GUIDELINES FOR THE MANAGEMENT OF GENDER-BASED VIOLENCE IN HEALTH CARE SETTINGS

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MINISTRY OF HEALTH AND WELLNESS

ISSUED: JANUARY 2024

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Table of Contents

Acknowledgements 7
Acronyms 8
Foreword 10
Purpose and Scope 11
Process for Development of the Guidelines 14
SECTION 1: BACKGROUND & INTRODUCTION 17
Introduction 18
1.0 Defining Gender-Based Violence 19
1.1 Health Sector Response to GBV 24
1.2 The Legal and Policy Framework 26
1.3 GBV Guiding Principles and Approaches 36
1.4 Epidemiology 43
SECTION 2: IDENTIFICATION OF SURVIVORS OF GBV 48
Summary: Identification of Survivors of GBV 49
2.0 Identification of Survivors of GBV 54
2.1 Pathway for GBV Management in the Health Care Setting 61
2.2 Informed Consent 62
2.3 Functions of the Team Members 63
2.4 Follow-Up Appointments 66
2.5 Providing First-Line Support to Survivors of GBV 67
2.6 First-Line Support: “LIVES” 69
2.7 Follow-up Support 78
2.8 LIVES CC: LIVES for Children, Adolescents, and their Caregivers 79
SECTION 3: PROVIDING PHYSICAL CARE FOR SURVIVORS OF GBV 81
Summary: Providing Physical Care for Survivors of GBV 82
Investigations and Treatment of the Survivor of Sexual Violence 83
3.0 Providing Physical Care for Survivors of GBV 85
3.1 History Taking 86
3.2 Conducting the Medical Examination 88

3.3 Conducting the Mental Status Examination....91
3.4 Assessment of Survivors of Sexual Violence....93
3.5 Investigations and Treatment of the Survivor of Sexual Violence....97
3.6 Self-Care for the Survivor....100
SECTION 4: PROVIDING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR SURVIVORS OF GBV....101
Summary: Providing Mental Health and Psychosocial Support for Survivors of GBV....102
4.0 Providing Mental Health and Psychosocial Support for Survivors of GBV....103
SECTION 5: RESPONSE TO SURVIVORS AND VULNERABLE POPULATIONS WITH SPECIFIC NEEDS....111
Summary: Response to survivors and vulnerable populations with specific needs....112
5.0 RESPONSE TO SURVIVORS AND VULNERABLE POPULATIONS WITH SPECIFIC NEEDS....114
5.1 Emergency Settings....119
SECTION 6: DOCUMENTATION AND MEDICO-LEGAL REPORTING....120
6.0 Documentation and Medico-Legal Reporting....121
6.1 Documentation....121
6.2 Medico-Legal Reporting....123
SECTION 7: INJURY SURVEILLANCE....126
7.0 Injury Surveillance....127
ANNEX 1: REFERRAL DIRECTORY....132
ANNEX 2: EXERCISES TO HELP REDUCE STRESS....135
REFERENCES....137

List of Figures

Figure 1.1: Primary Health Care and the context of the wider health system, community mobilization and inter-sectoral action.....25

Figure 2.3: summary of the pathway for the management of the survivor of GBV (All referrals should be made with the survivor's consent) 65

Figure 4 1: Mental Health and Psychosocial Support Intervention Pyramid.....105

Figure 7 1: Flowchart – Jamaica Injury Surveillance System (JISS) 130

Figure 7 2: Injury Surveillance Flowchart for Hospitals with a Triage System 131

List of Tables

Table 1.2 1: Human Rights Treaties to which Jamaica is signatory 27

Table 1.2 2: The Medico-Legal Framework 30

Table 1.2 3: The Multi-sectoral response to GBV 33

Table 2.5 1: Tips for providing first-line support 69

Table 2.6 1: LIVES 69

Table 2.6 2: Active listening dos and dont's 70

Table 2.6 3: Techniques for inquiring about needs and concerns 72

Table 2.6 4: Safety Planning 75

Table 2.6 5: How to help 77

Table 3.2 1: Physical Examination Checklist 89

Table 3.3 1: Screening Checklist for Mental Status Examination 92

Table 4 1: Mental Health Support 106

Table 5 1: Special considerations for male survivors of sexual assault 116

Table 6.2 1: Writing Reports and Giving Evidence in court: guiding principles for health care workers 125

Table 7 1: Data Collection 128

Acknowledgements

The development of these guidelines was spearheaded by the Non-Communicable Disease and Injury Prevention Unit, Health Promotion and Protection Branch of the Ministry of Health and Wellness. These guidelines set the standard for quality, compassionate care in the healthcare setting for gender-based violence (GBV) survivors and will strengthen GBV case management and external referral systems in order to improve services.

The Ministry of Health and Wellness (MoHW) would like to thank the United Nations Population Fund (UNFPA) and Pan American Health Organization (PAHO) for supporting the development and adaptation of tools and content for use in this resource manual. In addition, the contributions made by the following MoHW Units and other participating agencies during the stakeholder consultations were invaluable:

- University Hospital of the West Indies;
- Mental Health and Substance Abuse Unit, MoHW;
- The Regional Health Authorities; and
- The Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA).

This intervention is funded under Pillar 4 of the Spotlight Initiative (SI) – a global, multi-year initiative focused on eliminating all forms of violence against women and girls (VAWG). Pillar 4 focuses on the delivery of quality, essential services and therefore is aimed at addressing the following:

- accessibility, availability, and affordability of quality, coordinated services to victims and survivors of family violence;
- standard operating procedures (SOPs) and a formal referral pathway for victims and survivors of family violence; and
- safe spaces for victims and survivors of GBV, including shelters. This is especially so in rural areas.[1]

[1] Spotlight Initiative to eliminate violence against women. Country Programme Document. Jamaica. October 2019

Acronyms

A&E	Accident and Emergency
BGA	Bureau of Gender Affairs
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGC	Child Guidance Clinic
CISOCA	Centre for Investigation of Sexual Offences and Child Abuse
CSO(s)	Civil Society Organization
GBV	Gender-Based Violence
GBVIMS	GBV Information Management System
HCW	Health Care Workers
IAWG	Inter-Agency Working Group on Reproductive Health in Crises
ICRW	International Centre for Research on Women
IDB	Inter-American Development Bank
IPV	Intimate Partner Violence
JISS	Jamaica Injury Surveillance System
MCGES	Ministry of Culture, Gender, Entertainment and Sport
MISP	Minimum Initial Service Package
MoHW	Ministry of Health and Wellness
MSM	Men who Have Sex with Men
NCR	National Children's Registry
NCVP	National Commission on Violence Prevention
NSAP-GBV	National Strategic Action Plan to Eliminate Gender-Based Violence
NPGE	National Policy for Gender Equality
OCA	Office of the Children's Advocate
PAHO	The Pan American Health Organization
PLHIV	Persons living with HIV
SDG	Sustainable Development Goals
SOP	Standard Operating Procedures

SI	Spotlight Initiative
SRGBV	School-related gender-based violence
STIs	Sexually Transmitted Infections
TG	Transgender
TGW	Transgender Women
UN	United Nations
UNFPA	United Nations Population Fund
VAWG	Violence against Women and Girls
VDRL	Venereal Disease Research Laboratory
VRI	Violence-related Injuries
VSD	Victim Services Division
WHO	World Health Organization
WLHIV	Women Living with HIV
WSW	Women who have sex with women

Foreword

Violence is a significant global public health and human rights issue. Interpersonal violence is an unfortunate part of our existence. Sexual violence and gender-based violence (GBV) in particular, are topical issues.

The health sector is a key stakeholder in the prevention and control of gender-based violence (GBV). The work done with families and communities provide fertile ground for raising awareness about GBV, identification of GBV as well as providing survivors with an entry point into treatment, care and support services.

Seamless partnerships with other sectors – security, justice, social services, etc. – underpin the foundation for the prevention and control of GBV, in particular, the provision of support to survivors.

It is hoped that these guidelines will provide service providers with the necessary information to support them in the provision of the highest level of healthcare, while also providing first-line support, ensuring adherence to the guiding principles and making any referrals to additional services, as needed.

Purpose and Scope

Gender based violence is a public health issue and has many adverse effects – immediate and long- term, obvious and hidden and are not mutually exclusive but may be occurring simultaneously. Individuals who have experienced violence can suffer injuries (including genital injuries), unintended pregnancy and pregnancy complications, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistulae and chronic conditions. The mental health impacts of physical and sexual violence as well as other forms of interpersonal violence may include injuries such as bruises and fractures, acute stress reactions, post-traumatic stress disorder (PTSD), depression, anxiety, sleep disturbances, substance misuse, self-harm and suicidal behaviour. In addition, survivors may face stigma and rejection from their families and communities.

<table>
<tr><th colspan="4">GBV as a Public Health Issue</th></tr>
<tr><th>Fatal Outcomes</th><th colspan="3">Non-fatal Outcomes</th></tr>
<tr><td rowspan="2">● Femicide
● Suicide
● AIDS-related mortality
● Maternal mortality</td><td>Physical</td><td>Sexual & Reproductive</td><td>Psychological & Behavioural</td></tr>
<tr><td>● Fractures
● Chronic pain syndromes
● Permanent disability
● Gastro-intestinal disorders</td><td>● Sexually transmitted infections, including HIV
● Unwanted pregnancy
● Pregnancy complications
● Early sexual initiation</td><td>● Depression and anxiety
● Eating and sleep disorders
● Drug and alcohol abuse
● Poor self-esteem
● Post-traumatic stress disorder
● Self-harm</td></tr>
<tr><td colspan="4">Source: Bott, Morrison and Ellsberg, 2005 (adapted)</td></tr>
</table>

Globally, violence against women and girls remains commonplace with more than one in every 10 women and girls aged 15-49 was subjected to sexual and/or physical violence by an intimate

partner in the previous year (12.5%).[2] When examining lifetime prevalence the data shows a sharp rise to 1 in 3 women.[3] Men may also be victims of sexual violence and can experience violence from an intimate partner, although the rates are much lower. Boys may be at risk of child sexual abuse, which is usually perpetrated by family members or other persons who are known to the child. Sexual and gender minorities, people with disabilities, children and adolescents are also often at increased risk of violence.

In Jamaica, women and girls are disproportionately affected by intimate partner violence and sexual violence. It is recognised that survivors are also comprised of boys and men, especially sexual minorities such as men who have sex with men (MSM) and transgender persons. These boys and men experience higher risk due to social and cultural norms in the region and legislative barriers that criminalize anal sex and reinforce harmful gender norms. According to the Jamaica Women's Health Survey 2016, one in every four Jamaican women (25.2%) has experienced physical violence by a male partner, and 7.7% have been sexually abused by a male partner. Lifetime prevalence of intimate partner physical and/or sexual violence against Jamaican women is 27.8%; current prevalence was 7.0%.

