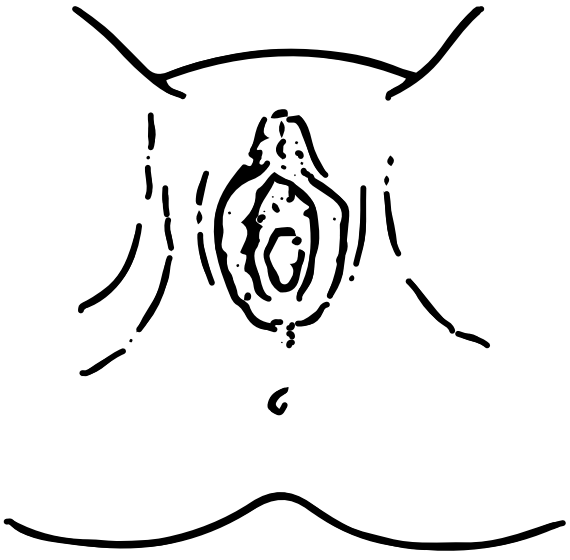
Title: _____

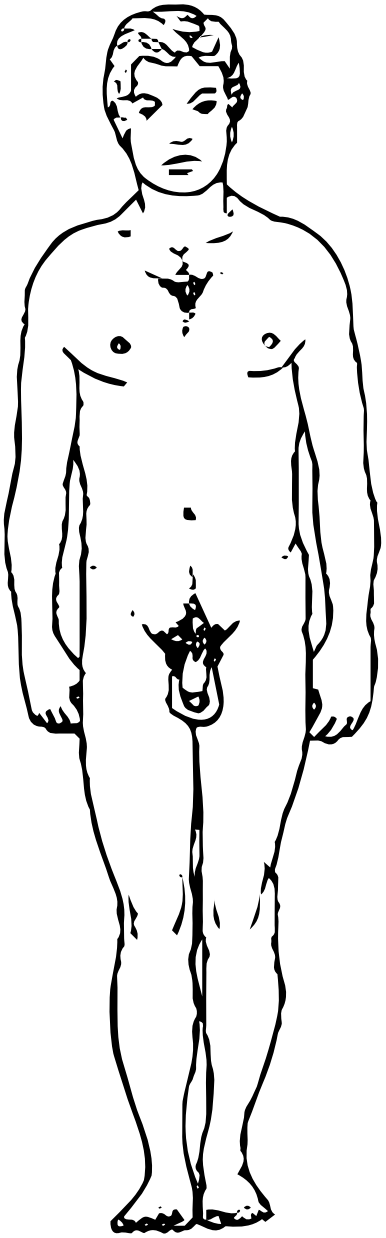
Printed name: _____

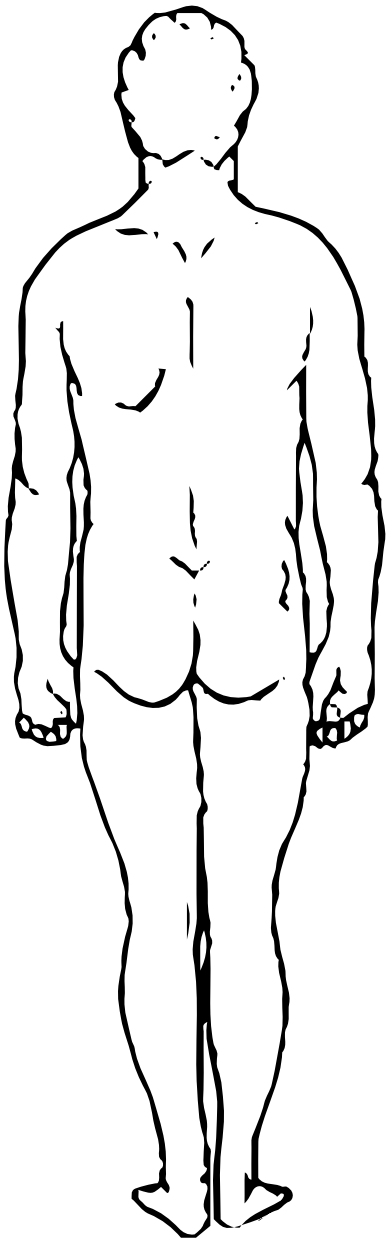
Signature: _____

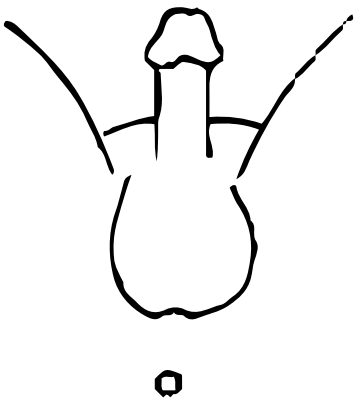
Date: _____ / _____ / _____ DD MM YY

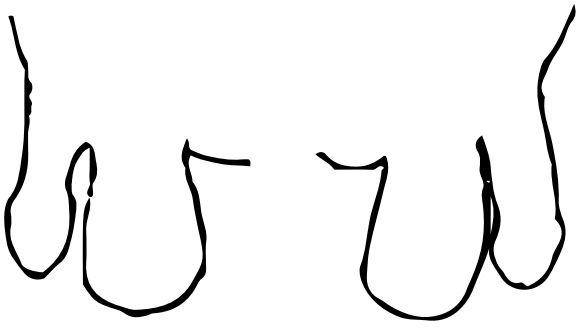


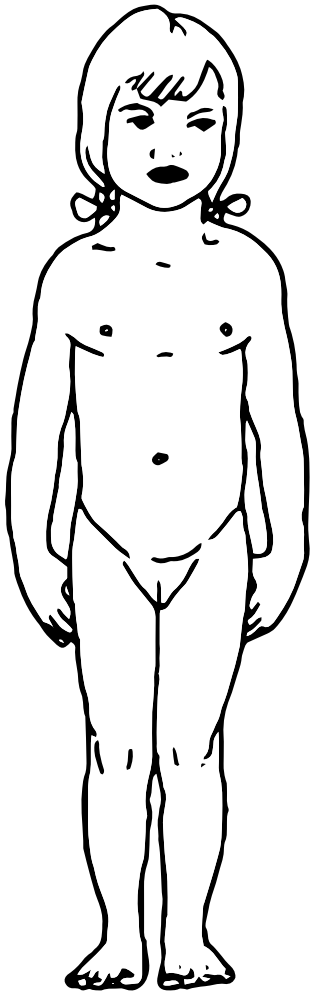


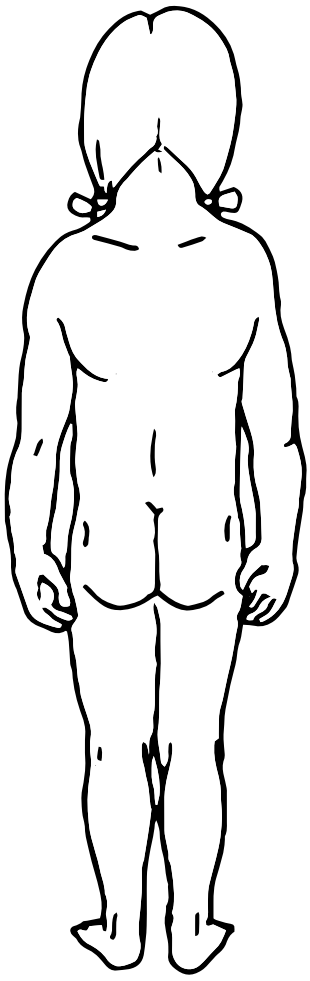


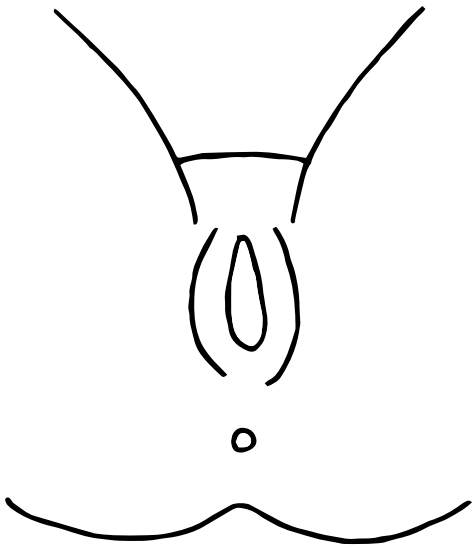


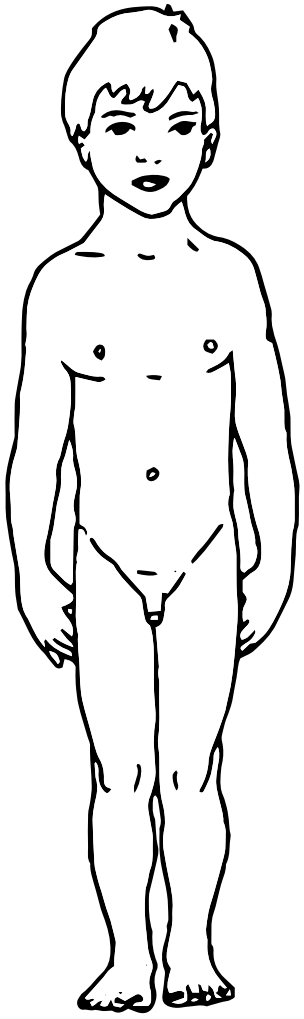


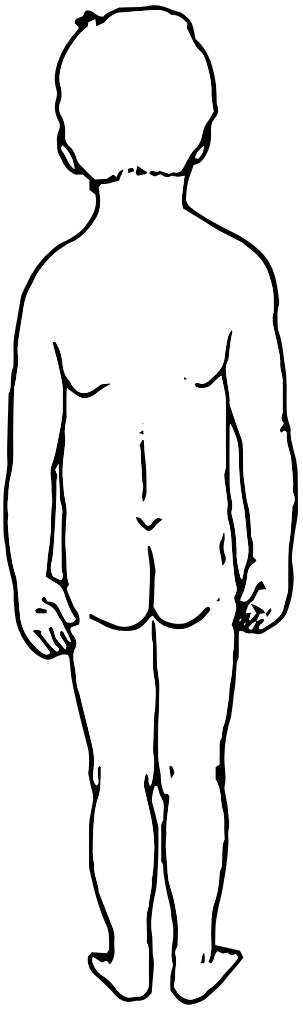


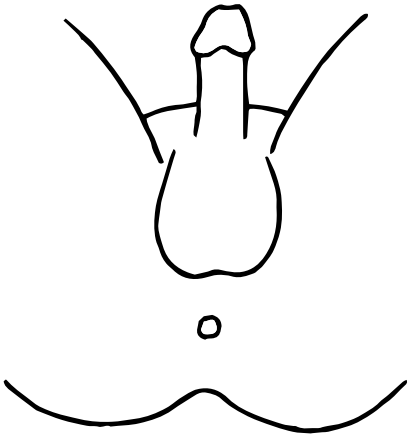


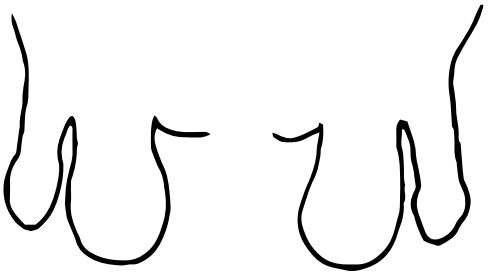












Annex 6.
Responding to Direct or Indirect Child Survivors

There is a strong correlation between violence perpetrated against children and violence perpetrated against adult women in the home.[17] Gender-based violence (GBV) affects children, either directly through experiencing sexual violence, or physical or emotional abuse from an intimate partner or household member, or oftentimes indirectly through the witnessing of domestic violence (DV) between parents, or between a parent and her/his partner. In other instances, children may be the direct inadvertent recipients of GBV, such as being beaten when attempting to protect/shield their family members from abuse. Under the UN Convention on the Rights of the Children (UNCRC), Governments and their officers have a special responsibility to protect children from all forms of violence, to support parents in their child-rearing responsibilities, and to intervene to protect children when they are at risk of or have experienced harm (Articles 19, UNCRC). Any child who witnesses GBV is exposed to ***emotional abuse,*** which has lasting adverse impacts on girls' and boys' mental health and overall well-being. ***Child survivors, by virtue of their age and vulnerability, require specialised treatment and support, different from adult survivors.***

