MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Ministry of Health and Wellness
January 2022

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MINISTRY OF HEALTH AND WELLNESS

ISSUED : JANUARY 2022

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MOHW-DOC-6000-5/1

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ABBREVIATIONS & ACRONYMS

ARVs	-	Antiretroviral drugs
ASA	-	Alleged sexual assault
ALTE	-	Apparent life-threatening event
CPFSA	-	Child Protection and Family Services Agency
CISOCA	-	Centre for investigation of sexual offences and child abuse
COC	-	Chain of custody
FII	-	Fatal or induced illness
GBV	-	Gender-based violence
GOJ	-	Government of Jamaica
HCW	-	Healthcare worker
IPV	-	Interpersonal violence
JCF	-	Jamaica Constabulary Force
JISS	-	Jamaica Injury Surveillance System
LGTBQ	-	Lesbian, gays, transgender, bisexual and queer
MDAs	-	Ministries, departments and agencies
MLSS	-	Ministry of Labour and Social Security
MNS	-	Ministry of National Security
MOEYI	-	Ministry of Education, Youth and Information
MOHW	-	Ministry of Health and Wellness
MOJ	-	Ministry of Justice
MSM	-	Men who have sex with men
NGO	-	Non-governmental organization
OCA	-	Office of the Children's Advocate
OCR	-	Office of the Children's Registry
PTSD	-	Post-traumatic Stress Disorder
SAFE Kit	-	Sexual Assault Forensic Examination Kit
STIs	-	Sexually Transmitted Infections
WRVH	-	World Report on Violence and Health

FOREWORD

Violence is a significant global public health and human rights issue. Interpersonal violence is an unfortunate part of our existence. It results in injuries which can be mild to severe, with temporary or long-term effects. Vulnerable groups include children and adolescents, women and girls, the elderly, persons in institutionalised care, persons with disabilities, and persons with mental health disorders. Sexual violence and gender-based violence (GBV) in particular are topical issues.

Healthcare facilities are common entry points to care for instances of interpersonal violence resulting in injury or other illnesses. It is of great importance that healthcare workers are trained in the care of persons who are survivors of interpersonal violence. An understanding of the support needed for these individuals, from arrival to a healthcare facility to follow-up months after, is necessary for the proper handling of cases of interpersonal violence. The ***LIVES*** (*Listen, Inquire, Validate, Enhance Safety, Support*) checklist summarises the skills in communication and empathy required in an encounter between a healthcare worker and a survivor of interpersonal violence.

An intersectoral and collaborative approach is invaluable in the management of interpersonal violence. The Ministry of Health and Wellness (MOHW) collaborates with other ministries, departments and agencies (MDAs), including the Jamaica Constabulary Force, governmental support services and non-governmental organisations, in an effort to properly manage interpersonal violence.

This document provides procedures for the healthcare worker handling a survivor of interpersonal violence. It provides the definitions of violence, highlights indicators of violence, the medicolegal framework relating to violence in Jamaica, and the protocols to be followed in management of a survivor of interpersonal violence. It is hoped that these procedures will equip the healthcare worker with the tools for the management of survivors of interpersonal violence presenting for healthcare in Jamaica.

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Process for Development of the Procedures

This version of the protocol was developed from the first draft of the Interpersonal Violence Clinical Guidelines which was developed in 2019. Both local and international documents were reviewed to determine the procedures. These include Ministry of Health and Wellness' protocols as well as the Childcare Guidelines from the Office of the Children's Advocate. Manuals focusing on screening tools and protocols for child and youth violence prevention from the World Health Organization were also consulted.

During the literature review, most of the literature focused on specific forms of interpersonal violence, including gender-based violence and sexual violence, specifically amongst women and children. The documents outlined treatment and clinical management of gender-based violence as well as violence against children and youth. The literature also spoke to interpersonal violence between youth as it relates to physical violence, including bullying. No clinical guidelines and protocols regarding these incidents and how the healthcare provider should proceed were found during the desk review. There was also a dearth of information related to managing violence against the elderly, persons with disabilities, those with mental health challenges and other at-risk populations. General information on interpersonal violence and procedures for its management in Jamaica was limited.

It is recognized that, clinically, all patients must be treated based on their ailments. However, depending on the population, special care must be taken along the multi-disciplinary care pathway. As part of the process, in-depth interviews were conducted with healthcare officials. This process highlighted some of the current clinical approaches in the healthcare system. The process highlighted the various entry points into care which can be taken by a client and the importance of assessing that violence has taken place, depending on the entry point into care.

Further to that, the process informed and acknowledged that clinicians must be astute when treating different sub-populations. This manual documents the combination of the literature and the findings on what currently takes in place in the healthcare facility in the management of interpersonal violence.

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Purpose and Scope

Violence is a public health issue both locally and globally, and the public health system is integral in the management of interpersonal violence. Medical doctors and other healthcare providers are gatekeepers in efforts to monitor, identify, treat and intervene in cases of interpersonal violence.

The purpose of this document is to provide standardized protocols for the management of survivors of interpersonal violence in the public health system. These procedures are intended to provide healthcare professionals (at all levels of care) with guidance for the identification and management of persons affected by interpersonal violence using the minimum standards of care.

This tool is primarily intended to be used by medical doctors, family nurse practitioners, registered midwives, and nurses, in assisting them with making informed decisions within the context of the system in which the care is being delivered. However, this tool may prove useful to other healthcare providers. Critical companion or reference documents to be used in tandem with these guidelines are listed below:

- Jamaica Injury Surveillance System Operational Manual for JISS 3 (2021);
- National Screening Guidelines for Priority Non-Communicable Diseases (NCDs) in Primary Health Care (2020);
- The Management of Suspected Victims of Trafficking in Persons: Protocol for Healthcare Workers (2017);
- Policy and Procedure Manual for the Referral and Transfer of Patients (2016);
- Mental Health Services Protocol for the Management of Adolescent Suicidal Behaviour in Accident and Emergency Departments (February 2015);

- Standards and Related Criteria for Adolescent Health: A guide for assuring quality health services for adolescents (2013);
- Community Mental Health Services Policies and Procedures Manual (2013);
- Accident and Emergency Department Policies and Procedures Manual (Revised August 2009);
- Protocol for the Management of Common Mental Disorders (October 2005);
- The Management of Victims of Child Abuse and Neglect: Guidelines (2004);
- Health Records Services Procedures Manual (August 2000).

Public health is multi-disciplinary and seeks to promote the health of the population through programmes and policies. So the interventions by healthcare workers are critical. Under the guiding ethical principles of the Medical Council of Jamaica, the practitioner has obligations to the community and the society at large. Healthcare providers play a critical role in the prevention, identification, response to disclosures of interpersonal violence, follow-up and support for persons experiencing its adverse health effects.

These clinical practice procedures speak to the treatment of physical and mental health issues and the respective referral paths, and provide recommendations for the minimum standards of care to identify and manage interpersonal violence in groups, including at-risk groups.

The key clinical issues to be covered include:

- Identification
- Clinical management
- Psychosocial support
- Medicolegal issues

SECTION 1: BACKGROUND & INTRODUCTION

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The health effects of interpersonal violence extend beyond physical injuries to mental ill-health and disabilities which can last a lifetime. Consequences may include sexually transmitted infections (STIs), unwanted pregnancies and depression. Exposure to violence increases the possibility of engaging in risky behaviours, such as smoking and harmful use of alcohol and drugs. These behaviours in turn become risk factors for non-communicable diseases such as cancers, cardiovascular diseases and diabetes. Providing high-quality care and support services to survivors of violence is important for reducing trauma, helping survivors heal and preventing repeat victimization and perpetration. Whilst fatality is the worst outcome of violence, many more survive with injuries that have life-long implications and become a burden to both the social and health systems. Children, women, and the elderly carry the burden of non-fatal injuries. It is these health consequences which need to be assessed and treated to assist in the process of violence prevention as a matter of public health concern. Due to the impact of violence on health, survivors of violence tend to access health services more, thus offering an opportunity for the health sector to identify at-risk groups and provide needed support.

The Government has adopted a multi-sectoral approach to this public health problem. In fact, the National Action Plan for Integrated Response to Children and Violence 2018-2023 names the Ministry of Health and Wellness (MOHW) as one of its partners. Other agencies included within the multi-sectoral response are the Ministry of Education, Youth and Information (MOEYI), the Ministry of Labour and Social Security (MLSS), the Ministry of National Security (MNS), the Ministry of Justice (MOJ), the Ministry of Culture, Gender, Entertainment and Sports (MCGES), the Bureau of Gender Affairs, the Child Protection and Family Services Agency (CPFSA), the Office of the Children's Advocate (OCA), and the Office of the Children's Registry (OCR).

The Jamaican healthcare system is uniquely placed to assist with the identification and treatment of interpersonal violence. It is anticipated that most Jamaicans will visit healthcare facilities at

some point over their life course. In addition, research shows that there are significantly higher reports of incidents of interpersonal violence in the public health system than those recorded by the police, due to under-reporting by the survivors and under-recording by the police.

Entry points to care may vary. This is especially so in the case of intimate partner violence and child abuse. Some may enter at the point of physical care while others enter from the point of mental care. At either point of entry, the healthcare worker must ensure that the adequate screening and referrals are done. Special care must be taken during the screening, identification and management of interpersonal violence amongst the various at-risk populations. These will be outlined further in Sections 4 and 5. It is imperative to take into consideration the biopsychosocial issues that the at-risk population may have. For instance, in the case of the hearing impaired, it is important to take into consideration the communication barrier which may affect the comprehensive identification, treatment and management of violence against this special group.

Further to this, it is recognized that the processes for management of interpersonal violence are also grounded in legislation and policy. Legislation such as the Child Care and Protection Act and the Mental Health Act give guidance on how referral and management of identified cases of violence amongst various groups must be managed. The medicolegal framework relating to violence in Jamaica is outlined in Section 1 (pages 18 and 19). Policies such as the Safety in School Policies and Child Care Guidelines give guidance on how referrals should take place if outside of the public health facility. Guidance on direct referral from school, family, or community for mental health screening and/or treatment is given in Figure 4 of Section 5 on page 53.

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Definition of Interpersonal Violence

Violence is defined as "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in, or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation".

All persons can experience violence, but certain groups are more vulnerable than others to specific types of interpersonal violence. These groups are: girls and women, children, youth, adolescents, the elderly, persons in institutionalized care, persons with mental health disorders, persons with disabilities, homeless persons, and sexual minorities.

The *World Report on Violence and Health* (WRVH) categorizes interpersonal violence into two types (Please see Figure 1, page 17), however it must be noted that each of the vulnerable populations can experience violence in either setting:

1. Family and intimate partner violence (formerly termed as domestic violence) - occurring between family members and intimate partners, usually though not always, taking place inside the home. This category includes child abuse and neglect in the home, intimate partner violence and elder abuse. Children, women at all ages, and older persons are more likely to experience non-fatal domestic violence.
2. Community violence - violence between individuals who may or may not know each other, and generally, although not exclusively, occurs outside the home. Boys and men are more likely to experience community violence including homicide. This includes youth violence, homicide, and random acts of violence, rape or sexual assault by strangers, and violence in institutional settings such as schools, workplaces, prisons and nursing homes (World Health Organization, 2004).