Based on the foregoing this resource provides guidelines for implementing the Ministry of Health and Wellness' response to the management of cases of gender-based violence (GBV) in the health care setting. These guidelines do not cover all forms of GBV; they focus primarily on forms of GBV that typically present in health care settings; children, adolescents and other vulnerable populations and settings are discussed.

These guidelines are intended to provide healthcare professionals (at all levels of care) with guidance for the identification and management of persons affected by GBV using the minimum standards of care taking into account available resources, materials, and drugs, and national policies and procedures.

[2] UN Women. 2022. Progress on the Sustainable Development Goals: The Gender Snapshot 2022.
[3] Violence Against Women Prevalence Estimates, 2018

This guideline covers identification; physical examination and collection of forensic specimens, investigation and treatment as well as referral pathways. It is primarily intended to be used by the first line support team i.e., medical doctors, mental health teams, medical social workers, registered midwives, and nurses, and other healthcare providers in assisting them with making informed decisions. This document will therefore enhance the knowledge, skills and attitudes necessary to detect gender-based violence and offer services to its survivors. It can also be used in planning care services and in training health care providers.

Users of the guide are encouraged to consult the following complementary guidelines:

1. Protocol and Standard Operational Procedures for the Treatment of Victims of Sexual Assault in Health Facilities (MoHW, June 2020); and
2. The Management of Victims of Child Abuse and Neglect: Guidelines (MoHW, 2004).

Process for Development of the Guidelines

The guidelines reflect Jamaica's commitment under the 2015-2025 Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women to: strengthen the capacity of health systems to provide effective care and support to women who have experienced intimate partner or non-partner sexual violence; and strengthen the role of the health system in preventing violence against women.

To support the development of a comprehensive effective evidence-based response the guidelines were undertaken using the following steps:

Desk Review: A desk review was undertaken to inform the development of the Guidelines. The documents that were reviewed included legislation, human rights commitments, guidelines, and protocols guiding GBV health sector interventions as well as international health regulations and guidelines along with local literature/research, and reports from government ministries, international development partners and civil society organizations (CSOs) working in the sector. The following protocols and guidelines have been used as base documents for the development of the guidelines:

- Caring for women subjected to violence: a WHO curriculum for training health-care providers (WHO, 2019).
- Clinical Management of the rape and intimate partner violence (IPV) survivors: developing protocols for use in humanitarian settings (World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), 2020);
- Essential Services Package for Women and Girls Subject to Violence (United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, 2015);
- GBV Information Management System (GBVIMS) Health Data Collection Form (Government of Trinidad and Tobago 2018);
- GBVIMS Intake and Initial Assessment Form (Government of Trinidad and Tobago, October 2010);

- Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook (WHO 2014);
- Intimate Partner Violence and Sexual Violence Health Care Form (Government of Trinidad and Tobago, September 2021);
- Management of Interpersonal Violence: Procedures for Healthcare Workers (MoHW, 2022);
- National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence: Trinidad and Tobago (Government of Trinidad and Tobago, 2021);
- Protocol for the Management of Common Mental Disorders (MoHW, 2005);
- Protocol and Standard Operational Procedures for the Treatment of Victims of Sexual Assault in Health Facilities (MoHW, June 2020);
- Responding to children and adolescents who have been sexually abused; WHO clinical guidelines (WHO, 2017);
- *Responding to child maltreatment: a clinical handbook for health professionals (WHO 2022);*
- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (WHO, 2013);
- The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings (IAWG, 2018);
- The Inter-Agency Minimum Standards for Gender Based Violence in Emergencies Programming (United Nations Population Fund (UNFPA), 2019);
- The Management of Suspected Victims of Trafficking in Persons: Protocol for Health Care Workers (MoHW, 2017);
- Violence against Women and Girls: Health Sector Brief (World Bank, The Global Women's Institute, Inter-American Development Bank (IDB), April 2015; and
- Violence against Women and Girls Resource Guide: Brief on Violence against Sexual and Gender Minority Women (World Bank, The Global Women's Institute, Inter-American Development Bank (IDB), International Centre for Research on Women (ICRW), September 2015).

National Consultation: A consultation was undertaken with key informants selected from stakeholders from the MoHW. In total, 33 participants joined the workshop representing various arms of the Ministry as well as other institutions. These included MoHW, the MoHW's

Regional Health Authorities, CISOCA, Eve for Life, University Hospital of the West Indies as well as other members of the project team.

This approach was taken subsequent to the circulation of a survey tool for completion at the field level. However, due to the low level of responses, the decision was taken by the MoHW to host a national consultation with stakeholders with the aim of completing the survey instrument previously circulated. The Consultation was aimed at:

- Identifying existing protocols used in the identification, management, treatment and referral of survivors of GBV accessing care in the healthcare setting;
- Identifying standards of practice for the identification, management, treatment and referral of survivors of GBV accessing care in the healthcare setting; and
- Identifying indicators and data collection methods to support the monitoring of the implementation of the proposed Guidelines for the Management of GBV in the healthcare setting.

Participants were broken into groups and instructed to complete the questionnaire as a group. The group was then tasked to present their responses in plenary for further discussion and clarification as necessary.

Drafting of the Guidelines: The Guidelines were drafted utilising the MoHW proposed model and based on the international guidelines as well as incorporating the feedback from the stakeholder consultations to ensure comprehensiveness and complementarity.

SECTION 1: BACKGROUND & INTRODUCTION

Introduction

Under international human rights law, acts of GBV are considered violations, as articulated in international conventions, particularly the Convention on the Elimination of All Forms of Discrimination against Women. Furthermore, the United Nations Declaration on the Elimination of Violence against Women defines violence against women as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women”. The Declaration emphasizes that violence is “a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women.”

1.0 Defining Gender-Based Violence

Gender-based violence is an umbrella term for the perpetration of harm to a person against their will that is the result of power imbalances that exploit gender related distinctions between males and females, amongst males, and amongst females. While women, men, boys and girls can experience gender-based violence, women and girls are particularly vulnerable. All forms of violence against women are gender-based and thus a particular focus of these guidelines. Such violence encompasses but is not limited to physical, sexual and psychological violence (a) occurring in the family, (b) occurring within the general community, against a particular community with specific characteristics based on religion, ethnicity, sexual orientation; in a school or religious institution, in a workplace; and (c) perpetrated or condoned by agents of the State and its institutions, wherever it occurs.[4]

The term "GBV" is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. The term "gender-based violence" also includes sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity. Concomitantly ongoing or past violence and abuse by an intimate partner or ex-partner – a husband, boyfriend or similar is referred to as Intimate Partner Violence (IPV) and also includes: physical violence, emotional/psychological abuse, controlling behaviours and sexual violence.

[4] Bureau of Gender Affairs – National Strategic Action Plan to Eliminate Gender-Based Violence (NSAP-GBV) in Jamaica 2017-2027.p7.

Types of Violence

At the national level as guided by Jamaica's National Strategic Action Plan to Eliminate Gender-based Violence the country recognizes the terms 'gender-based violence', 'sexual violence' and 'violence against women and girls' as distinct areas under 'gender-based violence'. This also includes sexual harassment and child sexual abuse. These areas are further defined as follows:

- *Violence against women and girls (VAWG):* This is a manifestation of the historical unequal power relations between men and women and society's perception of the roles that they play. VAWG includes: a) Violence that occurs within the family or domestic unit or within any other interpersonal relationship, whether or not the perpetrator shares or has shared the same residence with the woman, including, among others, rape, battery and sexual abuse; b) Violence that occurs in the community and is perpetrated by any person, including, among others, rape, sexual abuse, torture, trafficking in persons, forced prostitution, kidnapping and sexual harassment in the workplace, as well as in educational institutions, health facilities or any other place; and c) Violence that is perpetrated or condoned by the state or its agents regardless of where it occurs.

- Domestic *Violence/Intimate Partner Violence:* Generally, domestic violence is described as the sexual, physical, verbal, emotional, psychological and/or economic abuse of an adult by an intimate partner or spouse. These types of abuse can involve the use of threatening or intimidating words and acts, hitting, use of a weapon, rape, imprisonment, financial control, cruelty towards him/her or other people and things s/he cares about, and abusive and/or demeaning language. Violence against women and girls living with HIV because of their status, or violence against persons because of sexual orientation or gender identity, also occurs in domestic settings or is perpetrated by intimate partners.

- *Rape and Sexual Assault:* The Sexual Offences Act 2009 defines rape as the use of physical force, or to penetrate an adult woman's vagina without her consent. This definition includes marital rape where a husband can rape his wife in specified

circumstances. In the majority of cases, the perpetrator is someone the woman knows. In other jurisdictions, the penetrative sexual offence is no longer gender-specific and generally includes penetration of the genitalia by a penis, object, part of a body or mouth. Sexual Assault is non-consensual sexual contact that does not include penetration. Corrective rape, also known as curative rape, "is where a person is raped because of their sexual orientation or gender identity in an effort to "correct" them and make them become heterosexual or act as their assigned gender". Other forms of sexual violence covered by the National Strategic Action Plan to Eliminate Gender-Based Violence (NSAP-GBV) include violence against women and girls living with HIV because of their status and violence against transgender persons.

- *Childhood Sexual Abuse (Carnal Abuse):* According to UNICEF, "Child sexual abuse includes, but is not limited to rape, sexual intercourse with a child, incest; it also consists of non-physical contact and non-penetrative activities, such as involving children in watching sexual activities, encouraging children to behave in sexually explicit ways and exposing them to inappropriate sexual material."[8] At times, it may take the form of a breach of trust in which an individual, who has the confidence of the child, uses that trust to secure sexual favours. According to the Jamaica Sexual Offences Act (2009)[9], incest refers to sexual intercourse with a biological (blood) relative and is committed when any male person has sexual knowledge of his mother, daughter, sister or niece, where a female person permits her grandfather, father, son, brother or nephew to have carnal knowledge of her. On the other hand, WHO recognizes that incest can also involve other male in a position of family trust, e.g., neighbour, teacher – persons not related to the victim. Incest takes on the added psychological dimension of betrayal by a family member or another person who is supposed to care for and protect the child." Sexual abuse can involve fondling, oral, vaginal or anal contact and can also include the use of a child for prostitution and pornography. Sexual intercourse does not have to occur for the act to be considered sexual abuse.

- *Sexual Harassment:* refers to conduct that involves an unwelcome sexual advance, request for sexual favours or conduct of a sexual nature by one person toward another.