Health workers are most likely to be the first point of contact for a child[18], female or male, who has experienced abuse or neglect either directly or indirectly as a result of a GBV/Sexual Violence (SV)/DV incident. A health worker may learn of a girl or boy who has been abused or neglected in many ways:

- A child being brought to a health clinic or emergency department by a parent/caregiver for treatment of injuries
- Noticing or identifying, from a routine physical examination or unrelated medical complaint, that a child may have been physically abused, sexually abused or neglected
- A child being brought in by the police or other authority for a medical evaluation due to suspected physical or sexual abuse

17 UNICEF UNFPA (2015) Intersections of links between violence against women and violence against children in the South Pacific
18 Definition of a child is "Everyone under the age of 18"(Article 1, UNCRC)

As such, health workers are to ***ensure that a child, whether a girl or a boy, are protected from all forms of violence, abuse, neglect or exploitation*** (i.e. child protection issues). They are to:

- First and foremost, take the necessary steps to ensure the child's safety; for example, separating or preventing direct contact between the child and the alleged perpetrator of child abuse; ensuring the child/adolescent is accompanied by a safe and trusted adult; contacting the police for assistance etc.
- Provide child-sensitive medical treatment for injuries and any follow up medical care needed
- Report or refer any child suspected of, or known to have, experienced child abuse or neglect to the Child Protection authority under the MJCS
- Where necessary for an investigation and likely to result in evidence, conduct a child-sensitive forensic medical examination, collect forensic evidence, prepare a medical report, and testify in court as needed.
- In all their actions, health workers are to ensure that the best interests of the child/adolescent take priority.

Health workers have an essential role to play in identifying and addressing the health and psychosocial needs of children who have experienced abuse or neglect and providing a sensitive response that will help the child recover from trauma. A few of these signs/symptoms of abuse, by category are presented below:

Category of Abuse	Signs or Symptoms
Physical abuse	• Unexplained, burns, bites, bruises, or broken bones. • Frightened of parents or caregivers, afraid to go home, wary of adult contact, or frightened when other children cry.
Emotional abuse	• Being treated differently to other children or adolescents in the household. • Self-harm (hurting themselves with an object), or attempted suicide. • Fearful, anxious, depressed, or lowself-esteem.
Sexual abuse	• STIs, pregnancy, stomach pain when walking or sitting; pain, discoloration, bleeding or discharge in genitals, anus or mouth. • Unwilling to change for sports classes, lack of trust or fear of someone they know well. • Sudden change in behaviour, appetite, or personality; self-harm such as using an object to hurt themselves, or attempted suicide. • Unusual knowledge of sexual behaviours for their age and level of maturity, such as mimicking adult-like sexual behaviours and language with other children or toys. • Bed-wetting.
Neglect	• Malnourished, unclothed, dirty, and/or often sick. • Unattended physical and/or medical problems. • Frequently missing school, constant hunger, and/or saying no one looks after him/her. • Frequently unsupervised, caring for other family members, left alone, or allowed to play in unsafe situations and environments.

Health workers can incorporate open-ended screening questions[19] when completing intake processes with children and adolescents. When you are asking a child about something that could be awkward, uncomfortable, embarrassing, shameful, or sensitive, **open-ended question**s give you the best chance of getting the whole story. For example – "I notice that you have a bruise. How did it happen?" … "Tell me more about that"; or "You seem to get angry when I asked you that question…then pause to allow child to respond."

Also, it is normal for helping professionals (Child Protection Officers, NGO staff, teachers, nurses, doctors etc.) to feel uncomfortable asking screening questions. However, it is important to note that many children who are being abused or neglected do not show any signs or symptoms of abuse/neglect. Below are examples of **screening questions** to ask children and adolescents:

Physical Abuse:
- Have you ever been hurt by someone taking care of you?
  - How did that happen?
- Have you ever been taken to the hospital/emergency room because you were hurt?
  - How did that happen?

Sexual Abuse:
- Is anyone making you do anything that you feel uncomfortable about?
- What have you learned about "good touch/bad touch?" How did you learn that?
- What would you do if someone were trying to touch your private areas?
- What if it was someone that you know?