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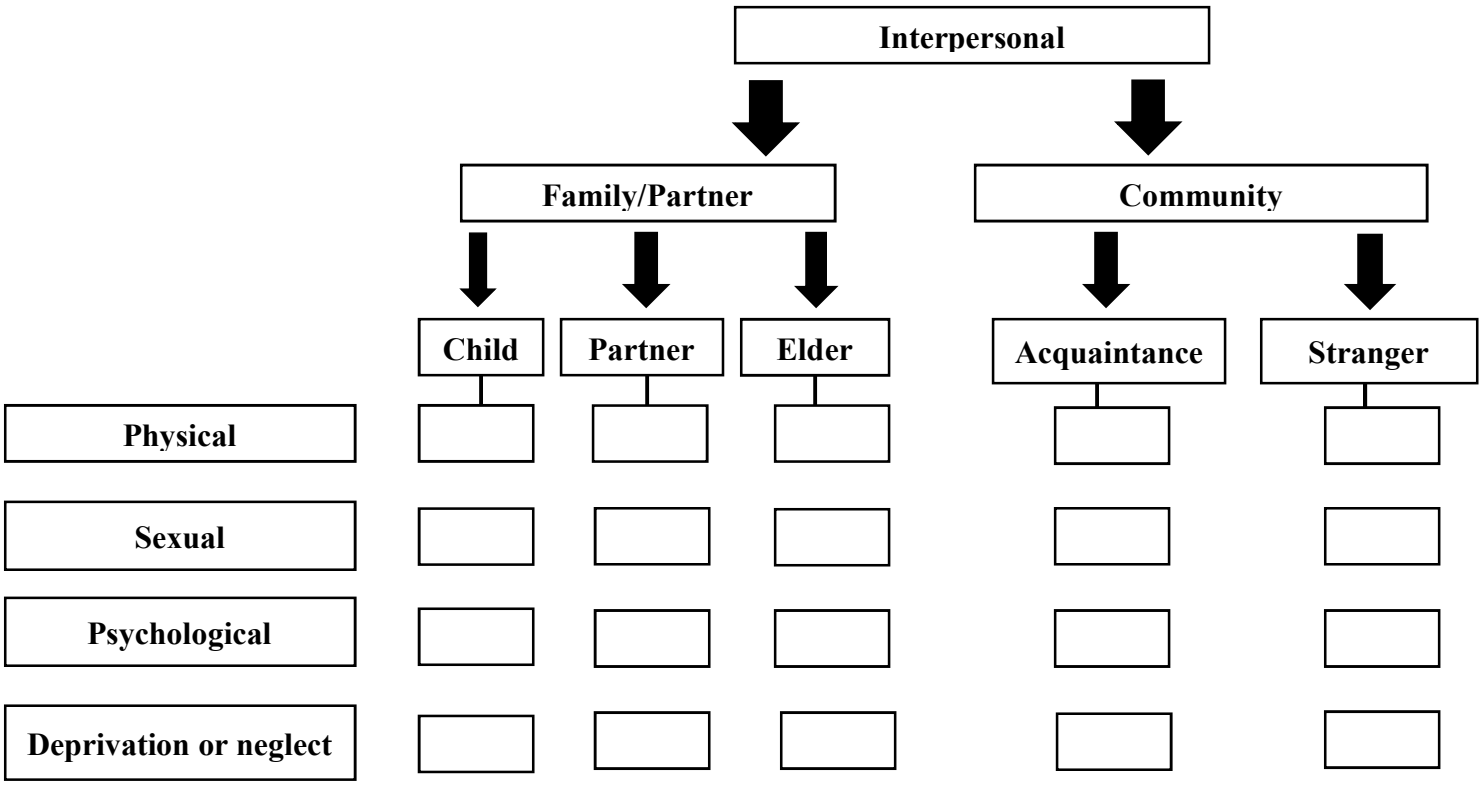
The main forms of violence at the family and community levels are characterized as follows:

1. **Child maltreatment** is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment.
2. **Intimate partner violence** refers to any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Women are especially vulnerable to intimate partner violence. Examples of types of this behaviour are listed below:
    a. Acts of physical violence, such as slapping, hitting, kicking and beating.
    b. Sexual violence, including forced sexual intercourse and other forms of sexual coercion.
    c. Emotional (psychological) abuse, such as insults, belittling, constant humiliation, intimidation (e.g. destroying things), threats of harm, threats to take away children.
    d. Controlling behaviours, including isolating a person from family and friends; monitoring their movements; and restricting access to financial resources, employment, education or medical care.
3. **Youth violence** refers to violence that occurs among individuals ages 10–29 years who may or may not know each other. It generally takes place outside of the home. It includes a range of acts from bullying and physical fighting, to more severe sexual and physical assault, to homicide.
4. **Elder abuse** can be defined as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person". Elder abuse can take various forms such as financial, physical,

psychological and sexual forms. It can also be the result of intentional or unintentional neglect. Based on the foregoing, the nature of violent acts can be physical, sexual or psychological or involve deprivation, exploitation or neglect.

Figure 1: Typology of Interpersonal Violence



Interpersonal violence can be divided into two main groups – Family and Intimate partner violence and Community violence. These groups are further broken down into more categories based on the individual affected, and can take the form of physical violence, sexual violence, psychological violence or violence in the form of deprivation or neglect. Source: World report on violence and health. Geneva (Switzerland): World Health Organization, 2002.

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The medicolegal framework relating to violence in Jamaica

In Jamaica, there is a medicolegal framework relating to violence, with a number of legislative acts that treat with varying forms of violence.

Legislation	Description
The Domestic Violence Act, 1996	The Act provides for enhanced protection for survivors of physical, psychological, and emotional abuse within the home – extending to marriage, cohabitation and visiting relationships. It includes intimate partner violence, family violence, child abuse, elder abuse or abuse by any member of a household.
Offences against the Person Act, 2010	This Act sets out offences against the person including homicide, assault, rape, child stealing, bigamy, abortions, infanticide, and unnatural offences. Under this legislation, a woman convicted of capital murder shall be exempted from the death sentence if determined by a jury to be pregnant. The Act also criminalizes prostitution and anal sex, as it calls for a punishment of up to 10 years of imprisonment for those convicted of buggery or living on the earnings of prostitution. This Act also speaks to protection of girls and women and suppression of brothels.
The Sexual Offences Act, 2011	The Act makes provisions for the prosecution of rape, and other sexual offences such as grievous sexual assault and marital rape. The Act also establishes "indecent assault" and other sexual acts that do not fall under rape or grievous sexual assault, such as sexual touching and grooming.
The Child Care and Protection Act, 2004	The Act governs Jamaica's child protection system and seeks to strengthen and promote the rights of children. It provides a framework for various forms of interpersonal violence such as abuse and neglect through mandatory reporting.
The Mental Health Act, 1997	This Act covers the admission, voluntary and involuntary treatment and discharge of persons with mental illness, as well as access to mental healthcare, and roles and responsibilities of mental health service providers.

Legislation	Description
The Disabilities Act, 2014	The Act includes specific healthcare standards for the provision of equitable services free of stigma and discrimination for persons with varying disabilities. It also speaks to the need for adequate and accessible health facilities.
The Trafficking in Persons (Prevention Suppression and Punishment) Act, 2014	The Act prescribes measures to combat trafficking in persons, with special attention to women and children. It covers sexual exploitation, servitude, forced labour, slavery and other forms of interpersonal violence.

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Epidemiology

Violence is a major preventable global public health and human rights problem. In 1996, the Forty-Ninth World Health Assembly adopted Resolution WHA49.25, declaring violence a major and growing public health problem across the world. This resolution was driven by the dramatic worldwide increase in the incidence of intentional injuries affecting people of all ages and both sexes, especially children and women. The serious consequence of violence for individuals, families, communities and countries, and the resulting strain on healthcare services, is undeniable.

Violence is a leading cause of death both globally and locally. At the end of 2012, it was reported that more than 1.3 million people had died from violence including interpersonal violence and collective violence (violence by one group against members of another group). Data also shows that 90% of deaths from violence are in low- and middle-income countries, with the socio-economically disadvantaged being more vulnerable. Additionally, the long-term impact of non-fatal violence has grave physical, psychological, economic and social consequences.

According to data from the Jamaica Injury Surveillance System (JISS) established in 1999, violence-related injuries (VRIs) are a major cause of morbidity and mortality in Jamaica. The main violence-related features of Jamaica's crime situation are as follows:

- Since 2010, Jamaica's violent crime rate has been on the decline but is still, however, higher than global and regional levels. In 2018, Jamaica's homicide rate fell from 56 per 100,000 in 2017, to 47 per 100,000. This rate remains alarmingly high as it is three times higher than the average for Latin America and the Caribbean (LAC), and the third highest homicide rate in the region (IACHR, 2018).

- Between 2009 and 2013, a decline is seen in homicides by 30.2 per cent, shootings by 25.8 per cent and femicide by 15 per cent, while rape, however, increased by 20.5 per cent.
- In Jamaica, 24% of patients treated for injuries at hospitals are youth and children under the age of 19 years.
- Boys were more likely to be bullied and were three times more likely to be murdered than girls. Eight (8) out of ten (10) children ages two (2) to fourteen (14) years, experience some form of violent discipline. Data from 2011 to 2015 indicates that the majority of children murdered during this period were males ages 11 to 17.
- In the age group 15-29 years, violence is a leading cause of death for males. The data shows that most survivors and perpetrators of physical violence are males in the age group 16-24 years. A study done in 2010 noted that 60.5% of males had been in a physical fight within the last 12 months, and 63.5% of males had been injured at least one or more times within the previous 12 months.
- Thirty per cent (30%) of young women ages 15 to 24 years have experienced some form of intimate partner violence, whether verbal, physical or sexual, and 24 per cent of girls ages 10-15 years say their first experience of sex was forced.
- One in every four Jamaican women (25.2 per cent) has experienced physical violence by a male partner, and 7.7 per cent have been sexually abused by a male partner. Lifetime prevalence of intimate partner, physical and/or sexual violence against Jamaican women is 27.8 per cent. One in four women (24.4%) reported being sexually harassed during their lifetime. Almost three in ten (28.8 per cent) women have suffered emotional abuse, and 8.5 per cent of Jamaican women report having experienced economic abuse. Of note, only 15.4 per cent of women who were survivors of gender-based violence reported the matter to the police (UNDP, 2012).

- The impact of gender-based violence on women's well-being is severe, with more than one-third of abused women suffering injuries from their abuse.

In 2013, homicides of the elderly (age 65 and older) accounted for 3.5 per cent of all homicides, a decline compared with the period prior to 2009. Globally, one in 17 elders experience abuse. Further reports indicate that one in six elders have reported abuse within the last 12 months. Elder abuse takes several forms - from psychological abuse, physical abuse or neglect, to financial abuse. Global statistics indicate that 14% of elders reported physical abuse while 12% reported neglect. Elders who have experienced abuse are twice as likely to die as those in the same age group who have not reported abuse. Such data indicates the need for intervention with respect to abuse in this population. Limited data exists in Jamaica on the issue of elder abuse. However, it has been acknowledged by clinicians that special care must be taken when treating injuries, as some injuries could be intentional, and may present differently from younger age groups.

Persons with disabilities are a vulnerable group to violence, for which limited data exists. This deficit is expected to be rectified as, in 2018, the Ministry of Culture, Gender, Entertainment and Sport had ensured their inclusion in all the violence against women (VAW) programmes, after highlighting that members of the disabled community require increased attention, regarding gender-based violence.

According to the Ministry of Local Government and Community Development, more than 2,000 persons in Jamaica are homeless and living on the streets. Homelessness puts persons at increased risk of violence, including sexual violence because of their vulnerability. Sex workers, sexual minorities and Persons Living with HIV often experience stigma and discrimination. Data shows that there is a link between GBV and HIV infection, showing that HIV and GBV mutually reinforce one another, with each increasing the likelihood of the other. The Global AIDS Alliance

also reports that fear of violence was a barrier to HIV disclosure by women. Fear of police and fear of the health sector may limit access to health and support services by this group.

SECTION 2: INTERPERSONAL VIOLENCE ACROSS THE LIFE COURSE AND IN SPECIAL GROUPS

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Interpersonal violence affects individuals at each stage of the life course – from children to the elderly. Additionally, there are special groups that are particularly vulnerable to violence, including persons with disabilities and mental health disorders, persons in institutional care, homeless persons, sexual minorities, sex workers, and Persons Living with HIV.

Children and Adolescents

The guidance in this section refers to the treatment of children and adolescents under the age of 18 years as stipulated by the Child Care and Protection Act (CCPA) which obligates 'prescribed persons' to report all children suspected to be in need of care and protection to the Office of the Children's Registry and any other relevant authority. A prescribed person, according to the CCPA, is:

- a physician, nurse, dentist, other health, or mental health professional
- an administrator of a hospital or other public medical facility
- a school principal, teacher, guidance counsellor, or any other teaching professional
- a social worker or other social service professional
- an owner, operator or employee of a child day care centre or other childcare institution
- any other person who by virtue of his/her employment or occupation has responsibility to discharge care towards a child.

In cases of sexual abuse, mandatory reporting is required when survivors are under the age of consent – 16 years of age, as set out in the Sexual Offences Act. In treating this age group and population, clinicians and other HCWs must therefore ensure that they are familiar with policy and legislation which protects them, such as, but not limited to, the CCPA, Child Justice Guidelines from the OCA, Sexual Offences Act, Trafficking in Persons (Prevention Suppression and Punishment) Act and National Safe School Policy.

According to the Child Care and Protection Act:

i. Children are entitled to be protected from abuse, neglect and harm or threat of harm

ii. Decisions relating to children should be made and implemented in a timely manner

For specific information, see the *Management of Victims of Child Abuse and Neglect: Guidelines (2004); Standards and Related Criteria for Adolescent Health: A guide for assuring quality health services for adolescents (2013)*; *The Management of Suspected Victims of Trafficking in Persons: Protocol for Healthcare Workers (2017)*.