- *School-related gender-based violence:* GBV in schools takes place within the context of gender inequality, cultural beliefs and attitudes about gender roles, especially those concerning male and female identity and sexuality. As in the wider society, GBV in schools mainly involves female students, and is perpetrated by male peers and other males in positions of authority. Outside of school, girls also fall prey to older men who provide them with favours and financial assistance. Sometimes these relationships lead to serious abuse and even death of the girls. Similarly, GBV also occurs on the semi-isolated spaces of university campuses. School cultures can contribute to gender violence. Often, gender stereotypes and inequities abound in the classroom, where different behaviours and roles are expected from girls and boys. Gender based violence in schools takes many forms, e.g., sexual harassment, aggressive or unsolicited sexual advances, touching, groping, intimidation, verbal abuse or sexual assaults. Schools that are not safe or that promote gender disparity breed the inequality that lasts a lifetime.

In keeping with Jamaica's commitments to international human rights treaties to which it is signatory the country specifically defines gender-based violence as comprising:

- *Physical violence:* defined as intentional harm inflicted on another person through the use of physical strength or a weapon. Non-severe repeated punishment is also considered physical violence.

- *Psychological violence:* refers to any behaviour that inflicts emotional harm on victims, diminishes their self-esteem, or damages or disturbs their healthy development or that of their family members including: behaviours engaged in to dishonour, discredit, or devalue personal worth; humiliating treatment; constant surveillance; repeated insults; blackmail; degradation; ridicule; manipulation;

exploitation; deprivation of economic means; and limitations in or impediments to victims' freedom of transit.

- *Sexual violence:* The World Health Organization (2002) has defined sexual violence as any unwanted sexual act or attempt to consummate an unwanted sexual act, unwanted sexual insinuations, and actions intended to market or use in any other way the sexuality of a person through coercion by another person, regardless of the relation of this person to the victim and in any area, including the home and the workplace. This definition includes violations by strangers, violations during armed conflicts, violations of individuals with disabilities and/or children, forced marriage, sexual harassment, refusal of and/or withholding of contraception and protection, forced abortion, and/or children forced prostitution.

- *Patrimonial or economic violence:* defined as actions or omissions on the part of the abuser that affect the economic life and sometimes the survival of family members. Laws in some countries describe patrimonial/economic violence as actions or omissions that involve harm, loss, transformation, subtraction, destruction, retention, or diversion of objects, personal documents, goods, values, rights, or economic resources.

Across the globe, sexism, misogyny, homophobia and transphobia lead to violence against sexual minorities ranging from bullying, harassment and violence in families and communities to sexual assault and brutal extrajudicial killing. Sexual minority women are also at high risk for multiple forms of interpersonal violence committed against them by colleagues, family members, neighbours, or intimate partners. Within the family, children who portray non-normative sexualities or expressions of gender are more vulnerable to physical and sexual abuse than their heterosexual siblings.

1.1 Health Sector Response to GBV

Healthcare providers are often the first and sometimes only point of contact for GBV survivors. They are on the front line and can play a central role in determining protection and addressing other concerns, such as emotional/psychological needs, developing prevention strategies and providing referrals to other services. Healthcare services should be delivered in a confidential, non-judgmental and non-discriminatory manner that considers the survivor's sex, age and specific needs. Special consideration should be given to the unique needs of women and girls who face barriers accessing services, male survivors of sexual abuse and child survivors of sexual abuse who require child-appropriate service provision.

A quality health service response to violence against women and girls is crucial, not only to ensure survivors have access to the highest attainable health standard, but also because healthcare providers (such as nurses, midwives, doctors and others) are likely to be the first professional contact for women who have been subjected to intimate partner violence or sexual violence. Women and girls often seek health services, including for their injuries, even if they do not disclose the associated abuse or violence. Studies show that abused women use health services more than non-abused women do. They also identify healthcare providers as the professionals they would most trust with disclosure of abuse.

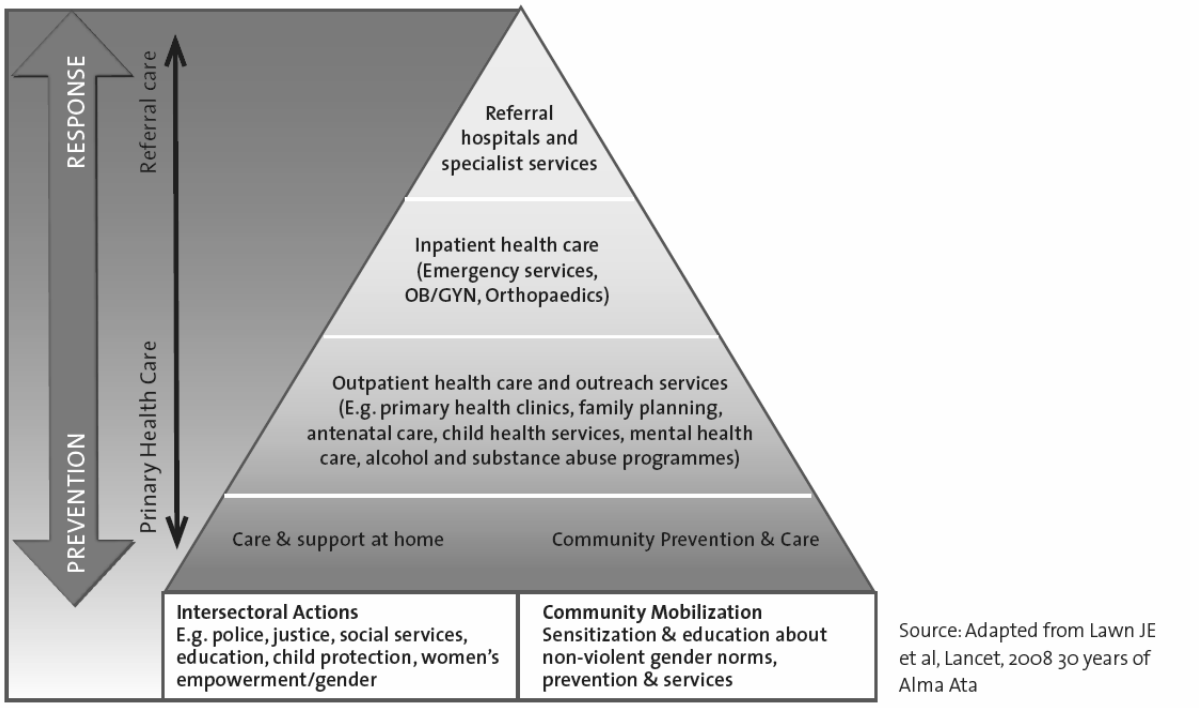
In order to respond to survivor's diverse needs and experiences, this guide addresses all health consequences, including the physical, mental and sexual and reproductive health consequences, of violence in keeping with the World Health Organization's (WHO) clinical and policy guidelines on the health sector response to partner and sexual violence against women (2013).

As called for in the Agreed Conclusions from the 57th session of the Commission on the Status of Women, and as per the WHO guidelines, this guide covers various health interventions: first line support; treatment of injuries and psychological and mental health support; for post-rape care including preventing pregnancies, and diagnosis and treatment for sexually transmitted infections.

Training for medical and other health professionals to effectively identify and treat survivors of violence as well as forensic examinations by appropriately trained professionals are also necessary. In addition, these guidelines take guidance from the Agreed Conclusions to ensure that health care services have the following characteristics: accessible, responsive to trauma; affordable; safe; effective and good quality.

Collaboration with other state actors and the community are key components of an effective GBV response. Health sector services for GBV survivors range from primary health care services to specialised care (Figure 1.1).

Figure 1.1: Primary Health Care and the context of the wider health system, community mobilization and inter-sectoral action



Source: Adapted from Lawn JE et al, Lancet, 2008 30 years of Alma Ata

1.2 The Legal and Policy Framework

International and Regional Commitments

In 2015, the 2030 Agenda for Sustainable Development was adopted by all United Nations Member States including Jamaica. The 2030 Agenda consists of 17 interlinked global goals designed to be a "blueprint to achieve a better and more sustainable future for all". The sustainable development goals (SDG) provide a global consensus for action on global challenges such as climate change, poverty and education, in addition, the SDGs acknowledge the crisis of violence against women (VAW) and consequently, there is a stand-alone goal on gender equality, alongside clear targets to end violence against women and girls, specifically:

- SDG 5: Achieve gender equality and empower all women and girls. Progress towards targets is measured by indicators.
- SDG Target 5.2: to eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and other types of exploitation.
- SDG Target 5.3: to eliminate all harmful practices such as child early and forced marriage and female genital mutilation.

The Strategic Plan of the National Commission on Violence Prevention (2020-22) further identified additional SDGs that impact risk for violence. They are:
SDG 1: No Poverty;
SDG 3: Good Health;
SDG 4: Quality Education;
SDG 10: Reduced Inequalities; and
SDG 11: Sustainable Cities and Communities.

Jamaica is a Member State of the Organization of American States (OAS) and of the United Nations (UN), and is a signatory to the following human rights treaties:

Table 1.2 1: Human Rights Treaties to which Jamaica is signatory	
Universal Declaration on Human Rights	The Declaration was proclaimed by the United Nations General Assembly in Paris on 10 December 1948. First document ever to set out fundamental human rights to be universally protected as well as a common standard of achievements for all peoples and all nations. Article 1: "All human beings are born free and equal in dignity and rights…" Article 3: "Everyone has the right to life, liberty and security of person." Article 5: "No one shall be subjected to torture or to cruel, inhumane or degrading treatment or punishment."
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	International Human Rights Treaty adopted in 1979. The Convention establishes not only an international bill of rights for women, but also an agenda for action by countries to guarantee the enjoyment of those rights. The Convention covers three main areas: civil rights; the legal status of women; and influence of culture and tradition on restricting women's enjoyment of their fundamental rights.
The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against women and girls (Convention of Belem do Para)	The Convention was adopted on June 9, 1994 and is an international human rights instrument which calls for the establishment in the Americas of mechanisms for protecting and defending women's rights, and for combating violence against women's physical, sexual, and psychological integrity, whether in the public or the private sphere.
The Beijing Declaration of the Fourth World Conference on Women	The Beijing Declaration is a global policy document on gender equality. It sets strategic objectives and actions for the advancement of women and the achievement of gender equality in 12 critical areas of concern: Women and poverty; Education and training of women; Women and health; Violence against women; Women and armed conflict; Women and the economy; Women in power and decision-making; Institutional mechanism for the advancement of women; Human rights of

Table 1.2 1: Human Rights Treaties to which Jamaica is signatory	
	women; Women and the media; Women and the environment; and the girl-child.
UN Commission on the Status of Women Outcome Document - 57th Session, on elimination and prevention of all forms of violence against women and girls (2013)	Section A (paragraphs (a) to (bb)) sets out actions to strengthen legal and policy frameworks that address gender inequality and violence against women and girls.
International Convention on the Rights of Persons with Disabilities (2013)	Urges State Parties to take all appropriate legislative, administrative, social, educational, and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
Convention on the Rights of the Child (1991)	Outlines the civil, political, social, health and cultural rights of children.
International Covenant on Economic, Social and Cultural Rights (1966)	Economic, social and cultural rights including labour rights, right to health, education, and adequate standard of living.
GLOBAL PLAN OF ACTION to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children (2016)	The plan focuses on all types of interpersonal violence against women and girls, and against children, including in situations of humanitarian emergencies and post-conflict settings, recognizing that such violence is exacerbated in these settings.
Regional Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women (CD54/9, Rev.2) – approved by PAHO's Directing Council in 2015	This strategy offers a concrete roadmap for health systems to address the Region's priorities in the area of violence against women.