Neglect:
- What kind of things make you scared when you are at home?
- What does the word "discipline" mean to you?
- How was your mother disciplined when she was growing up? How about your dad?
- What is discipline like for you? Your brothers or sisters?
- How do you think kids should be disciplined if they do something bad?
- Who is at your house when you come home from school (when you get up in the morning, go to sleep at night)?
- Who helps you get ready for school?
- What do you think you are worth as a person?
- Are there times when you feel bad about yourself? How does that happen?

If the child/adolescent does not acknowledge that anything happened when answering the open-ended questions, then it is fine to use close-ended questions (questions that invite one-word answers like "yes" or "no"), like "Did someone touch you in a way that made you feel bad, or uncomfortable or confused?" If a child answers "Yes" to a closed-ended question, then your next question should be an open-ended question: "Tell me about it." Then continue to ask questions in order to know what tests need to be ordered and treatment given.

19 Source: https://www.dorightbykids.org/how-do-i-recognize-child-abuse-and-neglect/what-questions-should-i-ask-what-questions-shouldnt-i-ask/

When a child survivor "closes up" and becomes quiet, it is ***important for the health workers to acknowledge their fears, explore their fears, and educate them accordingly:***

- **Acknowledge their fears:** "Are you afraid to tell me what really happened?" Survivors will often admit they are afraid, because this admission is not the same as giving details about the abuse.
- **Explore their fears:** "What are you afraid will happen if you tell me?" Even young children might say things like "I don't want to get taken from my mom" to which the health worker can further explore "Where did you hear that you might get taken from you mom?" and they often say "My mom told me."
- **Educate accordingly:** Talk with the survivor about their fears and educate them when possible.

In some cases, health care workers may need to employ non-intrusive, creative approaches to solicit information from the child. This may include the use of drawing and the arts, pictures and illustrations, toys, dolls or human-like figures. The HCW should be able to appreciate the theme of the child's drawings and play and the latter's accompanying narrative. It is essential for the HCW to allow adequate time for children to feel safe to disclose their experiences.

Whenever a health worker suspects that a girl or a boy is a direct or indirect survivor of a GBV/SV/DV incident, the health worker is to be deliberate about ***providing child-sensitive medical care. Health workers are to:***

- Maximize efforts to have the child undergo only one examination in order to minimize trauma.
- Offer a choice in the sex of the examiner, whenever possible.
- Conduct the history and medical examination in a room that is safe, private, quiet, and child-friendly.
- Make sure that there is another safe adult present during the examination.
- Allow the child to choose who is present in the room whenever possible. Ensure that the adult support person is not a witness to the abuse, the alleged perpetrator or a person who is sympathetic to the alleged perpetrator.
- Minimize the need for the child to repeatedly describe the incident, as this can be re-traumatizing. Limit questions to what is required for medical care. Where possible, obtain details of the child abuse incident from the police other service providers involved in the case, or the accompanying parent/caregiver/adult, rather than having the child repeat what happened to her/him multiple times to different people
- Use language and terminology that is appropriate to the child's age, developmental stage and that is non-stigmatizing. Reassure the child they are not to blame for their experience of abuse or neglect.
- Clearly explain confidentiality and any limitations, including the mandatory reporting requirement for health workers who become aware of a situation or act which may amount to child neglect, abuse, maltreatment and exploitation. Explain that the health worker is obligated to share with the child protection authority (MJCS Child Desk) information that

will facilitate an investigation and identify perpetrators or victims of child neglect, abuse, maltreatment and exploitation.