Girls and Women

Violence against girls and women includes any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. Intimate partner violence is the most common form of violence against women. Very few girls and women receive the protection, justice, and treatment that they need.

The healthcare provider should be cognizant of this vulnerable group and quickly identify signs of this abuse to provide prompt management and support. (Please see Appendix 1 for indicators of violence among vulnerable groups and Section 6 for the Management of Survivors of Sexual Assault).

Men

Despite the prevalence of violence among males, men tend to be reluctant to disclose instances of interpersonal violence and are generally less likely to seek medical services. Approach management with caution, care and sensitivity.

- The attending physician and other members of the team should become aware of his/her own bias regarding a male.
- Refer patients to any locally available programmes or agencies and relevant resources for additional support.
- Use gender-specific education, information and communication targeted to men.

The Elderly

Based on the literature, older adults do not usually report cases of elder abuse. The United Nations Population Fund (UNFPA) and HelpAge International (HAI) Desk Review (2011) indicated that violent crimes and abuse against older persons occur as frequently in their own homes as outside the home by strangers. Elderly persons in Jamaica face both subtle and extreme levels of discrimination and violent acts. There is a need for intervention with respect to abuse in this population. It is therefore the responsibility of the healthcare team, social services and police units to identify, report and intervene. In addition to violence, other issues that elderly persons tend to face are a higher prevalence of poverty, issues with food security, and inadequate specialized geriatric care. The care of the elderly should be highly individualized, taking into account the ageing process. The goal of management is to provide the elderly with a safe, fulfilling and enjoyable life.

- Elderly populations that are abused may require immediate care, long-term assessment and care, education and prevention measures.
- The clinician should as a matter of priority seek to balance the safety versus the autonomy of the affected person. Reporting of suspected cases of abuse to the police may be required with the consent of the person.
- If mental competence is in question, then the client should be referred to mental health services for assessment and appropriate intervention.
- The clinician/mental health officer/medical social worker should investigate and assess the affected individual with the aim of developing plans for appropriate care. Special attention should be paid to whether the client is living alone, controlling any underlying chronic conditions and keeping their clinic appointments.
- A multidisciplinary approach is recommended. The physician will be responsible for the treatment plan and the nurse in-charge will coordinate the implementation.
- The patient should be monitored until there is indication for return to a safe home environment or referral to organizations or support groups that address their unique needs.
- Medications: There is no specific medication to treat elder abuse. Anxiolytics and hypnotics should be avoided because of their ability to make the patient less able to defend him/herself against abuse.
- Follow-up care: Elder abuse is not a condition that can be assessed quickly. The intervention can become an extended process.

Special Groups

Persons with Disabilities and Mental Health Disorders

Healthcare providers shall ensure that the following minimum standards are adhered to, with special attention to women with disabilities, and persons with intellectual and mental disabilities and disorders, due to their increased vulnerability to abuse:

i. a person with a disability shall have access to the same range and standard of affordable health services as provided to other persons, including sexual and reproductive health services and population-based public health programmes; and

ii. a person with a disability shall be provided with the health services required because of that disability, including screening, early detection, treatment, rehabilitation, identification and intervention as appropriate, and services designed to prevent or minimize any further disability.

Additionally, they should ensure accessibility more generally to healthcare services, in compliance with the Disabilities Act. In keeping with the requirements for the Disabilities Act (2014), all necessary provisions should be made for the reception, assessment and treatment of persons with disabilities. This will lend greater efficiency to the interviewing process.

The clinician or medical social worker should consider referral to organizations or support groups that address the unique needs for persons with disabilities.

Persons in Institutional Care

There are numerous barriers to accessing healthcare for persons who reside in institutions. As a result, these persons are more likely to be diagnosed later and/or experience poor health outcomes. These include:

- unmet health needs;
- delays in receiving appropriate care; and
- inability to get preventive services.

Homeless Persons

The absence of facilities/programmes in some parishes to meet the needs of homeless persons, coupled with the lack of information on the services provided by some organizations, impedes effective coordination of programmes.

Challenges faced by these vulnerable persons include:

- homelessness/ inability to reconnect with family and society;
- drug abuse;
- having a criminal background; and
- being vulnerable to violence due to the lack of shelter.

Sexual minorities, Sex Workers and Persons Living with HIV

A sexual minority is a group whose sexual identity, orientation or practices differ from the majority of the surrounding society. This group, as well as sex workers and Persons Living with HIV, is another group that has been highlighted as being vulnerable to varying forms of violence.

Due to the criminalization of sex work and anal sex, there is reduced access to healthcare for this group, based on real or perceived stigma which deters disclosure of critical medical history. This hinders the ability of HCWs to correctly identify signs and symptoms of intimate partner violence.

SECTION 3: IDENTIFICATION OF INTERPERSONAL VIOLENCE IN HEALTHCARE PRACTICE

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Ethical Considerations & Principles of Care

In keeping with the *Vision for Health 2030 Plan – Ten Year Strategic Plan 2019-2030,* which embraces the progressive realization of universal access to health and universal health coverage as a central approach, the guiding principles of care are as follows:

1. Universal access, equity and gender equality
2. Patient engagement in care
3. Care coordination
4. Integrated, comprehensive care and multi-sectoral partnerships and actions
5. Reorientation of health systems and building capacity of the health workforce to support high-quality care, practice-based learning, and quality improvement
6. Evidence-based, or evidence-informed policies and programmes based on a life course approach
7. Emphasis on health promotion, education, primary prevention, early detection, treatment, rehabilitation and palliative care and quality of care for persons who have violent injuries or their risk factors.
8. Confidentiality: Confidentiality is an ethical principle that is associated with the provision of medical and social services. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. An exception to this will be sharing of information with medical colleagues when a patient is being referred, or when mandatory reporting is required (for example in a case of sexual assault of a child).
9. Non-discrimination: A non-discriminatory approach requires deliberate action that ensures all clients are treated equally and offered quality care, regardless of race, religion, national origin, sex, sexual orientation, gender identity or expression, or disability. Healthcare providers need to recognize and take into account gender and other social

inequalities that can disproportionately increase vulnerabilities to violence and pose barriers in access to services for some groups over others. Therefore, attention should be paid to the specific needs of groups in conditions of vulnerability.

10. Respect and Dignity: All HCWs shall use a survivor-centred approach, which means respecting the survivor's rights:

11. Treat the survivor with respect and without stigma, discrimination, or 'blame the survivor attitudes:

    i. Give the survivor correct and understandable information to determine informed consent and to not be told what to do, which contributes to feelings of powerlessness;

    ii. Give the survivor privacy and confidentiality and do not subject survivors to gossiping and shaming;

    iii. Protect the survivor from discrimination, including differential treatment based on gender, ethnicity, or other factors;

    iv. Give the survivor a choice in being attended to by a male or female service provider; and

    v. Give the survivor a choice in being accompanied by a relative or caretaker.

- Disclosure: Motivate clients to voluntarily disclose information by choice, without coercion or pressure in a professional and supportive manner through motivational interviewing. Persons who disclose any form of violence should be offered immediate support.
- Principle of best interests of the child: Every child has the right to have his or her best interests given primary consideration in the decisions that affect them.

- Principle of evolving capacities of the child or adolescent: As children acquire enhanced competencies, there is a diminishing need for protection and a greater capacity to take responsibility for decisions affecting their lives.

Identification

A structured and coordinated approach should be taken in the identification of individuals who are survivors of interpersonal violence. Please note that universal screening is not recommended. Consider the following in the identification of these individuals:

(i) Who can be affected by violence?

Any person suspected to be subjected to violence including, but not limited to, children and adolescents; youth; women and girls; men; the elderly; persons with disabilities; persons with mental illness; Persons Living with HIV; sexual minorities; sex workers; the homeless; and institutionalized persons.

Specialized training may be required in areas such as identifying and responding to clinical needs of survivors of different forms of violence, motivational interviewing and working with patients with complex psychological trauma, sign language for persons with disabilities, and any other practices associated with clinical management of the cases. This training should target all categories of staff (technical, administrative and ancillary) within the facility.

(ii) How to identify a person who may be subjected to violence

Healthcare providers should consider exposure to violence in all patients presenting with complaints that could be associated with possible violence. Child maltreatment should be considered when assessing children with conditions that may be caused or complicated by maltreatment. Violence should be considered when indicators such as those in the table below (and in Appendix 1) are noted. Identification of survivors of violence based on clinical enquiry/case finding is recommended.

Warning signs of violence

Category	Type of Violence
Violence against Children	Suspect violence in case of: **<u>Physical abuse</u>** ***Bruises, lacerations, abrasions or scars*** • Multiple bruises or injuries to the skin • Bruises in a child who is not independently mobile • Bruises in the shape of an implement used e.g. hand, stick • Bruises on any non-bony part of the body, including the cheeks, trunk, eyes, ears and buttocks (accidental bruises are generally over bony areas on the front of the body e.g. shins, knees) ***Bites*** • A human bite mark that is thought unlikely to have been caused by a young child ***Burns and scalds*** • A burn or scald in a child who is not independently mobile, or • A burn anywhere that would not be expected to come into contact with a hot object in an accident (e.g. the buttocks, trunk, upper arms)

Category	Type of Violence

	• Burns in the shape of an implement (e.g. cigarette, iron) or
	• Scalds that indicate forced immersion, e.g.:
	  o To buttocks, perineum and lower limbs
	  o To limbs in a glove or stocking distribution
	  o To limbs with symmetrical distribution
	  o With sharply delineated borders
	
	Fractures
	• if a non-mobile infant has one or more fractures in the absence of a medical condition that predisposes to fragile bones (for example, osteogenesis imperfecta, osteopenia of prematurity)
	• if X-rays have been undertaken:
	  o Occult fractures (fractures identified on X-rays that were not clinically evident) e.g. rib fractures in infants
	  o Fractures of different ages, showing different stages of healing
	
	Neurological injury, head injury (intracranial injury identified on CT scan or MRI):
	• An intracranial injury in the absence of confirmed major accidental trauma or known medical cause
	• If the child is under 3 years and there are also:
	  o Retinal haemorrhages, or
	  o Rib or long bone fractures, or
	  o Other associated inflicted injuries
	  o Multiple subdural haemorrhages with or without subarachnoid haemorrhage and with or without hypoxic ischaemic damage (damage due to lack of blood and oxygen supply) to the brain

Category	Type of Violence
	<u>Other possible clinical presentations</u> ***Apparent life-threatening event (ALTE):*** • Combination of apnoea (central or obstructive), colour change (cyanotic, pallid, erythematous or plethoric), change in muscle tone (usually diminished), and choking or gagging ***Poisoning*** • With prescribed and non-prescribed drugs or household substance (e.g. bleach) ***Non-fatal submersion injury*** • Near drowning ***Fabricated or induced illness (FII)*** • Unusual attendance at medical services • Reported symptoms and signs only appear or reappear and are reported when the parent or carer is present • An inexplicably poor response to prescribed medication or other treatment • New symptoms are reported as soon as previous ones have resolved • There is a history of events that are biologically unlikely (e.g. infants with a history of very large blood losses who do not become unwell or anaemic) • Despite a definitive clinical opinion being reached, multiple opinions from other healthcare agencies are sought and disputed by the parent or carer, and the child continues to be presented for investigation and treatment with a range of signs and symptoms. • The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for

Category	Type of Violence
	example, wheelchairs) more than would be expected for any medical condition that the child has **<u>Sexual abuse</u>** ***(i) Anogenital signs and symptoms*** • A genital, anal or perianal injury (e.g. bruising, laceration, swelling or abrasion) • A persistent or recurrent genital or anal symptom (for example, bleeding, dysuria or discharge) that is associated with behavioural or emotional change and that has no medical explanation. • Foreign bodies in the vagina or anus. (Foreign bodies in the vagina may be indicated by an offensive vaginal discharge). ***(ii) Sexually transmitted infections*** • Including symptoms in the mouths or rarely in infected joints (gonorrhoeal septic arthritis) ***(iii) Pregnancy in a child or young teen*** ***(iv) Sexualised behaviour*** **<u>Emotional abuse</u>** • Adverse parent- child interactions o Negativity or hostility towards the child o Rejection or scapegoating of the child • Developmentally inappropriate expectations of, or interactions with, a child (including inappropriate threats or methods of disciplining) • Exposure to frightening or traumatic experiences • Using the child for the fulfilment of the adult's needs (e.g. in marital disputes)