These international commitments help to guide governments to address GBV as a development and human rights challenge due to the positive impact on multiple development outcomes including health at the individual, family and community levels.

In addition, Jamaica also regularly reports on progress on the fulfilment of the 2015-2025 Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women.

National Commitments

Discrimination against women, the unequal rights of women, and gender-based violence constitute a violation of human rights. According to the Commonwealth Secretariat (2002: 44) of which Jamaica is a member state, gender-based violence involves "a violation of human rights that results in all forms of violence based on gender relations. It includes physical harm, sexual acts, emotional and psychological abuse and economic deprivation. Its forms include: rape, carnal abuse, family violence, sexual harassment, sexual assault, battery, buggery, wounding with instruments".

The Government of Jamaica's commitment to eliminating gender-based violence (GBV) is also outlined in the Gender Sector Plan under Vision 2030 – Jamaica's National Development Plan. The Ministry of Culture, Gender, Entertainment and Sport (MCGES) is charged with responsibility for gender matters. The Bureau of Gender Affairs, a division of the MCGES specifically leads the charge on gender mainstreaming and issues affecting women. Launched in 2018, Jamaica's response to Gender-based Violence is governed by the 10-year National Strategic Action Plan to Eliminate GBV in Jamaica (2017-2027) to prevent violence, protect and deliver adequate services to victims and deal appropriately with perpetrators. Recognizing that GBV is a public health, human rights and development issue, the Plan defines GBV as:

…. Gender Based Violence is an umbrella term for the perpetration of harm to a person against their will that is the result of power imbalances that exploit gender related distinctions between males and females, amongst males, and amongst females. While women, men, boys and girls can be victims of gender-based violence, women and girls are the main victims. Such violence encompasses but is not limited to physical, sexual and psychological violence (a) occurring in the family, (b) occurring within the general community, against a particular community with specific characteristics based on religion, ethnicity, sexual orientation; in a school or religious

institution, in a workplace; and (c) perpetrated or condoned by agents of the State and its institutions, wherever it occurs.

The plan is supported by the following policies:

- National Policy for Gender Equality (2011);
- National Strategic Action Plan to Eliminate Gender-based Violence (2017-2027);
- National Plan of Action for an Integrated Response to Children and Violence; and
- National Shelter Strategy.

The Jamaica Women's Health Survey 2016 in highlighting the National Strategic Action Plan explains that the Plan recognizes that GBV exists on a continuum of "physical, sexual, psychological/emotional, economic abuse and exploitation." This is critical to the definition of GBV as it demonstrates the interrelated nature of GBV, and the multi-sectoral response required to eliminate and/or mitigate against it.[5]

The domestic application of these human rights instruments has informed the development of the following pieces of legislation:

Table 1.2 2: The Medico-Legal Framework	
The Disabilities Act, 2014	The Act sets out provisions that are specific to protecting the well-being of children with disabilities, as well as guidelines on the protection of the rights and interests of PWDs in the following areas: protection from discrimination, education and training, employment, participation in political office and public life, healthcare, access to premises and housing and public passenger vehicles (The Disabilities Act, 2014). Under the Disabilities Act, the health facility and health worker are required to ensure that services are provided to persons with disability without discrimination. Discrimination is defined to include any distinction, exclusion or restriction on the basis of disability that robs the disabled person of the equal enjoyments of their rights, legal interests, privileges, benefits and treatment. The

[5] Carol Watson Williams. Women's Health Survey 2016 Jamaica. Co-publication of the Statistical Institute of Jamaica, Inter-American Development Bank and the United Nations Entity for Gender Equality and the Empowerment of Women.

Table 1.2 2: The Medico-Legal Framework	
	Act includes specific standards that emphasize the need to ensure equal access to a range of health services, including sexual and reproductive health services, of the same range and standard as other users.
The Domestic Violence Act, 1996	The Act provides for enhanced protection for victims 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, protection of women and girls, suppression of brothels, child stealing, bigamy, abortions, infanticide, 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. The offence of buggery in the Offences Against the Person Act proscribes all anal penetration by a penis.
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 offence of Grievous Sexual Assault covers an array of acts involving anal, vaginal or oral penetration without consent – either by a body part or an object - as well as other acts involving the non-consensual touching of the sexual organs with the mouth. The Sexual Offences Act sets the age at which children can consent to sexual intercourse at 16. Major offences under this Act often require proof of sexual intercourse, defined in s.2 of the Act as the penetration of the vagina of one person by the penis of another person. Offences such as rape, sexual intercourse with a minor and incest all require proof of vaginal penetration by a penis. In the case of rape, the

Table 1.2 2: The Medico-Legal Framework	
	offence can only be committed by a man against a woman and there must be proof of the absence of consent. For other offences, either the male or female party may be found guilty as a perpetrator. The Act also creates the offence of Sexual Intercourse with a person, who by virtue of their disability is unable to consent to the act. This applies to persons who, by virtue of their mental disorder or physical disability are unable to consent to sexual intercourse because they are not able to: ● understand what the Act is; ● form a decision as to whether to engage in the act (or as to whether the Act should take place); ● communicate any such decision.
Law Reform (Age of Majority) Act	This Act sets the age for consenting to medical procedures without the requirement for parental permission at 16.
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 Child Care and Protection Act introduced a framework for the mandatory reporting of children in need of care and protection to the Children's Registry. Doctors and other health workers having a duty of care towards children are classified as prescribed persons and required to report any information that may lead to the suspicion that a child is being (or at risk of being) abused, neglected or otherwise in need of care and protection. This includes all suspected victims of sexual abuse and all children under the age of 16 who are (consensually or otherwise) victims of the offence of having sexual intercourse with a child under the age of consent.
The Trafficking in Persons (Prevention Suppression and Punishment) Act	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 including psychological.

Table 1.2 2: The Medico-Legal Framework	
The Sexual Harassment (Protection and Prevention) Act, 2021	The Bill seeks to protect women and men from unwanted sexual advances.
The Child Pornography (Prevention) Act 2009	The Act prohibits the production, distribution, importation, exportation or possession of child (male or female person under the age of eighteen years) pornography, and the use of children for child pornography. The Act also provides for connected matters.
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.

The institutional framework to support Jamaica's response to GBV is multi-sectoral as it acknowledges that violence against women and girls is not caused by any one, single factor (Crowell and Burgess, 1996, Heise, 1998, Heise, 2011) and therefore requires a joint framework (see Table 1.2.3).

Table 1.2 3: The Multi-sectoral response to GBV	
MINISTRY	**BODIES, DEPARTMENTS and AGENCIES**
Ministry of Culture, Gender, Entertainment and Sport (MCGES)	Bureau of Gender Affairs (BGA): a division of the MCGES responsible for coordinating the national gender response in Jamaica. The BGA focuses on the policy level in order to ensure that gender analysis is integrated into all national policies, plans, programmes and projects.[6] The BGA is the entity leading the implementation of the National Policy for Gender Equality (NPGE) and the National Strategic Action Plan on Gender-Based Violence (NSAP-GBV). The BGA is also managing helplines and shelters for survivors of GBV.
Ministry of Health and Wellness: quality, confidential, age-appropriate and compassionate	Regional Health Authorities' Child Guidance Clinics (CGC): provides counselling support to children.

[6] https://www.globgov.com/JM/New-Kingston/888408944588461/Bureau-of-Gender-Affairs-Jamaica

Table 1.2 3: The Multi-sectoral response to GBV	
MINISTRY	**BODIES, DEPARTMENTS and AGENCIES**
health-care services. This includes acute/emergency care to victims of violence and mental health services as indicated.	
Ministry of National Security	Centre for Investigation of Sexual Offences and Child Abuse (CISOCA): The agency investigates allegations of sexual offences and child abuse. The agency ensures that victims receive the necessary health treatment and rehabilitation interventions. The Community Safety and Security branch of the Jamaica Constabulary Force is in charge of Domestic Violence prevention and response for the police. It operates Domestic Violence Intervention Centres (DVI Care). The DVI Care Centres do initial and risk assessments; provide first line support; do proper investigation; care for the safety of the survivors, including preventative detention of perpetrators, when it is the case; refer survivors to other services they need and want access to, including counselling inside or outside the centres.
Commission of Parliament	Office of the Children's Advocate (OCA): under Section 12 of the Child Care and Protection Act, enacted in 2004, the OCA is mandated to enforce and protect the rights and best interests of children. The organization also receives and investigates complaints as well as providing legal representation and referrals where required for child victims.
Ministry of Justice	Victim Services Division (VSD): VSD of the Ministry of Justice provides survivors of GBV with support, including counselling, victim rights advocacy, court support and preparation, and various programmes of therapeutic intervention amongst other technical services.[7] Parish Justice Centres are designed to improve access to justice and therefore has been mandated to handle, provide legal information and referrals as well as child

[7] Legislation and Support Framework: Jamaica. https://idbinvest.org/sites/default/files/2020-12/Jamaica%20Table%20Final.pdf

Table 1.2 3: The Multi-sectoral response to GBV	
MINISTRY	**BODIES, DEPARTMENTS and AGENCIES**
	diversion, dispute resolution, restorative justice matters.
Ministry of Education and Youth: Multi-sectoral coordination of the National Plan of Action for an Integrated Response to Children and Violence, which outlines the national commitment, made to the Global Partnership to end violence against children. This will be implemented by the relevant ministries, departments and agencies (MDAs) of Government as well as civil bodies including NGOs, FBOs, CBOs, the private sector and International Development Partners (IDP).	Child Protection and Family Services Agency: leads Jamaica's child protection system. It is governed primarily by the Child Care and Protection Act which empowers the agency to act in the best interest of the child as it carries out its function of investigating cases of child abuse; caring for the children in State care and engaging in advocacy to prevent child abuse. National Children's Registry: Under the Child Protection and Family Services Agency (CPFSA), the NCR has the mandate to encourage, receive, record, assess and refer for timely investigation and curative action, reports of known or suspected instances of child abuse and other threats to children i.e., children who are missing, have been, are being or are likely to be abandoned, neglected, physically or sexually ill-treated, or are otherwise in need of care and protection.[8]

[8] https://childprotection.gov.jm/ncr/

1.3 GBV Guiding Principles and Approaches

The guiding principles and approaches are linked to human rights and they serve as the foundation for planning and implementing GBV-related programming (See Table 1.3.1). It is important to underscore that:

- GBV encompasses a wide range of human rights violations. Preventing and mitigating GBV involves promoting gender equality and beliefs and norms that are respectful and non-violent.
- Safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations at all times.
- GBV-related interventions should be context-specific in order to enhance outcomes and "do no harm".
- Participation and partnership are cornerstones of effective GBV response and prevention.