- Respect the wishes of children (e.g. not forcing them to give information or be examined) while balancing this with the need to protect their best interests and safety. In situations where a child's wishes cannot be prioritized, the reasons should be explained to the child before further steps are taken.
- Seek informed consent from the child or their non-offending parent/caregiver as appropriate. If the child is under the legal age of consent for obtaining clinical care, it is still best to seek their "assent" by explaining the procedure and why it is needed, in simple child-friendly terms, and seeking the child's permission. In situations where a child's wishes cannot be prioritized, the reasons should be explained to the child.
- If parents/caregivers refuse any required preventive or necessary medical exam and treatment for their child, regardless of their religious and moral beliefs, recourse may be made to a court to order the parents/caregivers to provide the child with the required treatment.
- Conduct a comprehensive assessment of the child's physical and emotional health in order to facilitate appropriate treatment and/or referrals.
- During the examination, explain what will be done in child-friendly language and prior to each step.
- Demonstrate trustworthiness by following through on anything told to the child or caregiver and providing emotional support.
- Minimize delays while conducting the examination in accordance with the child's wishes (for example, not rushing the child through the examination).
- Clearly explain what to expect after the exam and provide instructions for follow-up.

Health workers can provide support to a child who is being abused or at-risk of harm by following these key guidelines:

1. **Safety first!** Make sure that you, the child, and others are safe from harm.
2. **Listen.** Use your communication skills. Do not pressure the child/adolescent to talk. Be patient and reassure them that you are there to help and to listen.
3. **Offer practical comfort and information.** Offer the child/adolescent gestures of comfort to help them feel safe, such as a quiet place to talk, water or a blanket. Ask them what they need – do not assume that you know.
4. **Help the child/adolescent regain control.** Support the child/adolescent to breathe slowly. If they are out of touch with their surroundings, remind them where they are. Encourage them to reach out to supportive people in their lives.
5. **Provide clear information.** Give reliable information to help the child/adolescent understand the situation and what help is available. Keep the message simple, child-friendly and repeat it or write it down if needed.
6. **Know your limits.** Do not offer support which is beyond your role. If you cannot help, refer to someone who can.
7. **Refer.** If a child/adolescent has told you that they are experiencing violence, abuse, neglect or exploitation, immediately report child protection issue(s) to social welfare/child protection officer and/or the police.

Annex 7.
Referral Contacts

Services provided	Who to refer to Location	Contact Info	Responsibility to follow-up
Shelter/ housing	Local Chief Local Church Leader Police	Each village has contacts	
Crisis Center **Support Groups**	Vanuatu Women Center (Port Vila) Tafea Counselling Center Sanma Counselling Center Torba Counselling Center	25764/24000 88660/7101869 36076/36157/37110 7793459/7102422	
Legal Aid	Vanuatu Women Center Contact local Police Posts (below)	25764/24000	
Police and Protection	Vanuatu Police Family Protection Unit Port Vila, Efate	22222/5454000/23163	
	Luganville, Santo Malekula Tanna Ambae Torba	7336418/ Hotline – 111 7770942/33886 7793087/88658 7791394 7793066	
Counseling and Support	Tafea VWC Committee	Aneitym, Aniwa, Futuna, Port Narvin, Williams Bay, Imaki	
	Shefa VWC Committee	Burumba– Epi, Lamenu island, Emae, Tongoa	
	Penama VWC Committee	East Ambae, Gaivo, Huritahi, Lavul, Loltong, Melsis, Nasawa, Nduindui, Not Ambae, Pangi, Walaha	
	Malampa VWC Committee	Aulua, Burbar, Lolihor, Lonhali, Maskelynes, Notwes Bay, Uripiv, Wala,Wawafonhal	
	Sanma VWC Committee	Big Bay bush, Matantas, South Santo, Winsau	
	Torba Province	Gaua, Hiu, Loh, Mota, Mota Lava, Ureparapara, West vanua Lava	

Services provided	Who to refer to Location	Contact Info	Responsibility to follow-up
Mental Health Care	Vila Central Hospital	22100/1081	
	Northern Provincial Hospital (NPH)	36015/36345/7742448	
	Lolowai Hospital	7728074	
	Norsup Hospital	33875/48410	
	Lenakel Hospital	88659/33910/7100156	
Child Care	Ministry of Justice Child Desk	VOIP 5184/5489089	
Private medical clinic	Vanuatu Medical Centre	22826/25860	
Referral hospital	Vila Central Hospital	22100/22070/33070/24012	
	Northern Provincial Hospital - Santo	36015	
Provincial hospitals	Lenakel Hospital - Tanna	88659/33910	
	Norsup Hospital - Malekula	33875/48410	
	Lolowai Hospital – Ambae	7728074	
	Torba Hospital – Vanua Lava	5441582	