Category	Type of Violence
	• Failure to promote the child's appropriate socialisation (e.g. involving children in unlawful activities, isolation, not providing stimulation or education) • Parents or carers punish a child for wetting or soiling despite professional advice that the symptom is involuntary • Emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant • If a parent or carer refuses to allow a child to speak to a healthcare worker on their own when it is necessary for the assessment of the child **Emotional, behavioural, interpersonal and social functioning** Any form of maltreatment may be associated with - • Marked change in behaviour or emotional state • Recurrent nightmares containing similar themes • Extreme distress • Markedly oppositional behaviour • Withdrawal of communication (Some of these features may also be seen in a wide range of adolescents for other reasons, including use of drugs). **Neglect** • Basic needs are not provided (e.g. food, appropriate clothing) • Faltering growth because of lack of provision of an adequate or appropriate diet • Persistent infestations, such as scabies or head lice • Inappropriately explained poor school attendance • Access to appropriate medical care or treatment not ensured (e.g. failure to immunise) • Failure to administer recommended treatment or medication • Malnutrition

Category	Type of Violence
	• Persistently poor hygiene • Inappropriate supervision • **Cold injuries** • **Abandoned children** • **Unsafe living environment** • **Lack of supervision; may present as repeated accidental injury**
Violence against Adults	Suspect violence in case of: • ongoing emotional health issues, such as stress, anxiety or depression • harmful behaviours such as misuse of alcohol or drugs • thoughts, plans or acts of self-harm or (attempted) suicide • injuries that are repeated or not well explained or repeated health consultations with no clear diagnosis • noting that partner is intrusive during consultations • frequent missed healthcare appointments for the individual or their children; display of emotional and/or behavioral problems by their children **<u>Sexual abuse</u>** ***Anogenital signs and symptoms***: • A genital, anal or perianal injury (e.g. bruising, laceration, swelling or abrasion) • A persistent or recurrent genital or anal symptom (for example, bleeding, dysuria or discharge) that is associated with behavioural or emotional change and that has no medical explanation • Foreign bodies in the vagina or anus (Foreign bodies in the vagina may be indicated by an offensive vaginal discharge). • Repeated sexually transmitted infections • Unwanted pregnancies (women) • Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)

(iii) When should identification take place?

It is important for healthcare providers to be aware that health problems may be caused or made worse by violence (both current and past violence). Survivors of violence often seek healthcare for related emotional or physical conditions. However, they often do not tell others about the violence due to shame or fear of being judged. Healthcare providers should be sensitized and have a low threshold for asking about interpersonal violence, as answers can improve diagnosis and treatment.

Health workers should ask, when signs and symptoms raise concerns that violence is a possibility, for example:

- As part of the health history (e.g. social history/review of systems)
- As part of the standard health assessment (or at encounters in urgent care)
- During new-patient encounter
- During periodic comprehensive health visits, for example, Child Health Visits (assess for current IPV only)
- During a visit for a new chief complaint
- At new intimate relationship.

(iv) Where should identification take place?

- Health workers should ask about violence in private, as part of a face-to-face healthcare encounter, at entry point or interface with the healthcare professional in primary or

secondary care. No friends, relatives or caregivers should be present, except in the case of young children.

- Prior to asking them about violence, patients should be informed of any legal reporting requirements or other limits to provider/patient confidentiality.
- When asking about violence, use language that is appropriate and relevant to the culture and community you are working in.
- Asking about violence should be done in an empathetic, respectful and non-judgemental manner.
- Encourage the patient to talk, and show that you are listening.
- Encourage the patient to continue talking, if they wish, but do not force the patient to talk. (Say, for example, "Do you want to say more about that?")
- Allow silences. If patient cries, give him/her time to recover.

(v) When should health workers not ask about violence?

Attempts should be made to refer to a suitable facility, if:

- the healthcare provider cannot secure a private space in which to conduct screening
- there are concerns that assessing the patient is unsafe for either patient or provider

SECTION 4: MANAGEMENT OF INTERPERSONAL VIOLENCE

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Interpersonal violence is a complex and multi-factorial disorder. Its management is equally complex and requires a multidisciplinary approach. Each member of the team should be clearly aware of their roles and responsibilities within the scope of their disciplines, and also the system of referral for further care.

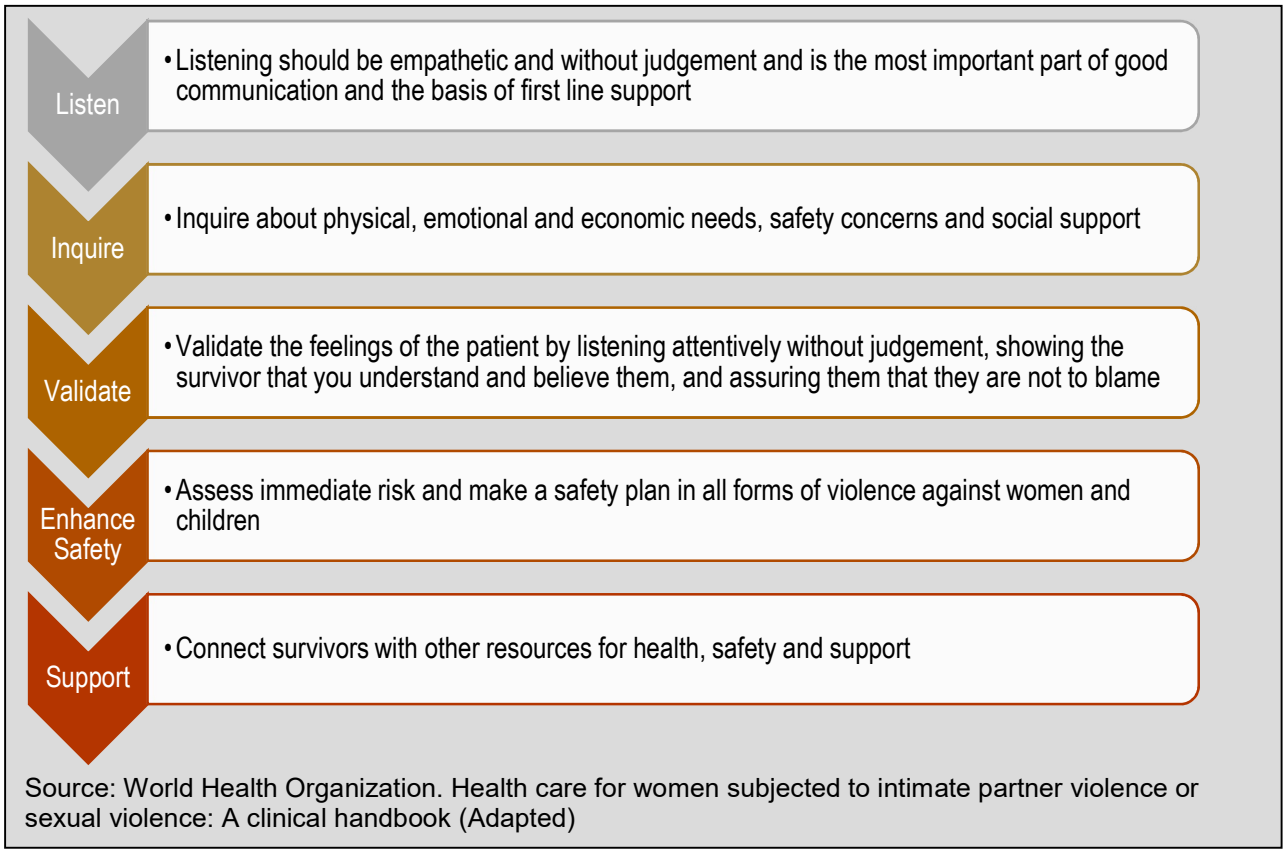
Goals of Management

The main objectives of managing persons affected by interpersonal violence are to:

- prevent further abuse;
- create a safe space/supportive environment where the client can discuss the abuse;
- enable the multidisciplinary team to provide acute treatment and care as necessary;
- enhance the security of the survivor (making a safety plan and evaluating risk);
- connect survivors with resources available within and outside the health system; and
- plan for follow-up.

In Figure 2 below, the LIVES checklist is a useful tool to guide communicating with a patient that is a survivor of Interpersonal Violence – Listen, Inquire, Validate, Enhance Safety, Support.

Figure 2: Checklist for Communicating with the Patient (LIVES)



Source: World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook (Adapted)

The Management Team and First-line Support

The core multidisciplinary team for first-line support should include the following healthcare professionals as dictated by medical management protocols; notably, first-line support is the minimum requirement and the most important care that health workers can provide to survivors of violence.

For walk-in patients at the primary healthcare facility:

- Registration Clerk
- Registered Nurse and/or Midwife
- Family Nurse Practitioner
- Medical Officer
- Social Worker
- Mental Health Team

Other relevant Ministries, Departments and Agencies (MDAs) that may be engaged in direct service provision for interpersonal violence, as in the case of sexual assault and child abuse, are:

1. Centre for Investigation of Sexual Offences and Child Abuse (CISOCA);
2. Jamaica Constabulary Force (JCF);
3. Ministry of Education, Youth and Information (MOEYI);
4. Child Protection and Family Services Agency (CPFSA);
5. Office of the Children's Advocate (OCA);
6. Office of the Children's Registry (OCR);
7. Department of Correctional Services (DCS);
8. Victim Services Division, Ministry of Justice

Civil society organizations may also be engaged; they play a role in the social support of survivors of interpersonal violence.

Functions of Team Members

The health service team should provide services in a non-judgemental environment, free from stigma and discrimination and acknowledging the patient's right to confidentiality. They should

ensure timely reporting in keeping with national laws and policies. Their duties are outlined below:

Health Records Officer

- Register the client for services prior to examination; and
- Complete intake procedures, including injury surveillance questions to assist with classification and coding of injuries for health records.

Registered Nurse and/or Midwife

- Assist with public education, identification of affected persons, nursing care, psychosocial support for affected person and their families, safety planning and referral advice; and
- Provide the necessary first-line support and make the appropriate referral (if operating at a facility without a physician).

Clinician

- Take medical history;
- Conduct the physical examination, make relevant diagnosis, treat the client, refer for specialized services, and provide for continuity of care;
- Collect the relevant specimens, and request relevant imaging and/or laboratory investigations;
- Update the health record; and
- Timely reporting in keeping with national laws and policies

Medical Social Worker

- Assess the social, emotional and economic factors relevant to medical diagnosis and treatment;
- Manage caseload and maintain accurate case files;
- Consult regularly with other members of the health team to find ways of helping patients and families to cope with any personal and environmental stress that may affect recovery;
- Undertake follow-up visits to the homes of patients and other relevant persons/places in order to assess the needs of patients and conduct family counselling;
- Help patients and their families to identify community resources;
- Identify and communicate with the public, voluntary and private agencies; and
- Apply available resources; refer to other social support services as appropriate.

Mental Health Team

- Assess for key mental health conditions and refer for treatment for acute conditions;
- Provide counsel and support for affected persons and their families/significant others;
- Establish effective partnerships/relationships with community support partners;
- Provide psychological support and psychotherapy services;
- Maintain appropriate records of cases;
- Conduct case follow-ups to ensure referrals are appropriately actioned or clients have accessed the relevant services;
- Establish effective partnerships/relationships with community support partners

- Provide comprehensive psychiatric evaluation and treatment for acute cases, based on referrals from the mental health nurse.