Women-centred care

Women-centred care is guided by two fundamental principles: respect for women's human rights and promotion of gender equality. What does this mean in practical terms?

1. A rights-based approach. Women's human rights are set forth in international human rights agreements. These rights include the right to:
    - Life - a life free from fear and violence;
    - Self-determination - being entitled to make their own decisions including sexual and reproductive decisions; entitled to refuse medical procedures and/or take legal action;
    - The highest attainable standard of health - health services of good quality, available, accessible and acceptable to women;
    - Non-discrimination - health care services offered without discrimination, and treatment is not refused based on race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation, or political beliefs;

- Privacy and confidentiality - provision of care, treatment and counselling that is private and confidential; and inform the survivor about any limitations to confidentiality; and
- Information – the right to know what information has been collected about their health and have access to this information, including their medical records.

2. Gender sensitivity and equality. Gender sensitivity means being aware of how differences in power between women and men determine the way that men and women treat each other, their access to resources to protect their health and often how the health system treats them. Assuring gender equality in health means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy. It is important to understand that: violence against women is rooted in unequal power between women and men; that women may have less access than men to resources, such as money or information, and they may not have the freedom to make decisions for themselves; women may be blamed and stigmatized for violence and may feel shame and low self-esteem.[9]

Survivor-centred approach

- Providers should apply in their interventions the Survivor-centred approach: A survivor-centred approach creates a supportive environment in which survivors' rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. A survivor-centred approach is based on the following guiding principles:
    - Safety - The safety and security of survivors and their children or family members are the primary considerations.
    - Confidentiality - Survivors have the right to choose to whom they will or will not tell their story, and any information about them should only be shared with their informed consent.
    - Respect - All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor. The role of helpers is to facilitate recovery and provide resources to aid the survivor.

[9] World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization; 2014. https://www.who.int/reproductivehealth/publications/violence/ vaw-clinical-handbook/en/.

- Non-discrimination - Survivors should receive equal and fair treatment regardless of their age, disability, gender identity, religion, nationality, ethnicity, sexual orientation or any other characteristic.
- Honesty - Survivors should receive honest and complete information about possible referrals for service, be made aware of any risks or implications of sharing information about the situation, and have the right to limit the types of information shared and whom it is shared with.[10]

Community-based approach

A community-based approach ensures that affected populations are engaged actively as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct involvement of women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions, and build on existing community-based protection mechanisms.

Humanitarian principles

The humanitarian principles of humanity, impartiality, independence and neutrality should underpin the implementation of the Minimum Standards, and are essential to maintaining access to affected populations and ensuring an effective humanitarian response.

"Do no harm" principle

A "do no harm" principle involves taking all measures necessary to avoid exposing people to further harm. This means ensuring that a survivor agrees to participate on the basis of their having full information, including risks and benefits; them being competent to decide; respecting and responding to their wishes and no coercion, threats or promises of benefits being used to secure that consent.

Best interests of the child

Guided by the Child Care and Protection Act, children (that is, any person under the age of eighteen years) have the right to have their best interests assessed and determined, and taken

[10] United States Agency for International Development (USAID). GUIDING PRINCIPLES For Working with Gender-Based Violence Survivors. https://pdf.usaid.gov/pdf_docs/PA00TMNM.pdf

as a primary consideration in all decisions that affect them. The Act states that the following factors must be taken into account in order to make a determination:

a. the safety of the child;
b. the child's physical and emotional needs and level of development;
c. the importance of continuity in the child's care;
d. the quality of the relationship the child has with a parent or other person and the effect of maintaining that relationship;
e. the child's religious and spiritual views;
f. the child's level of education and educational requirements;
g. whether the child is of sufficient age and maturity so as to be capable of forming his or her own views and, if so, those views are to be given due weight in accordance with the age and maturity of the child;[11] This is also referred to as the 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.

Informed Consent

The survivor should fully understand what s/he is consenting to. Before agreeing, s/he should be first informed about all the available options for support. The full range of choices should be presented to the survivor, regardless of the individual beliefs of the health care worker or others dealing with survivors. In addition, information should be disclosed only with the consent of the survivor.[12] In the case of children, informed consent is normally requested from a parent or legal guardian and the children.

Elements of informed consent include:

- Tell a survivor what is going to happen to him/her.
- Explain to him/her the benefits and risks of an intervention (medical treatment, interview, etc.)
- Explain that s/he has the right to decline or refuse any part of an intervention.
- Explain that pressure will not be exerted in any form.

[11] Government of Jamaica. 2004. The Child Care and Protection Act

[12] gbvguidelines.org was first indexed by Google in September 2015. https://gbvguidelines.org/wp/wp-content/uploads/2016/12/mod4_Confidentiality-the-Right-to-Choose-and-Consent.doc

- Explain that if the survivor does not want to be interviewed about the events (to a healthcare worker or humanitarian worker), this will NOT affect access to health and other services and does not preclude participation in future proceedings related to legal justice.
- Inform the survivor about any mandatory reporting in the setting.
- Inform the survivor that information about him/her will be discussed in the team.
- Ensure that the survivor understands what you have told him/her.

Table 1.3 1: Sixteen (16) Minimum Standards for an Effective GBV Response

Access to quality, confidential, age-appropriate and compassionate health-care services is a critical component of a multi-sectoral response to GBV. Health-care programmes that are safe, sensitive, confidential, accessible (e.g., free or low cost, easy to reach, non-judgmental) can facilitate immediate and life-saving care for survivors and initiate a process of recovery that results in physical and mental health benefits for individual survivors, and wide-ranging benefits for families, communities and societies.

Accordingly, in the design and implementation of an effective GBV response, 16 critical components have been identified. These are outlined below:

GBV GUIDING PRINCIPLES
All aspects of GBV programming are survivor-centred to preserve and promote the confidentiality, safety, non-discrimination and respect for the choices, rights and dignity of women and girls, including GBV survivors.

WOMEN'S AND GIRLS' PARTICIPATION AND EMPOWERMENT
Women and girls are engaged as active partners and leaders in influencing the humanitarian sector to prevent GBV and support survivors' access to quality services.

STAFF CARE AND SUPPORT
GBV staff are recruited and trained to meet core competencies, and their safety and well-being are promoted.

HEALTHCARE FOR GBV SURVIVORS
GBV survivors access quality, survivor-centred healthcare, including health services for sexual and intimate partner violence and other forms of GBV, and referrals to prevent and/or reduce the effects of violence.

PSYCHOSOCIAL SUPPORT
GBV survivors safely access quality, survivor-centred psychosocial support focused on healing, empowerment and recovery.

GBV CASE MANAGEMENT
GBV survivors access appropriate, quality case management services including coordinated care and support to navigate available services.

REFERRAL SYSTEMS
Referral systems are in place to connect GBV survivors to appropriate, quality, multi-sectoral services in a timely, safe and confidential manner.

WOMEN'S AND GIRLS' SAFE SPACES
Women and girls only safe spaces are available, accessible and provide quality services, information and activities that promote healing, well-being and empowerment.

SAFETY AND RISK MITIGATION
GBV actors advocate for and support the integration of GBV risk mitigation and survivor support across humanitarian sectors.

JUSTICE AND LEGAL AID
Legal and justice actors support GBV survivors to access safe and survivor-centred legal services that protect their rights and promote their access to justice.

DIGNITY KITS, CASH AND VOUCHER ASSISTANCE
GBV survivors receive dignity kits, and/or cash and vouchers to reduce GBV risk and promote safety and dignity.

ECONOMIC EMPOWERMENT AND LIVELIHOODS
GBV survivors access economic support as part of a multi-sectoral GBV response.

TRANSFORMING SYSTEMS AND SOCIAL NORMS
GBV programming addresses harmful social norms and systemic gender inequality in a manner that is accountable to survivors.

COLLECTION AND USE OF SURVIVOR DATA
Survivor data are managed with survivors' full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

GBV COORDINATION
Coordination results in timely, concrete action to mitigate risks, and prevent and respond to GBV.

ASSESSMENT, MONITORING AND EVALUATION
Information collected ethically and safely is used to improve the quality of GBV programmes and accountability to survivors.

* Adapted from the Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

1.4 Epidemiology

Based on local statistics, women and girls are most at risk and affected by intimate partner and sexual violence, albeit that boys and men are also affected. For sexual minorities such as men who have sex with men (MSM) and transgender persons, they also experience higher risk due to social and cultural norms in the region and legislative barriers that criminalize anal sex and reinforce harmful gender norms. Other risk groups include persons with disabilities, the homeless and the elderly.

- *Women and Girls:* According to the Jamaica Women's Health Survey 2016, one in every four Jamaican women (25.2%) has experienced physical violence by a male partner, and 7.7% have been sexually abused by a male partner. Lifetime prevalence of intimate partner physical and/or sexual violence against Jamaican women is 27.8%; current prevalence was 7.0%. Almost three in ten (28.8%) women have suffered emotional abuse, and 8.5% of Jamaican women report having experienced economic abuse. The most prevalent act of intimate partner sexual violence is being physically forced to have sex (6.7%); 4.2% had sex with their partner because of fear, and 1.4% were forced to engage in sexual activities they found degrading or humiliating. Adolescent girls and women 25 to 29 years old had the highest rates of current physical and/or sexual violence, with rates of 11.1% and 14.4% respectively.