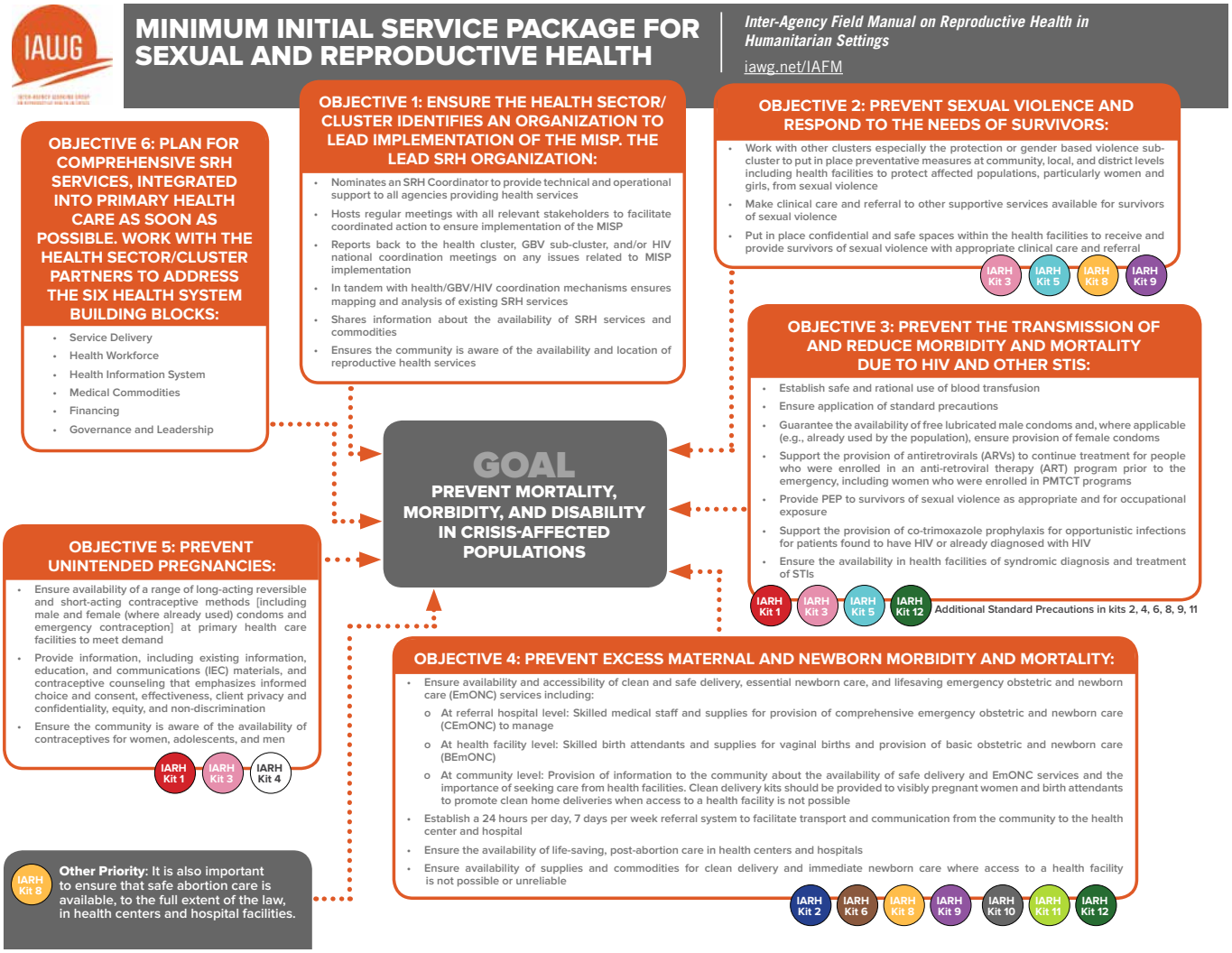
Annex 8.
Role of Health Care Professionals for GBV in Emergencies

This Annex provides supplementary information for health workers to consider in providing clinical and medical care to GBV survivors during humanitarian situations.