The Role of the Jamaica Constabulary Force (JCF) in Interpersonal Violence cases presenting for healthcare

For violence-related injuries that require police investigation or cases of child maltreatment where a police report is made, outlined below are some of the main roles and responsibilities of the police officer:

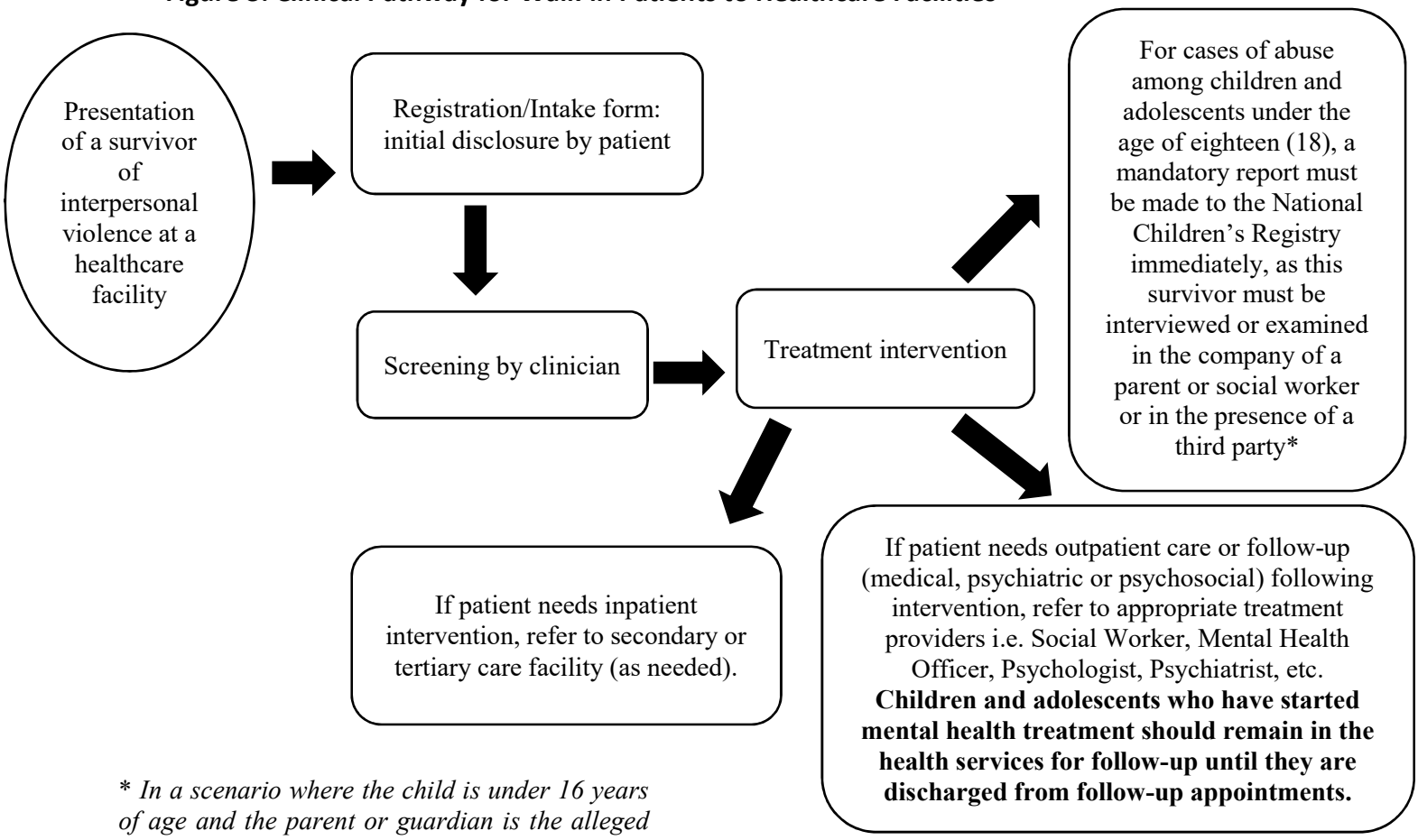
- Guiding the client through the registration process (based on the age of the client and the nature of the violence);
- Processing survivors in a timely manner and collecting evidence such as the Sexual Assault Forensic Examination (SAFE) kits in the case of sexual assault;
- Observing/witnessing the collection of the packaged specimen for cases of sexual assault and maintaining the chain of custody (COC);
- Managing the chain of custody(COC) and retrieving forensic evidence following the medical examination; and
- Providing the required forms for legal proceedings, as necessary.

SECTION 5: PATHWAYS TO CARE FOR THE SURVIVOR OF INTERPERSONAL VIOLENCE

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

An interdisciplinary clinical pathway has been outlined below in Figure 3 to align services and clarify referral routes along with a recognized care pathway, for persons experiencing various forms of violence. The aim is to improve early identification, reduce risks, and coordinate support by providing a standardized understanding of risk to raise the index of suspicion. These diagrams serve to map out the process for healthcare workers, in order to guide them through disclosure, to the screening and treatment intervention, and referral to specialist and statutory services (as required). Based on the point of entry, only two main clinical care pathways are outlined here, however, special care must be taken with children and youth, women, the elderly, persons with disabilities, sexual minorities, as well as other at-risk groups.

Figure 3: Clinical Pathway for Walk-in Patients to Healthcare Facilities

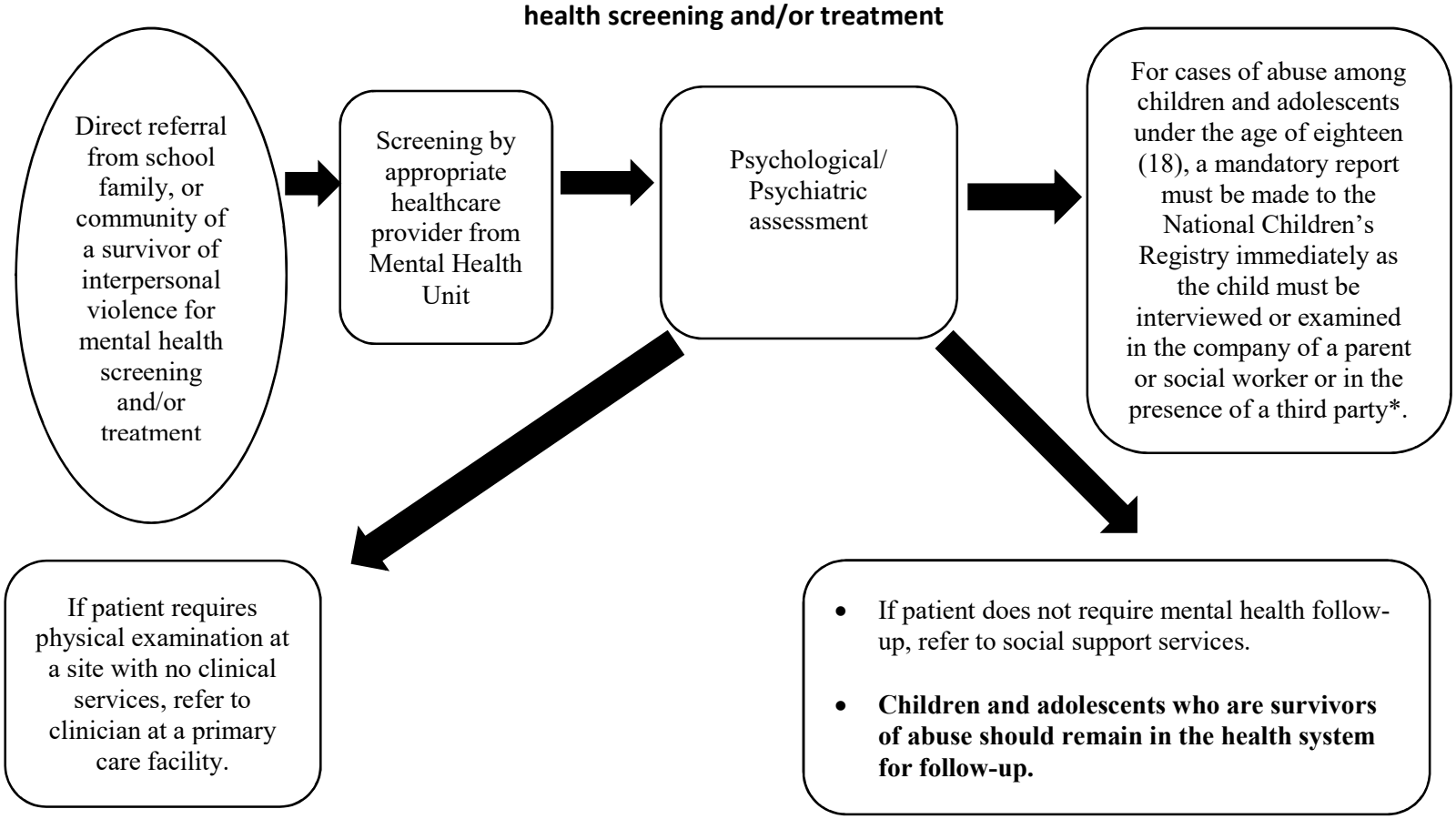


** In a scenario where the child is under 16 years of age and the parent or guardian is the alleged abuser, a representative from the CPFSA can be proxy for the guardian for medical decisions for treatment.*

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Figure 4 shows the pathway for a direct referral for mental health services from a non-health facility (school, family or community). This involves screening by a healthcare provider from the Mental Health Unit, a psychological/psychiatric assessment, referral for physical examination (as needed) and appropriate reporting as indicated.

Figure 4: Clinical Pathway for direct referral from school, family, or community for mental health screening and/or treatment



** In a scenario where the child is under 16 years of age and the parent or guardian is the alleged abuser, a representative from the CPFSA can be proxy for the guardian for medical decisions for treatment.*

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Assessment of the Survivor of Interpersonal Violence

The goals of the assessment are:

i. to create a supportive environment in which the client can discuss the interpersonal violence
ii. to enable the health professional to gather information about health problems associated with the interpersonal violence
iii. to assess the immediate and long-term health and safety needs for the client, in order to develop and implement a response.

Immediately after disclosure, conduct the assessment:

- Assess immediate safety
- Stabilize the client with life-threatening conditions and refer immediately for emergency treatment
- Assess the patient for physical and psychological signs and symptoms of abuse
- Immediately provide first-line support.

NB. *Some actions may occur simultaneously.*

First-line support

First-line support provides practical care and responds to a person's emotional, physical, safety and support needs without intruding on his/ her privacy. This may be the only intervention that can be conducted. After first-line support, carry out a detailed medical history and physical examination.

Documentation

The clinician should ensure proper documentation and entry in the health record. Consider the following:

- ✔ Relevant history
- ✔ Results of physical examination
- ✔ Laboratory and diagnostic procedure
- ✔ Results of assessment, intervention and referral
- ✔ Non-disclosure by patient of relevant information such as previous medical history

The clinician should use the body maps included on the medical history form, or use photographs where necessary, to supplement written description.

Taking the medical history

In line with the principle of 'do no harm', when the medical history is being obtained and, if needed, a forensic interview is being conducted, healthcare providers should seek to minimize additional trauma and distress for survivors of violence.

Clinicians should consider the following points to respect and validate the client during the history taking and physical examination:

- Always interview the client alone to obtain a history.
- Begin by asking direct questions in a non-threatening manner. Build trust and rapport by asking about neutral topics before delving into direct questions about the abuse. This should be followed by asking clear, open-ended questions without repetition.
- Inform/Remind the patient that any information shared will be confidential. The limits of confidentiality should be explained.

- Be empathetic, supportive and non-judgemental in your initial response. This can determine whether the client discloses further information.
- Affirm that the client has made an important step.
- Reassure the client that you (the clinician) believe in him/her, that the abuse is not his/her fault and that he/she has a right to safety. It is important to not insist that a child or adolescent answers questions or discloses information that may compromise their safety.
- Use language and terminology that is appropriate to age and non-stigmatizing. Trained interpreters may be utilised where needed.
- Minimize the need for the survivor to repeatedly tell their history of abuse, as it can be re-traumatizing.
- Allow the survivor to answer questions and describe what happened to them in a manner of their choice, including, for example, by writing, drawing or illustrating with models. This is especially relevant to children.
- Conduct a comprehensive assessment of their physical and emotional health. This is critical to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals.

Informed consent is the process in which a healthcare provider educates a client about the risks, benefits, and alternatives of a given procedure or intervention. The client must be competent to make a voluntary decision about whether or not to undergo the procedure or intervention. It is the obligation of the provider to make it clear that the client is participating in the decision-making process, and the provider should avoid making the client feel forced to agree with him/her. The provider must make a recommendation and provide the patient with the reasoning for said recommendation. The client must be provided with sufficient information using age-appropriate language about all available options and their benefits and consequences.

It is critical that the client provide permission to conduct the physical examination and therefore the process of informed consent should be undertaken prior. If consent to conduct an examination is refused, the physician should respect the wishes of the patient and document this. Notify the Senior Medical Officer, Medical (Officer) Health, Consultant on duty, and other appropriate stakeholders as necessary.

Conducting the medical examination

General Medical History

- general medical information (review of systems)
- questions about the assault (only ask about what is needed for medical care)
- gynaecological and genitourinary health (in cases of sexual assault)
- reproductive/sexual health (in cases of sexual assault)
- mental health

Physical examination

After disclosure and before the physical examination, obtain informed consent as necessary and discuss with the affected person, speaking with the police in keeping with existing requirements by law.

Conduct a head-to-toe examination, including genito-anal exam. The main reason for the physical examination is to determine what medical care is needed. It is also used to complete any legal documentation. In cases of sexual assault, a genito-anal and oral examination is necessary. In the case of prepubertal girls, a speculum examination should not be performed.