  The Survey also found that intergenerational violence is a significant predictor of women's experience with intimate partner violence in adulthood. Prevalence rates for intimate partner violence were also high among women who were beaten as children. Almost half, 47.7%, of women who experienced intimate partner sexual violence had been beaten as children, as were 38.1% of women who were physically abused by their partners. Comparatively, only 18.5% of women who had never been abused were hit during childhood. Being humiliated or insulted as a child was also correlated to lifetime experience with intimate partner violence. [13]

[13] UN Women. Women's Health Survey 2016, Jamaica

Data from the Jamaica Injury Surveillance System (JISS), which is hospital-based, shows that 40,690 victims of intimate partner violence were seen at the hospitals for the period 2016-2020. In the incidents that involved boyfriend/girlfriend, husband/wife, relative or friend 7,336 males were injured compared to 13,840 females. Ninety-five percent (95%) of sexual assaults are perpetrated against women and girls and 60% occurred in the 10-19 age group.

- *Rural women and girls:* UNICEF 2012 Situation Assessment and Analysis on Children's and Women's Rights in Jamaica, noted that incest in rural areas is more prevalent than reported; girls from deep rural primary and secondary schools gave multiple reports of incest, by stepfathers and other male relatives.[14]

- *Men and Boys:* The JISS assessment of the hospital data, showed males exceeding females as victims of violence and that males are almost twice as likely to become victims of Violence Related Injuries (VRIs). When analysed by age groups, males account for more victims than females in all but the 1 to 9 and the 10 to 19 years old age groups, where they are both equal for the period. The ratio of males being victims steadily increases from 1.5 times (20 to 29 age group) to 3.6 (60 & over age group). Although the number of cases begin to decrease in age groups starting at the 30 to 39 year olds group, the ratio increases incrementally, showing that males are the main victims of VRIs all the way to the 60 and over age group. Males represented 5% (126) of the sexual assault cases reported at JISS sites during the period 2016-2020. Male children and adolescents (0-19 years) comprised 87% of sexual assaults on males.

- *Sexual Minorities, Sex Workers and Persons Living with HIV:* The 876 survey found that as much as 43.1% of Transgender Women (TGW) reported being refused police service due to their transgender status. A further 83.3% of TGW reported verbal insults, 46.1% reported physical violence, and 17.6% reported rape in the 12 months preceding the survey. For Sex Workers, violence from survivors is common, many of whom heavily resist condom use and secure condom-less sex through violent and coercive means. Violence is also commonly reported against female sex workers in the forms of

[14] Ricketts, Heather, Jones, Jennifer and Henry-Lee, Aldrie, 2012. UNICEF Jamaica, March 2012, Draft. Situation Assessment and Analysis on Children's and Women's Rights in Jamaica

kidnapping, abuse, beatings, stabbings, being robbed, gang-raped, and deserted in remote areas (Eldemire-Shearer & Bailey, 2008; Logie, Wang et al., 2017).

According to the Jamaica Stigma Index Report, many of the survey's participants (Persons living with HIV) reported experiencing human rights violations, including rape (13%), public disclosure of HIV status (5%), and forced HIV testing. It was noted that large proportions of each key population—MSM, Women who have Sex with Women (WSW), bisexual people, people who have sold sex, and people who have used drugs—reported experiencing some form of stigma or discrimination due to their membership within that key population. The most common forms of stigma and discrimination faced by respondents who identified as a key population member included verbal harassment and discriminatory remarks. When asked if they had experienced some form of stigma or discrimination related to their HIV status (not including in the health system) within the past 12 months, 183 participants (33%) answered affirmatively; 268 (48%) reported ever having experienced stigma or discrimination related to their status. The most common forms of stigma and discrimination were gossip and discriminatory remarks, followed by verbal harassment. Twenty-seven (27%) per cent of Transgender (TG) and non-binary persons, 24% of MSM, 25% of WSW, 14% of sex workers, and 9% of bisexual persons reported being physically harassed and hurt over the last 12 months due to their sexual practices and/or gender identities.[15]

- *Persons with Disabilities:* The national Gender Sector Plan purports that among persons with disabilities, violence-related mental health issues are poorly identified because women are reluctant to disclose spousal abuse. The plan also states that women with disabilities are also vulnerable to GBV. This is due to the inadequacies of reproductive health care and education, ignorance of contraception, and dependency on caregivers which results in under-reporting of abuse and exacerbates their vulnerability to physical and sexual abuse. The Jamaica Council for Persons with Disabilities included reports that women with disabilities were sexually preyed upon because of their disabilities. Most at-risk were women who are visually impaired and women with intellectual

[15] Jamaican Network of Seropositives and Health Policy Plus. 2020. The People Living with HIV Stigma Index: Jamaica. Washington, DC: Palladium, Health Policy Plus.

disabilities. The Council received 28 reports of rape for 2013, 26 females (primarily deaf and intellectual disabilities) and two males (deaf). Sexual exploitation of women was also reported, particularly of women with intellectual disabilities in 2013.

- *Elderly:* Senior citizens are also targets for sexual violence. The Ministry of Health and Wellness data shows that elderly persons are also victims of assault. Data from the JISS for the period 2016-2020, indicted that 31 persons over the age of 60 years were sexually assaulted; 30 of the 31 were females. This represents 1% of all reported sexual assaults and sexual assaults among females.

- *Children and Adolescents:* In 2016, data from the police revealed that 8% of the victims of selected major crimes were children. Approximately 60% of these young victims were girls. In 2016, girls accounted for 97.3 per cent of the 1,094 child abuse reports received by the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA 2016). Most cases were reports of sexual intercourse with a person under 16 years, below the age of consent (469); 277 were cases of rape; 63 were grievous sexual assault; sexual touching (35); cruelty to child (21);) and buggery (20), which was often the sexual abuse of a boy by an adult male (ESSJ 2016).[16] Data from the National Strategic Plan for Sexual Health and HIV also showed increased transactional sex among younger females, with girls 13 years and younger accounting for the highest prevalence of transactional sex at 14%, decreasing by almost half at 14 years of age to 7%, and declining even further to 3% for females 15-19 years of age.

  As it relates to general child abuse however, over the period 2016-2020, data from the JISS showed an almost equal distribution of the 484 cases between the sexes; 51% (246) were females and 49% (238) were males.

  In a survey done among primary school students in Jamaica on school-related gender-based violence (SRGBV), 61.7% of the Jamaican primary school students participants surveyed reported having experienced touching, teasing, and making jokes about sex

[16] Caribbean Policy Research Institute (CAPRI). UNICEF. Situation Analysis of Jamaican Children - 2018. pg 20

along with bullying. The study recorded some 162 incidences of gender-related bullying, representing 33% of the responses received.[17]

[17] Brookings Institution. Gender based violence in primary schools - Jamaica. https://www.brookings.edu/wp-content/uploads/2021/01/Gender-based-violence-in-primary-schools_Jamaica-FINAL.pdf. pg. 7.

SECTION 2: IDENTIFICATION OF SURVIVORS OF GBV

Summary: Identification of Survivors of GBV

Survivors of GBV often seek health care for related emotional, sexual, reproductive or physical health conditions, including injuries and symptoms of stress. Their health problems may be caused by the violence itself or made worse by it. Often, an individual will not tell you about the violence due to shame or fear of being judged, or fear of their partner.

Although GBV is not uncommon, universal screening/routine enquiry (asking patients at each encounter/visit) for GBV is **not** recommended.

Suspect violence in case of:

- Unexplained bruises, lacerations, abrasions or scars
- 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
- Unusual attendance at medical services/repeated health consultations with no clear diagnosis
- An inexplicably poor response to prescribed medication or other treatment
- New symptoms are reported as soon as previous ones have resolved
- Repeated sexually transmitted infections
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)

***In children and adolescents, behavioural cues for abuse may also be present**

- Social withdrawal,
- Bed wetting,
- Fear and anxiety,
- Regressive behaviour compared to what would be expected for age,
- Sexual behaviour that is indiscriminate, precocious or coercive
- Reports of displays of sexualised behaviours.

- Suspect sexual abuse in case of persistent and/or recurrent anal/genital symptoms that are without a medical explanation.

What to do if you suspect GBV

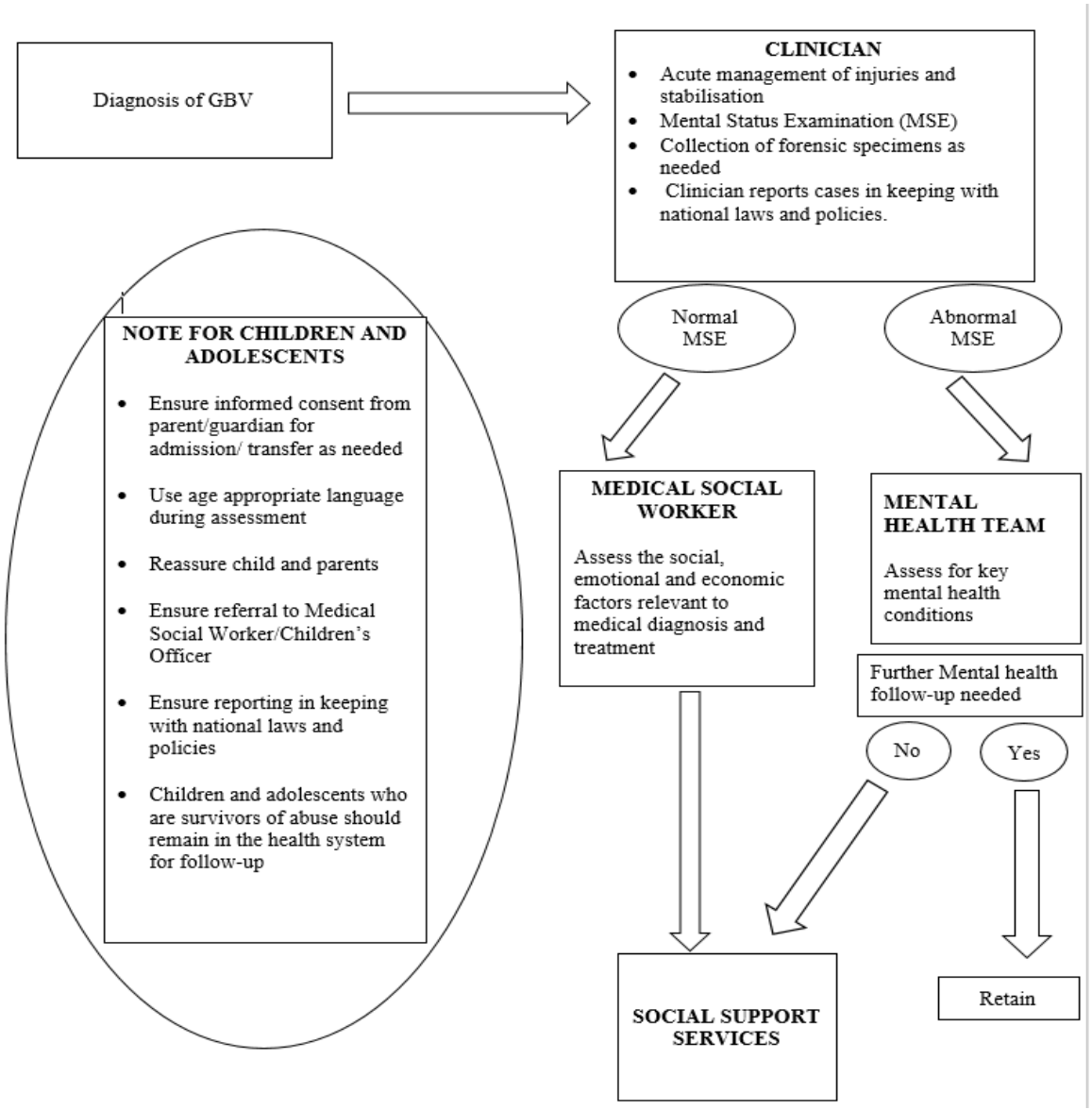
Before speaking to an individual about GBV, consider the following:	**Minimum requirements for asking about partner violence**
● Never raise the issue of GBV unless the person is alone. Even if the person is with a woman, that woman could be in support of the abuser. ● If you do ask about violence, do it in an empathic, non-judgmental manner. ● Use language that is appropriate and relevant to the culture and community you are working in. Some people may not like the words "violence" and "abuse". It is important to use the words that the person uses.	● A protocol/standard operating procedure ● Training on how to ask, providing first line support or beyond ● Private setting ● Confidentiality ensured ● System for referral in place