1. **Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) Checklist** https://iawg.net/index.php?p=actions/asset-count/count&id=35998
   Health providers can use this checklist as a guide to establish minimum GBV services and monitor service provision at the onset of a humanitarian crisis when the health system is unable to provide comprehensive GBV services. At the onset of the humanitarian response, monitoring is done weekly and reports should be done with the overall health sector/cluster or protection sector/cluster. Once services are fully established, monthly monitoring is sufficient.

3. Prevent Sexual Violence and Respond to Survivor's Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	Yes	No
	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100		%
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		
3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100		%
		Yes	No
3.5	Information on the benefits and location of care for survivors of sexual violence		

2. **Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) Cheat sheet** https://cdn.iawg.rygn.io/documents/MISP-Reference-English.pdf?mtime=20200322131753&focal=none
   Health providers can use this quick reference tool to recall the minimum actions required to prevent sexual violence and respond to the needs of survivors as contained in Objective 2 of MISP. The "cheat sheet" also highlights the importance of ensuring availability of RH Kit 3 (Post Rape Treatment Kit), RH Kit 8 (Management of Complications of Miscarriage and Abortion), and RH Kit 9 (Repair of Cervical and Vaginal Tears).



3. **Inter-agency Minimum Standards for GBV in Emergencies Programming**
   Standard 4 Health Care for GBV Survivors - Key Actions for health care for GBV survivors provide the standards that GBV survivors ought to receive from their health care workers (p.27 https://gbvaor.net/gbviems/)

KEY ACTIONS Health Care for GBV Survivors	Preparedness	Response	Recovery
Preposition supplies to ensure women and girls receive PEP within 72 hours of potential exposure.	✔		
Work with health-care staff to ensure women and adolescent girls have immediate access to reproductive health services at the onset of an emergency (no needs assessment is necessary) as outlined in the MISP.[126]		✔	✔
Work with health-care staff to ensure GBV survivors have access to high-quality, life-saving health care based on World Health Organization (WHO) standardized protocols.[127]	✔	✔	✔
Work with health-care actors to assess health facility readiness and health service provision, and advocate to address gaps to ensure an adequate health response is in place and accessible to survivors.	✔		
Enhance the capacity of health-care providers, including midwives and nurses, to deliver quality care to survivors through training, support and supervision, including on GBV prevention and response, clinical management of rape and intimate partner violence.	✔	✔	✔
Establish and maintain safe referral systems among health and other services and among different levels of health care, particularly where life-threatening injuries or injuries necessitating surgical intervention require referral to a facility providing more complex care.	✔	✔	✔
Work with communities to develop safe access, including transportation options, for GBV survivors to obtain health services.	✔	✔	✔
Ensure that a consistent GBV focal point is present in health sector meetings and activities, and that a health sector focal point participates in GBV meetings.		✔	✔
Provide support to health-care actors to train and support medical and non-medical personnel on the needs of GBV survivors and the importance of promoting survivor-centred, compassionate care that is appropriate to the survivor's age, gender and developmental stage.	✔	✔	✔
Strengthen the capacity of community health providers, traditional birth attendants and other community-based health actors who are important entry points for referrals and basic support.	✔	✔	✔
Work with health actors to ensure follow-up and referral of cases.	✔	✔	✔
Work with health providers and community leaders to inform the community about the urgency of, and the procedures for, referring survivors of sexual violence if safe to do so.	✔	✔	✔
Disseminate information and engage communities on the health consequences of intimate partner violence and child marriage, which often increase in emergencies, if safe to do so.	✔	✔	✔
Re-establish comprehensive reproductive health-care services and strengthen national health systems after the immediate emergency onset and during transition phases.		✔	✔

4. **Gender-based violence referral pathway for emergencies/disasters:**
   - The risk of GBV is increased in emergencies and all humanitarian actors have a responsibility to reduce the risk of GBV through prevention, mitigation and response actions (IASC -Guidelines for Integrating GBV Intervention in Humanitarian Action https://gbvguidelines.org/en/).
   - The Vanuatu National Disaster Act (2000) and National disaster Management Plan (NDMP) governs disaster response led by the National Disaster Management Office https://ndmo.gov.vu/ .
   - GBV Referral pathways should be adapted from the National service delivery protocol (forthcoming).