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Both male and female survivors of violence may be very sensitive to being examined or touched. It is strongly recommended that a female nurse be present during the examination. This is for the protection of the client and the clinician. Proceed slowly. Ask often if the patient is okay and if you can proceed.

Table 1 is a checklist for important steps in the physical examination of a survivor of interpersonal violence.

Table 1: Physical Examination Checklist

Look at all the following	Look for and record
- General appearance including sex and gender - Hands and wrists, forearms, inner surfaces of upper arms, armpits - Face, including inside of mouth - Ears, including inside and behind ears - Head - Neck - Skin - Chest, including breasts - Abdomen - Buttocks, thighs, including inner thighs, legs and feet	- Active bleeding - Bruising - Redness or swelling - Cuts or abrasions - Evidence that hair has been pulled out, and recent evidence of missing teeth - Scars, bruising, bite marks, redness and swelling - Injuries such as bite marks or other wounds - Evidence of internal traumatic injuries in the abdomen (distention, tenderness) - Ruptured ear drum
Genito-anal examination	
- Genitals (external) - Genitals (internal examination, using a speculum*; speculum not to be used for prepubertal females) - Anal region (external)	- Active bleeding - Bruising, odours and discharge - Redness or swelling - Cuts or abrasions - Foreign body presence
**This is not an exhaustive list. Any other finding by the examining physician should be considered	

Investigations and Treatment

Treat any physical injuries, and immediately refer patients with life-threatening or severe conditions for emergency treatment.

Ensure findings are properly documented in the medical record. Specifically, the police, lawyers or courts will want to know about:

- type of injury (cut, bruise, abrasion, fracture, other)
- description of the injury (length, depth, other characteristics)
- location of the injury on the body
- possible cause of the injury (e.g. gunshot, bite marks, other)
- the immediate and potential long-term consequences of the injury
- treatment provided

Conducting the Mental Status Examination

The physician should assess the client's mental status as part of the medical examination. There may be presentation of more severe mental health problems as evidenced by disorders of mood, thoughts, behaviour and inability to function. These conditions may include intellectual disability, developmental disorders, dementia and others. This will require referral for a more comprehensive assessment and treatment by a mental health professional. The referral may be immediate or routine, depending on the need of the client.

In the case of a child, a family evaluation may be required to address dysfunctional family dynamics, especially in the case of incest. In the case of a minor, as with the physical examination, an adult surrogate should be present.

Conduct a brief assessment of the client and consider the list below in Table 2 - a checklist for the important steps in the mental status examination of a survivor of interpersonal violence.

Table 2: Screening Checklist for Mental Status Examination

Indicator	Questions
Appearance and behaviour	Is there evidence of neglect in the patient's appearance? Are clothing and hair cared for or in disarray? * Is the client distracted or agitated? Is the client restless or calm? Are there any signs suggestive of intoxication or misuse of drugs?
Affect	Is the affect flat, blunted, high, sad, labile?
Mood (both what you observe and what is reported)	Is the client calm, crying, angry, anxious, very sad, elated, without expression?
Speech	Is the client silent? How does the client speak (clearly, coherently or with difficulty)? Too fast/too slow? Is the client confused?
Thoughts	Does the client have thoughts about self-harm? Are there bad thoughts or memories that keep coming back? Is the client seeing the event over and over in their mind? Is there evidence of psychosis?

*This should be taken into the social context and current trends. In the case where a client is unable to communicate, other strategies such as drawing or play therapy may be applied.

Source: Adapted from WHO (2014)
For specific reference see *Protocol for the Management of Common Mental Disorders: Policy Manual (October 2005)*

SECTION 6: MANAGEMENT OF THE SURVIVOR OF SEXUAL ASSAULT

Assessment of the Survivor of Sexual Assault

Ensure to ask about:

- The date, time and place of the assault;
- The nature of the surroundings or specific location in which the assault took place (e.g. in bushes, inside a car, on a bed, etc.);
- The patient's activities prior to the assault;
- How many attackers had sexual or physical contact with the patient;
- The nature of any violence and whether a weapon was used, and, if so, what type of weapon;
- Whether the patient lost consciousness at any point in time;
- Whether the patient was forced or tricked into using alcohol or drugs;
- Whether there was any fondling, kissing, licking or anal, oral or vaginal penetration or attempts at any of those activities;
- Whether the patient was forced or tricked into fondling, kissing, licking or penetrating the attacker or a third party;
- Whether the attacker used a condom;
- Whether ejaculation occurred and, if so, where on the patient's body it occurred;
- Whether an object was used to penetrate the patient and, if so, what type of object and where did penetration occur;
- Whether the patient bathed, douched, brushed his or her teeth or attempted to cleanse or wash any part of his or her body or changed any clothing after the assault;
- Whether the patient has used a tampon or sanitary napkin since the assault.

Notes: Sexual Violence against children and adolescents

- If the child is below the age of consent (16 years), the clinician should initiate a conversation with the parent/caregiver and ensure that a consent form is signed to allow the assessment to proceed.
- Immediately after disclosure, the clinician should interview the child and/or parent/caregiver/accompanying adult to obtain past and current history of abuse. The findings should be supported by body maps and/or photographs where possible to support written findings. The method of photograph transmission is to be defined by a Legal Officer.
- The unaccompanied minor, without supervision of a parent/guardian, who turns up for medical care must be seen, treated and the appropriate referral(s) made in accordance with the Child Care and Protection Act or governing laws.
- The nurse in-charge or his/her designate should record the child's name or alias, the informant(s) name(s) and details, including the relationship to the child/adolescent. Contact information, alias, date, time, sex, address, including landmark for the child and caregiver, must be collected.
- When the clinician suspects a diagnosis of child abuse, the medical social worker should be contacted, and the relevant child protection services, namely, CISOCA, the Office of the Children's Advocate (OCA) and the CPFSA. The OCA should also be contacted in cases of institutional-based abuse. (If a medical social worker is not available, the clinician should contact the Office of the Children's Registry/ CPFSA, OCA and CISOCA).
- The multidisciplinary team should ensure follow-up appointments in keeping with their specific disciplines. Children and adolescents may require multiple medical and psychological visits for an extended period of time. Referrals may be needed to support services. For example, after assessment of a survivor of sexual assault, a referral should immediately be made by the clinician to mental health services.

- Ensure that the environment/health facility is child/adolescent friendly.

Examination of the Survivor of Sexual Assault

The examination of the survivor of sexual assault is a very sensitive process. It is also a forensic examination and will require collection of forensic evidence. The clinician should ensure in particular that the child/adolescent is given age-appropriate information throughout the duration of the procedure. Ensure the child/adolescent is comfortable and inform client throughout the examination about the process in understandable language for his/her age group. The child below the age of 16 can determine who they want in the room. During the medical examination of an alleged sexual assault survivor, the police officer performs the functions of being a witness ONLY and must be present to collect the packaged specimen and maintain the chain of custody (COC). The child/adolescent survivor should be able to have a say in the gender of the officer that is present.

Survivor of Sexual Assault: Physical examination and collection of forensic specimens

(The physician should wear powder-free gloves and change them often to prevent cross-contamination)

- The patient's clothing is removed.
- The general physical examination is carried out followed by a genital examination (unless due to injury requiring treatment, a genital examination is warranted earlier). The genital examination involves inspection and swabbing of the external genitalia, collection of samples and recording of any injuries or abnormalities. A vaginal examination or rectal anoscopy is more extensive and must only be conducted with the consent of the patient, and only if necessary for investigation (for example if patient had loss of consciousness, or used mind-altering drugs).

It should be noted that biological specimens are usually not viable beyond 72 hours. For legal purposes, the Medical Officer must be able to unequivocally identify all specimens. This should be undertaken in compliance with national protocols on forensic examination as the court will not accept any specimen if there is any doubt about its authenticity.

- All specimens must be identified by date and time, the name of the client, the contents, method of collection, place of collection and the physician's name (in block capitals) and signature.
- All forensic specimens are to be placed in the appropriate containers, then in envelopes that should be sealed and labelled. Clothing is to be packaged separately in plastic bags, sealed and labelled.
- All forensic specimens are to be handed directly to the police officer by the nurse or physician in charge.

A detailed receipt is to be obtained when specimens change hands (write on the receipt the name of the client, the date, place of collection and the full name of the police officer, his/her badge number and division).

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Survivor of Sexual Assault: Investigations and Treatment

- Conduct microscopy and dipstick urinalysis for blood, to rule out bladder trauma.
- Perform pregnancy testing if indicated and repeat after completion of pregnancy prevention treatment.
- If there is a history of sexual assault, conduct a VDRL, HIV, Hepatitis A, B and C tests. Tests need to done one week after initial visit and then repeated in three months.
- Other tests may be required based on the condition of the patient.
- Treatment of the female where rape is suspected should be with emergency contraceptives as outlined in the guideline documents for treatment of survivors of sexual assault. Ensure that the correct age-appropriate dosages are given to child/adolescent survivors.
- The treatment of HIV and STIs should be managed similarly to the treatment outlined in the guideline documents for the treatment of survivors of sexual assault, ensuring that dosages are age-appropriate. Give age-appropriate HIV Post Exposure Prophylaxis (PEP) treatment along with counselling. For children under the age of 16, this should be given in the presence of a caregiver.
- Review immunization history and provide immunization as appropriate. A vaccination profile should also be done as explained in the guideline documents for the treatment of survivors of sexual assault, while considering age-appropriate dosages.
- The Hepatitis B virus can be sexually transmitted. Therefore, individuals subjected to sexual violence should be offered immunization for Hepatitis B, based on immunization history.

SECTION 7: MANAGEMENT OF THE SURVIVOR OF ABUSE WHO REQUIRES REFERRAL

The survivor of abuse may sustain injuries that are severe and life-threatening, warranting admission at as secondary care facility. Such a patient should be assessed, stabilised and prepared for transfer. The receiving facility should be notified of the arrival of the patient, and make preparations for the admission of the patient.

For specific guidance, see *Policy and Procedure Manual for the Referral and Transfer of Patients (2016)*.

Notes: Referral of the Survivor of Child Abuse

Below is an example of this process – a specific stepwise approach for the survivor of child abuse who requires referral.

I. When the diagnosis of child abuse is made in a child whose injuries are life threatening, immediate hospitalization is mandatory.
II. The clinician should examine the child, make a preliminary diagnosis and stabilize the child prior to transfer to the hospital.
III. All findings should be carefully documented on a letter of referral to accompany the child to the hospital. A telephone call should be made to the clinician receiving the child at the hospital.
IV. The emergency room physician in collaboration with the Ward Medical Officer should examine the child and manage as per protocol, depending on the injury.
V. The Nurse/Records Officer should record the child's name, the informant's name, address, relationship to child and contact telephone number(s).
VI. A consent form should be signed by the caregiver/guardian following discussions with the clinician. (The Police should be contacted if the parent/caregiver refuses admission of the child to hospital, as this situation has medicolegal implications).

VII. The clinician should obtain relevant history from the caregiver/guardian, write accurate and legible notes of the physical findings with labelled drawings (or photographs where possible) to support physical findings.

VIII. The physician should contact the Senior Medical Officer/Consultant on call. Contact should be made with the Senior Admitting Physician/Medical Officer/Paediatrician prior to the child being transferred to the ward.

IX. If the Emergency Room Physician confirms the diagnosis of Child Abuse, the Police and the Hospital Medical Social Worker should be contacted. If a Medical Social Worker is not available, then contact should be made with the Children's Officer stationed in the Family Court where such Court is available, or the CPFSA's Parish Office.

X. On admission of the child, the clinician/medical officer/paediatrician (not the intern or Medical Student) should:

- Establish rapport with both the parent/caregiver and the child
- Arrange a private area for a more in-depth interview
- Assure child survivor of confidentiality where possible
- Avoid accusatory or judgemental attitudes or statements
- Take careful history, if possible, from both caregiver and child survivor individually if this has not been previously done in the emergency room
- Ascertain whether the child survivor has a previous history of abuse and/or hospitalization and request that the old file be located
- During the physical examination, the clinician/medical officer/paediatrician should:
    - Undress the child completely and inspect the entire body, assisted by a nurse
    - Examine the child with sensitivity and patience
    - Look for signs of sexual abuse even if no history is volunteered.

- After the physical examination, the clinician/medical officer/paediatrician should:
    - Write accurate and legible notes of the physical findings, with labelled drawings (or photographs where possible) to support physical findings.
    - Prepare a management plan
    - Inform the parent and child of the results of the examination and the management plan
    - Request consultation from a specialist as needed
    - Order relevant laboratory tests (e.g. skeletal survey, CBC, sickle, lead levels, urinalysis, urea, electrolytes) and any relevant forensic tests
    - Request that the child survivor have a psychiatric evaluation (requests for a psychiatric evaluation should be directed to the nearest Child Guidance Clinic, or, if there is none, to the Regional Psychiatrist or Parish-based Mental Health Officer).
    - Listen and answer, as far as possible, any questions that the parent/child may have
    - Reassure the parents/caregivers and the child.