What if you suspect violence but the person does not disclose it?

- Do not pressure the person; give the person time to decide what they want to tell you. Let the person know that if it ever happens to them, or someone else, they are welcome to come back and talk about it.
- Believe them (it may not be a case of violence) and tell the person about services that are available if their situation changes and they or someone they know should choose to use them. Use the referral protocol at your facility to refer the person to other services, according to their wishes.
- Offer information on the effects of violence on their health, and their family's health especially children
- Offer the person a follow-up visit.

Summary of the pathway for the management of the survivor of GBV

(All referrals should be made with the survivor's consent)



- Medical follow-up at the health centre or hospital is a necessary step, especially as it relates to the survivor 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).
- The **first follow-up visit should be at the initial managing facility**; thereafter a referral should be made to the appropriate primary care facility.

Providing First-Line Support to Survivors of GBV

First-line support ("LIVES") is the most helpful care you can give.

The provision of first-line support involves:

1. providing support for immediate physical health needs
2. providing support for immediate emotional/psychological needs
3. ongoing safety needs
4. ongoing support and mental health needs

Tips for providing first-line support
• Choose a private place to talk with the survivor, where no one can see or overhear you (but not a place that indicates to others why you are there, for example, the use of signage such as "GBV room" is highly discouraged). • Assure the survivor that you will not repeat what she/he says to anyone else, and you will not mention that they were there to anyone who does not need to know. If you are required to report the situation, explain in advance what you must report and to whom. • Encourage the survivor to continue talking, but do not force them to talk. You could ask, for example, "Do you want to say more about that?" • Allow silences. If the survivor cries, give them time to recover. • Remember: Always respect the survivor's wishes.

LIVES	
Listening	Listen closely, with empathy, and without judging. Practice active listening using open questions.
Inquiring about needs and concerns	Assess and respond to the survivor's various needs and concerns – emotional, physical, social and practical (e.g. childcare)
Validating	Show the survivor that you understand and believe them. Assure them that they are not to be blamed
Enhancing safety	Discuss a plan to protect the survivor from further harm if violence occurs again
Supporting	Support the survivor by helping them to access information, services and social support

Follow-up Support

- With the consent of the survivor, the clinician should refer the survivor to the Medical Social Worker for assessment and counselling as required; if the decision is for the survivor in a medico-legal case to be seen by the psychosocial services outside of the health sector, this should be done in collaboration with the police officer.
- If the survivor is unwilling or unable to engage with other services at this time, the clinician should document this in the health record, 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 survivor is discharged from acute care.
- Explain to the survivor 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 domestic violence intervention centres
- Social services departments
- Helplines for survivors of GBV
- Shelters for survivors of GBV
- Crisis centres and/or shelters
- Counselling and emergency hotlines
- Social Workers, Psychologists, Counsellors
- Non-governmental organizations, including church groups
- Other key agencies in your area

Where necessary, the health care provider should provide support by making warm referrals to service providers; for example, in high risk cases, if the survivor needs and requests support, contact could be made with the police and with the helpline/shelter unit.

2.0 Identification of Survivors of GBV

Survivors of GBV often seek health care for related emotional, sexual, reproductive or physical health conditions, including injuries and symptoms of stress. Their health problems may be caused by the violence itself or made worse by it. They may be facing ongoing abuse at home, or they may still be affected by abuse that occurred in the past. Often, an individual will not tell you about the violence due to shame or fear of being judged, or fear of their partner.

A survivor who has experienced physical violence may have physical injuries or other health conditions that require medical treatment. They may present to you seeking services for a particular condition, whether or not they disclose that it is related to violence. If someone is being physically abused, they will likely have bruises or physical injuries consistent with being punched, choked, or knocked down and they'll likely have a weak or inconsistent explanation for these injuries. It is also common for someone to try to cover up the physical signs with clothing, makeup or glasses.

Any survivor may present with emotional health issues either as a direct result of emotional violence or as an indirect result of other types of violence; survivors may present with emotional health issues such as anxiety, depression, substance abuse, etc. Survivors of sexual violence may present with reproductive health complaints such as sexually transmitted diseases, unwanted pregnancies, and abdominal/genitourinary conditions.

It is important to provide the highest level of healthcare to all survivors, in accordance with relevant protocols, while also providing first-line support, ensuring adherence to the guiding principles and making any referrals to additional services, as needed. Healthcare providers should not discriminate against survivors, judge or blame them for the violence they experience, nor deny them the care that they need.

Although GBV is not uncommon, universal screening/routine enquiry (asking patients at each encounter/visit) for GBV is not recommended; evidence suggests that universal screening does not necessarily lead to a reduction in GBV nor an improvement in quality of life or health

outcomes. Clinical inquiry is recommended, that is, health care workers should be aware of possible signs of violence and raise the topic, if they suspect injuries or conditions may be related to violence.

Suspect violence in case of:

- Bruises, lacerations, abrasions or scars
    - including those possible caused by an acid attack
- Multiple bruises or injuries to the skin
- Bruises in the shape of an implement used e.g., hand, stick, etc.
- 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 anywhere that would not be expected to come into contact with a hot object in an accident (e.g., the buttocks, trunk, upper arms)
- Burns in the shape of an implement (e.g., cigarette, iron) or
- Scalds that indicate forced immersion, for example:
    - To buttocks, perineum, and lower limbs
    - To limbs in a glove or stocking distribution
    - To limbs with symmetrical distribution
    - With sharply delineated borders
- Fractures
    - fractures in the absence of confirmed major accidental trauma or known medical cause
- If X-rays have been undertaken:
    - Occult fractures (fractures identified on X-rays that were not clinically evident) e.g., rib fractures
    - 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
- Other possible clinical presentations
- Poisoning with prescribed and non-prescribed drugs or household substance
- Non-fatal submersion injury
- Near drowning
- Fabricated or induced illness (FII)
- Unusual attendance at medical services/repeated health consultations with no clear diagnosis
- 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
- Intrusive partner during the consultation
- Emotional or behavioural signs in the children*
- Missed health care appointments including appointments for children
- 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
- Repeated sexually transmitted infections
- Unwanted pregnancies
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches)

*In children and adolescents, behavioural cues for abuse may also be present:

- Social withdrawal,
- Bed wetting,
- Fear and anxiety,
- Repeated or coercive sexualized behaviours or preoccupation,
- Regressive behaviour compared to what would be expected for age,
- Sexual behaviour that is indiscriminate, precocious, or coercive,
- Reports of displays of sexualised behaviours.

Suspect sexual abuse in case of persistent and/or recurrent anal/genital symptoms that are without a medical explanation.

What to do if you suspect GBV

If you are treating someone at your healthcare facility and suspect that they may have experienced GBV (or that it may be ongoing), there are safe and supportive ways that you can start a conversation with the person.

Before speaking to an individual about GBV, consider the following:	**Minimum requirements for asking about partner violence:**
● Never raise the issue of GBV unless the person is alone. Even if the person is with a woman, that woman could be in support of the abuser. ● If you do ask about violence, do it in an empathic, non-judgemental manner. ● Use language that is appropriate and relevant to the culture and community you are working in. Some people may not like the words “violence” and “abuse”. It is important to use the words that the person uses.	● A protocol/standard operating procedure ● Training on how to ask, providing first line support or beyond ● Private setting ● Confidentiality ensured ● System for referral in place

How to ask about Intimate Partner or Sexual Violence

Here are some statements you can make to raise the subject of intimate partner violence/sexual violence indirectly before you ask direct questions:

- I have seen persons with problems like yours who have been experiencing trouble at home.
- Is anything at home troubling you?
- Many people experience problems with their spouse or partner, or someone else they live with. Do you feel safe at home?

Direct questions

- Are you afraid of your partner or someone else at home?
- Has your partner or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when?
- Does your partner or someone at home bully you or insult you?
- Does your partner try to control you, for example by not letting you have money or go out of the home?
- Has your partner or someone else forced you into sex or forced you to have any sexual contact you did not want?
- Has your partner threatened to kill you?

Depending on the answers, continue to ask questions, and listen to the person's story. If the person answers “yes” to any of these questions they are a survivor of intimate partner violence/sexual violence, and you should offer empathic first-line support as you continue to assess their needs.

What if you suspect violence but the person does not disclose it?

- Do not pressure the person; give the person time to decide what they want to tell you. Let the person know that if it ever happens to them, or someone else, they are welcome to come back and talk about it.
- Believe them (it may not be a case of violence) and tell the person about services that are available if their situation changes and they or someone they know should choose to use them. Use the referral protocol at your facility to refer the person to other services, according to their wishes.

- Offer information on the effects of violence on their health, and their family's health especially children
- Offer the person a follow-up visit

When inquiring about child abuse the following should be noted:

Children and adolescents should always be offered the opportunity to be seen on their own, without caregivers. Clarify the confidential nature of the discussion with the child or adolescent and indicate in what circumstances parents or other adults will be given information.

It is important to listen carefully, observe nonverbal cues and establish a rapport with the child or adolescent. Establishing a rapport means developing mutual trust with the child or adolescent and creating some affinity. The child or adolescent should trust you and not be scared to talk to you.