SECTION 8: DISCHARGE AND FOLLOW-UP OF SURVIVORS OF INTERPERSONAL VIOLENCE

Where it is safe to do so, the survivor of interpersonal violence will need to be prepared to return home. This preparation will include:

- ✓ an explanation of injuries sustained and their possible impact on the survivor's health,
- ✓ establishing safety at home,
- ✓ instructions on continued care for injuries at home, as well as follow-up appointments with healthcare services, and
- ✓ other support services.

Enhancing Safety

Assess and prepare a safety plan after taking care of immediate needs. Where the client is involved in a current abusive relationship, the Medical Officer and/or Medical Social Worker should talk through the plans for safety. Some clients may not be able to return home safely, and contact should be made with the police, the CPFSA (in the case of children), or other support services (as indicated).

SAFETY PLAN

The survivor of violence should include the following in their safety plan:

- A list of phone numbers and contact information for reliable contacts among family or friends, as well as the numbers for the police, ambulance and nearest hospital. (The survivor should keep their phone handy, charged and connected).
- A safe area at home in which to hide, in the event that the survivor is not able to leave the home in an instance of violence
- A safe word agreed upon with reliable contacts, to alert them that the individual is in danger
- The contact numbers for psychological help and support hotlines
- A bag packed with government identification, clothes, money, debit or credit cards, medicine, food and water, for the survivor and/or their children.

(***Adapted from UNICEF blog post: COVID-19: Create your safety plan in case of domestic violence***)

Self-care

- Discuss with the patient the examination findings, what they may mean for their health, and any treatments provided. Invite them to voice questions and concerns.
- Ensure to explain wound care, and if it is a case of sexual assault, advise client to refrain from sex until STI treatment is completed.

Follow-up appointments

- Medical follow-up at the health centre or hospital is a necessary step, especially as it relates to the client being informed of the results of the laboratory tests and any further treatment that may be required.
- The recommended minimum for follow-up is 2 weeks, 3 months and 6 months after the assault (depending on health status this may be more frequent). However, children and adolescents will require multiple psychological visits for an extended duration. The first follow-up visit should be at the initial managing facility; thereafter a referral should be made to the appropriate primary care facility. For secondary care services, the managing physician may opt to refer to a primary care facility acceptable to the affected person.

Continuity of Care

- Coordinate and monitor an integrated care plan with patient and/or support team and other health professionals as necessary.
- At every follow-up visit, review the medical records and ask about new episodes of interpersonal violence.
- Review laboratory investigations and repeat tests as necessary [see section on medical examination].
- Assess for mental health disorders, pregnancy, compliance with treatment for HIV and other STIs.
- Communicate concerns and assess both safety and coping or survival techniques.
- Repeat safety planning options to the client.
- Ensure that the client has a connection to a primary care provider.

Support

The clinician should refer the client to the Medical Social Worker for counselling in the health service as required, preferably with the consent of the client or in collaboration with the police officer, if the decision is for the client in a medicolegal case to be seen by the psychosocial services outside of the health sector.

If the patient is unwilling or unable to engage with other services at this time, the clinician should document in the Medical Records, schedule a follow-up appointment and provide information about local services. Psychosocial support from agencies of the Ministry of Labour and Social Security, for example, will complement the management of health services after the patient is discharged from acute care.

- Explain to the client that various forms of violence are illegal and that the survivor of a crime has legal rights
- Explain the physical and emotional consequences of chronic battering
- Provide written information about support options and help offered by:
  - Police interpersonal violence units
  - Social services departments
  - Crisis centres and/or shelters
  - Counselling and emergency hotlines
  - Social Workers, Psychologists, Counsellors
  - Family and/or friends
  - Non-governmental organizations, including church groups
  - Other key agencies

SECTION 9: INJURY SURVEILLANCE

MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

The interpersonal violence landscape is rapidly changing as violence prevention has increasingly become a national focus and an international priority. There is need to sustain surveillance, provide timely statistical data to monitor trends and achieve national and global violence prevention goals. Sentinel surveillance is an ongoing effort to collect, analyse, interpret and disseminate health-related information on a continuous basis. Sentinel surveillance is generally the best way to monitor trends and detect changing patterns and emerging health problems.

Quality data on interpersonal violence is critical for prevention planning. Obtaining this information therefore requires that healthcare personnel understand what to report and how to report, in addition to being motivated to follow the reporting procedures. Both activities require forms to record relevant data as well as a central repository for the collected information.

The Jamaica Injury Surveillance System (JISS) provides detailed guidance on the collection, collation, reporting and documentation on core data variables. It is the data hub, generating data for both violence-related and unintentional injuries.

Data collection

The JISS monitors four (4) categories of injuries. They are:

- Violence-related Injuries (VRIs) – Violent injuries that were intentionally perpetrated
- Accident/Unintentional Injuries (AUIs) – Injuries of a non-violent, unintentional nature
- Suicide Attempts (SAs) – Attempt on one's life for whatever the reason(s)
- Road Traffic Crashes (RTCs) – Injuries caused from a motor collision (involving a motor car, bike, truck, etc.).

The following key patient data variables should be collected on each VRI case:

- Place of occurrence

- Victim-perpetrator relationship e.g. girlfriend/boyfriend
- Circumstance e.g. fight
- Method e.g. gunshot, stab wound
- Drug use
- Alcohol use

Accident and Emergency staff must create records and interview the patient and/or family or legal guardian in an effort to compile data on the patient's injuries and their locales. This information is fed into the electronic database system. Entering patient information for injuries and locales should cover the following:

Information required	Description
1. Patient's name, address, demographics, next of kin information :	a. Patient's name must be recorded in full, including middle name(s) b. Patient's address must be recorded with full specifics so as to allow for detailed spatial assessments of populations, their communities and the effects of injuries on both population and communities. c. Patient demographics are required for statistical analysis, especially for the social and economic implications brought on by these injuries. d. Next of kin information is extremely vital to the recording process. This information when supplied, helps to locate relatives in case of death, or immediate approval for surgery and investigations (especially in children and patients who are unresponsive). i. Patient's Surname (helps to identify each record as unique) ii. Date of Birth (along with 'Age', establishes true age) iii. Gender (key demographic indicator) iv. Patient/Incident Location Address (including community codes)
2. Type of injury patient suffered and injury-	a) Violence-related Injuries: i. Circumstances of Injury

Information required	Description
related questions to ascertain the cause and characteristics of injuries:	ii. Victim-Perpetrator Relationship iii. Place of occurrence iv. Method of Injury v. Alcohol use b) Accident/Unintentional Injuries: i. Mechanism of injury ii. Place of Occurrence iii. Alcohol use iv. Drug use c) Suicide Attempts: i. Circumstances leading to suicide ii. Method of suicide iii. Previous attempts iv. Alcohol use v. Drug use d) Motor Vehicle Crash: i. Mode of Crash ii. Motor Vehicle User Position iii. Motor Vehicle Counterpart iv. Use of safety gear v. Alcohol use vi. Drug use
3. Injury Location outlined specifically, and according to Statistical Institute of Jamaica (STATIN) defined communities and their boundaries.	Injury Location involves collection of specific information on where the injury occurred: i. Street addresses inclusive of street numbers

Outlined below are the flowcharts outlining the process for reporting and documentation of injuries at sentinel sites, beginning with patient assessment upon arrival.

Figure 5: Flowchart – Jamaica Injury Surveillance System (JISS)

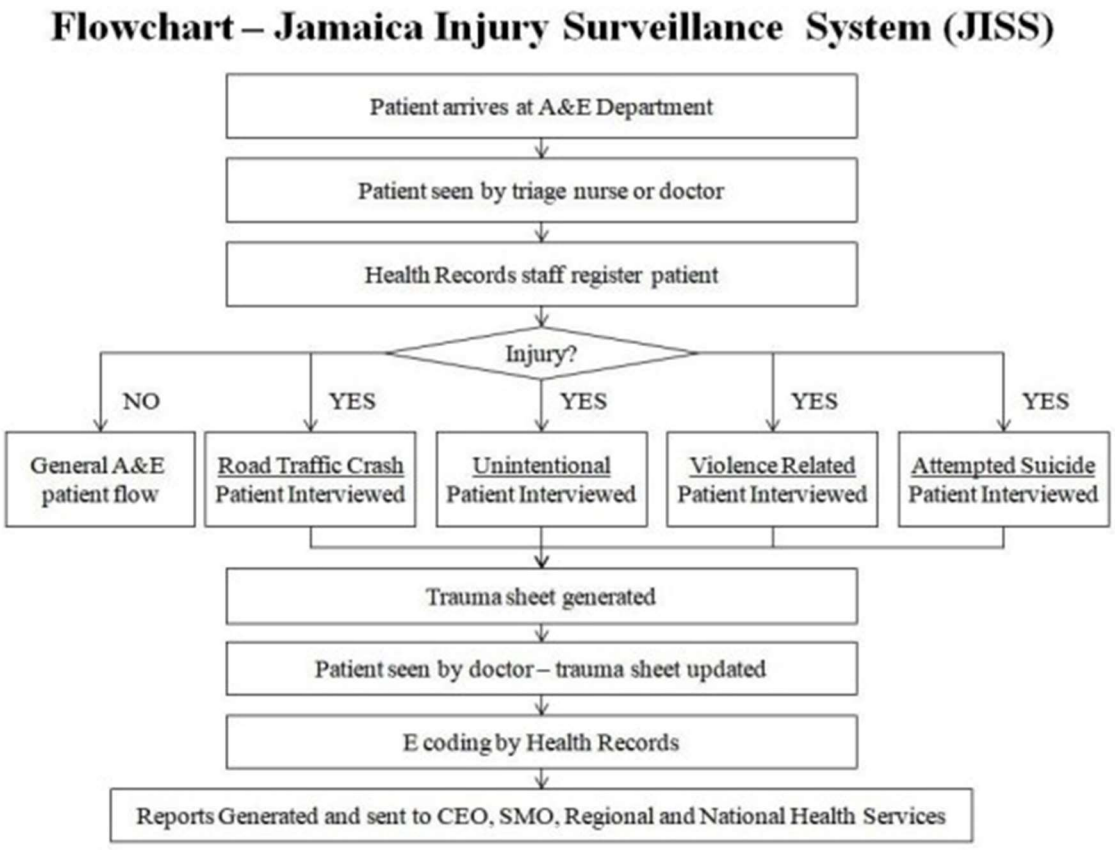


Figure 6: Injury Surveillance Flowchart for Hospitals with a Triage System

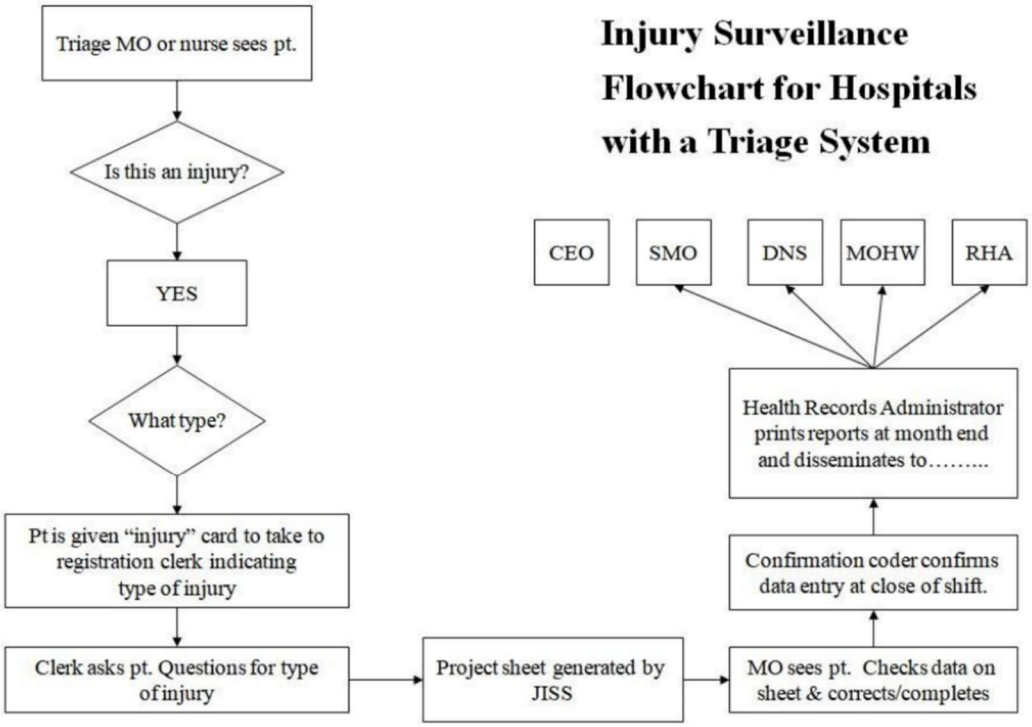
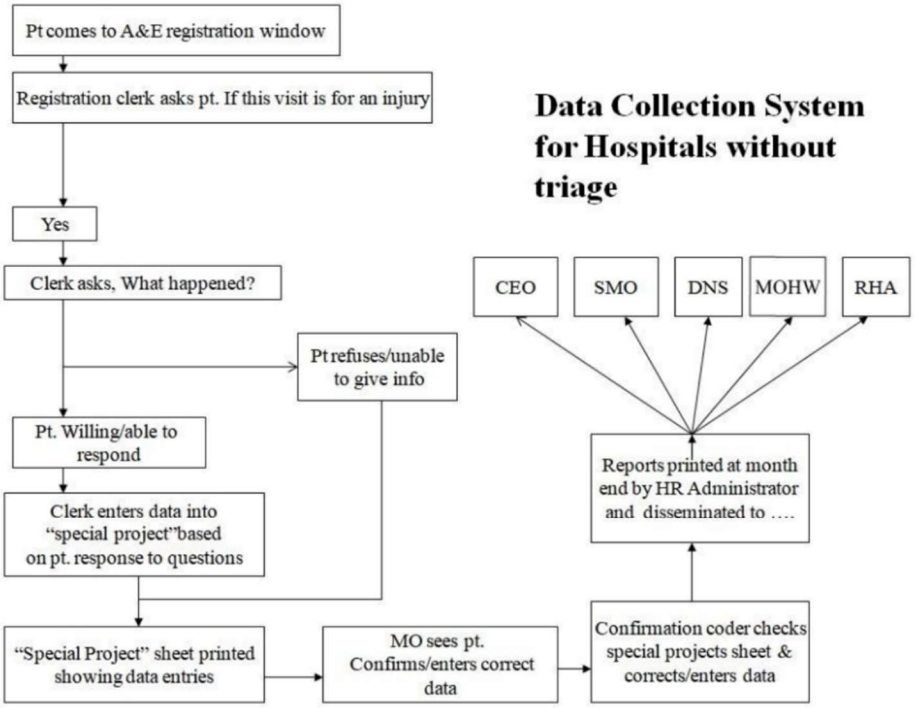


Figure 7: Injury Surveillance Flowchart for Hospitals without a Triage System



For detailed guidance on the procedures for controlling access, data storage and production and validation of records, see the *Jamaica Injury Surveillance System Operational Manual for JISS 3 (2021).*

DIRECTORY OF SUPPORT SERVICES

Agency	Details
Caribbean Community of Retired Persons (Head Office)	2 Phoenix Avenue Kingston 10 Telephone: (876) 469-1944 Email: info@ccrponline.org Services: Collaborates with the National Council for Senior Citizens (NCSC) and the Ministry of Labour & Social Security in upholding the rights of senior citizens. Members are entitled to Medical and Health Insurance Plans and discounts from participating service providers.
Centre for Investigation of Sexual Offences and Child Abuse	3 Ruthven Road, Kingston 10 Telephone: (876) 926-6538 or (876) 926-4079 or (876) 926-5325; Fax: (876) 908-2261 Services: Investigates sexual offences, initiates medical help and seeks/offers counselling for abused children.
Child Guidance Clinics	Emergency Telephone Numbers: • North East Region: (876) 972-2272 • Southern Region: (876) 962-3370 • Western Region: (876) 861-4108 or (876) 776-9509 (to make appointments) • South East Region: (876) 930-1152
Child Protection and Family Services Agency	48 Duke Street, Kingston Telephone: (876) 948-6678/ (876) 948-2841-2, Hotline: 888-PROTECT Services: Counselling and advice, investigation for family reunification, foster care and residential facilities.
Dispute Resolution Foundation	1a North Avenue, Kingston 4 Telephone: (876) 906-2456 or (876) 960-6160; Fax: (876) 547-9769 Email: drf@drf.org Services: Mediation services between parents and children.

Jamaica Council for Persons with Disabilities	18 Ripon Road, Kingston 5 Telephone: (876) 968-8373 Email: jcpd@mlss.gov.jm Services: Registers persons with disabilities to ensure that they can access certain benefits, training in independent living skills, scholarships and educational opportunities, employment and income generating grants.
Jamaica Network of Seropositives (JN+)	3 Trevennion Park Road, Kingston Telephone: (876) 929-7340 or (876) 839-8000 (CUG) Email: jnplus@hotmail.com Services: Self-support groups, sensitization sessions with service providers to improve service delivery and the care and support for persons living with HIV, educational and employment opportunities.
National Children's Registry	12 Carlton Crescent, Kingston 10 Telephone: (876) 619-0723 (Digicel) / (876) 631-4566 (Flow)/ (876) 948-6678/ (876) 948-2821-2 Services: Receipt, record, assessment and referral for timely investigation and curative action, reports of known or suspected instances of child abuse and other threats to children.
National Council on Drug Abuse	13 Molynes Road, Kingston Telephone: (876) 926-9002 Services: Drug counselling and referrals, training and support services
National Council on Senior Citizens	11 West Kings House Road Kingston Telephone: (876) 906-9277 Services: Works in collaboration with local and international organizations and other stakeholders to effect the National Policy for Senior Citizens through programmes and initiatives on behalf of all persons 60 years and older, including home help, computer

	classes, skills training, feeding programme, and referrals.
National Women's Shelter	Hotline Telephone (24-hour): (876) 553-0372 and (876) 929-2997 Services: Provision of support to women and children impacted by gender-based violence, as well as other forms of abuse.
Programme of Advancement through Health and Education	Ministry of Labour & Social Security 14 National Heroes Circle, Kingston 4 Telephone: (876) 922-8000-13 Services: Family assessment and financial support.
Victim Support Unit	Ministry of Justice 47E Old Hope Road, Kingston 5. Telephone: (876) 946-0663/ (876) 946-9287 Services: Mediation and counselling, crisis intervention, advocacy and training for professional and allied personnel working on survivors' issues.
Violence Prevention Alliance	Institute of Sustainable Development 13 Gibraltar Way, Kingston 7 Telephone: (876) 702-2079 Email: vpajamaica@gmail.com Services: Promotion of primary prevention of violence, integrated community development and public education.
Women's Centre of Jamaica Foundation	The Kingston Counselling Centre 42 Trafalgar Road, Kingston 10 Telephone: (876) 906-1607/ (876) 929-7608 Email: womenscentre@cwjamaica.com Services: Continuing education for teen mothers, skills training for women & day care facilities.

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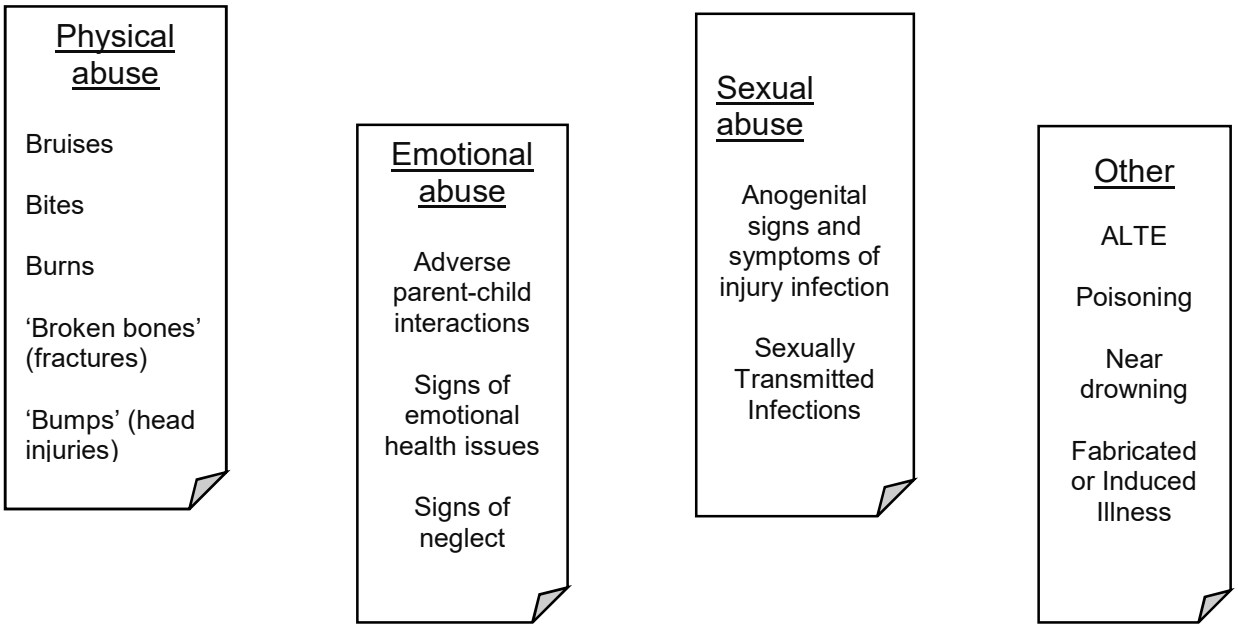
APPENDICES

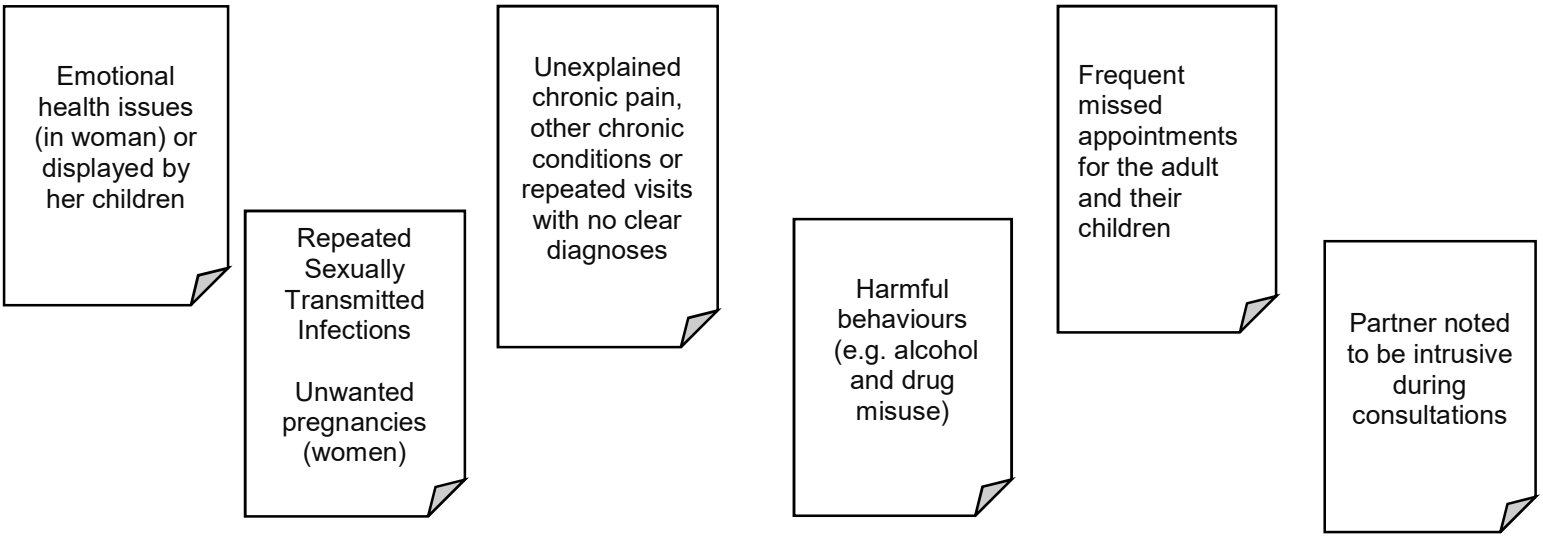
MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Appendix 1 - Warning signs of violence

Indicators of violence in Children



Indicators of violence in Adults



MANAGEMENT OF INTERPERSONAL VIOLENCE: PROCEDURES FOR HEALTHCARE WORKERS

Appendix 2 – Summary of the pathway for the management of the survivor of abuse