Seek an explanation for any signs or symptoms you have noted that could be the result of child abuse. Gather further information about the sign or symptom in an open-ended manner; do not ask suggestive questions.

It can be more challenging for symptoms of abuse that are not physical, such as behavioural cues like aggression, tearfulness, or withdrawal. Here you might ask a few questions about the situation at home and how people get along with each other, or if the child or adolescent is concerned about anything. Remember that you can encourage younger children to draw or use pictures to show their answers.

Suitable explanations are those that indicate a certain physical sign is due to an injury that was clearly described, and where the symptom matches the time and type of injury. There could be other explanations for a child's or adolescent's behaviour, for example the loss of a family member, living through parental separation, moving houses or changing schools, which (among others) can all be events causing stress.

Record exactly what is observed, who said what, and when and why this is of concern. All the information gathered can be used to exclude the possibility of abuse; actively suspect the possibility of abuse; or to continue investigating through further clinical inquiries with the child or adolescent.

When the clinician suspects 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).

For cases of abuse among children and adolescents under the age of eighteen (18) years, a mandatory report must be made to the National Children's Registry (NCR) immediately. If the child is below the age of consent for a medical examination (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. This survivor must be interviewed or examined in the company of a parent or social worker or in the presence of a third party. (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). Children over the age of 16 years can consent to a medical examination.

2.1 Pathway for GBV Management in the Health Care Setting

The core multidisciplinary team for the care pathway for GBV should include healthcare professionals as dictated by medical management protocols and be sufficient to deliver quality GBV services. The health service team should provide services in a non-judgmental environment, free from stigma and discrimination and acknowledge the survivor's right to confidentiality. Let the survivor know that you will maintain confidentiality, except when you perceive a risk to them (e.g., imminent serious risk for their life, suicide, or self-harm) or to others, or if there are legal requirements. Health care workers should ensure timely reporting in keeping with national laws and policies (see Section 1: The Medico-legal Framework).

2.2 Informed Consent

Documenting consent for treatment, referrals and reporting to authorities is crucial and follows the standard protocols for obtaining informed consent. Informed consent is the process in which a healthcare provider educates the survivor about the risks, benefits, and alternatives of a given procedure or intervention. The survivor must be competent to make a voluntary decision about whether to undergo the procedure or intervention. It is the obligation of the provider to make it clear that the survivor is participating in the decision-making process, and the provider should avoid making the survivor feel forced to agree with them. The provider must make a recommendation and provide the survivor with the reasoning for said recommendation. The survivor must be provided with sufficient information to make an informed decision, using culturally- and age-appropriate language about all available options and their benefits and consequences.

- Use the institutionally approved Consent Form to obtain consent
- Document purpose for obtaining consent i.e., for treatment, referrals to other services (internal and external) and reporting to authorities
- Where standard forms are not available, please document consent fully within the health record

2.3 Functions of the Team Members

The duties of the team members are outlined below:

Health Records Officer

- Register the survivor for services prior to examination; and
- Complete intake procedures including injury surveillance questions to assist with classification and coding of injuries for health records (see Section 7: Injury Surveillance)

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;
- Provide the necessary first line support and make the appropriate referral (if operating at a facility without a physician); and
- Timely reporting in keeping with national laws and policies.

Clinician

- Take a medical history;
- Conduct the physical examination, make relevant diagnosis, treat the survivor, 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;

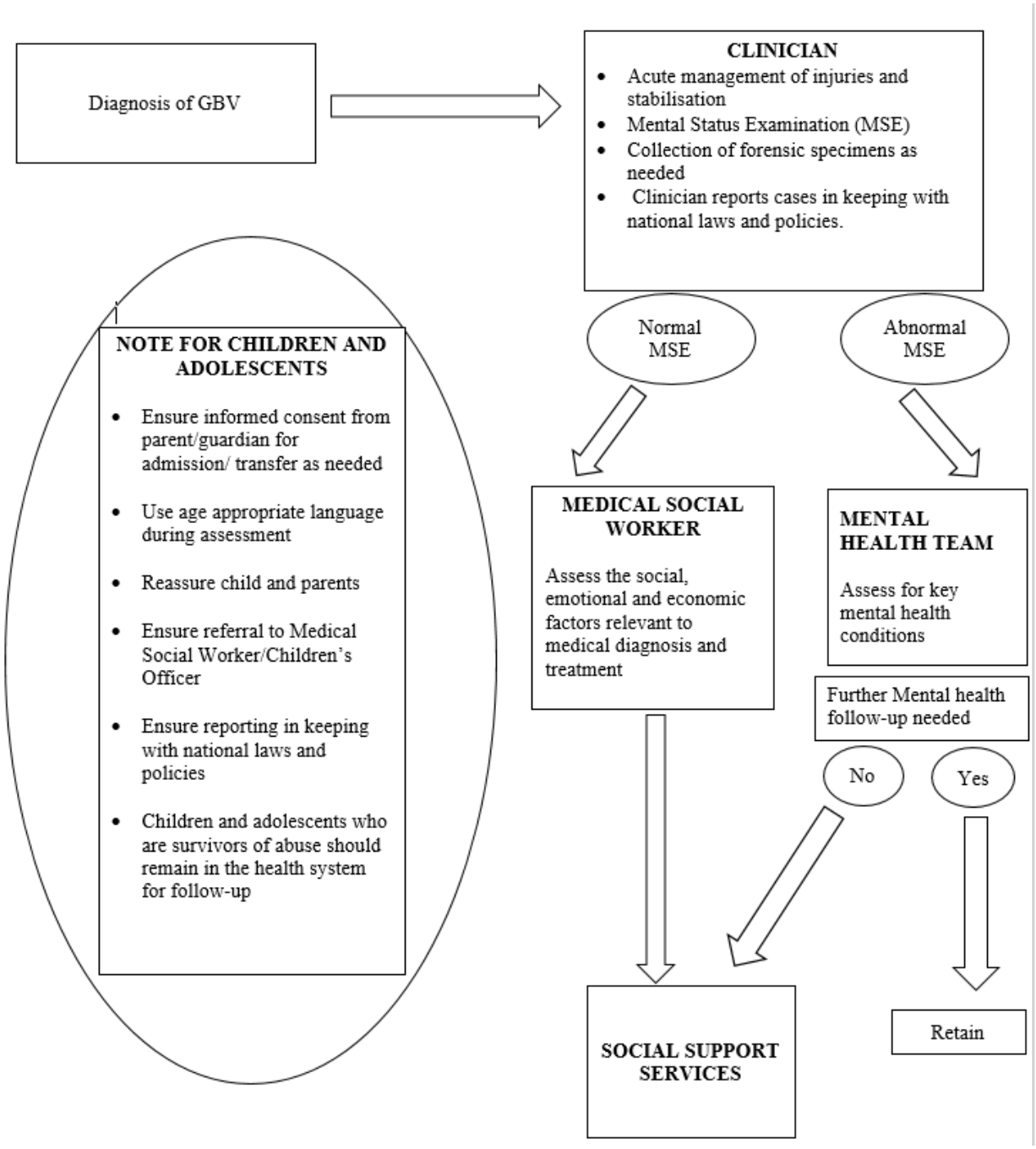
- Consult regularly with other members of the health team to find ways of helping survivors and families to cope with any personal and environmental stress that may affect recovery;
- Undertake follow-up visits to the homes of survivors and other relevant persons/places in order to assess the needs of survivors, and conduct family counselling;
- Help survivors and their families to identify community resources;
- Identify and communicate with the public, voluntary and private agencies;
- Apply available resources; refer to other social support services as appropriate.
- Timely reporting in keeping with national laws and policies

Mental Health Team

- Assess for key mental health conditions and refer for treatment for acute conditions;
- Provide counselling 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 survivors have accessed the relevant services;
- Establish effective partnerships/relationships with community support partners;
- Provide comprehensive psychiatric evaluation and treatment for acute cases;
- Timely reporting in keeping with national laws and policies

The summary of the care pathway for the survivor of GBV is outlined in Figure 2.3.

Figure 2.3: summary of the pathway for the management of the survivor of GBV (All referrals should be made with the survivor's consent)



2.4 Follow-Up Appointments

Medical follow-up at the health centre or hospital is a necessary step, especially as it relates to the survivor 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). 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 survivor or caregiver. Ensure that the survivor has a connection to a primary care provider.

- At every follow-up visit, review the health record and investigate new episodes of violence using survivor-centred communication skills, focused on empathy and active listening.
- Review laboratory investigations and repeat tests as necessary (see Section 3: Providing Physical Care to Survivors of GBV)
- Assess for mental health disorders, pregnancy, compliance with prophylaxis/treatment for HIV and other Sexually Transmitted Infections (STIs) and refer for care as necessary
- Communicate concerns and assess both safety and coping or survival techniques
- Repeat safety planning options to the survivor

Survivors that are identified as requiring additional mental health and psychosocial support should, with their consent, be referred to the mental health team for continued care. Children and adolescents will require multiple psychological visits for an extended duration.

2.5 Providing First-Line Support to Survivors of GBV

The provision of first-line support involves:

5. providing support for immediate physical health needs (see Section 3: Providing Physical Care for Survivors of GBV)
6. providing support for immediate emotional/psychological needs
7. ongoing safety needs
8. ongoing support and mental health needs

First-line support is an essential part of the care that you can provide to survivors of GBV. It involves responding to someone who discloses violence in a way that is supportive, helps to meet the survivor's needs, and prioritizes continued safety without intruding on her/his privacy. First-line support helps to meet the survivor's emotional and practical needs and may be offered whether the person chooses to have a physical examination or requires any additional physical or mental health treatment. First-line support is consistent with principles of psychological first aid, which helps people who have been through various adverse or distressing events. This type of support can be lifesaving, particularly in an emergency.

Listen to the survivor, inquire about the survivor's needs and concerns, and validate her/his feelings and experiences. This is the first step in providing supportive, survivor-centred care.

With first-line support, you do NOT need to:

- solve the survivor's problems;
- convince the survivor to leave a violent relationship;
- convince the survivor to go to any other services, such as the police or the courts; or
- ask detailed questions that force the survivor to re-live painful events.

If these decisions do not come from the survivors themselves, these actions could do more harm than good. It is important to empathically listen to them and their needs and provide them with the proper information to support them in making their informed decision on the way forward.

Common Questions about First-Line Support

Why should I not offer advice?

Persons who have experienced GBV need someone who will listen to them actively and without judgement. Listening well, responding with empathy, and giving the survivor space to make their own decisions are far more helpful than you may realize; that may be the most important things you can do. This approach shows the survivor that they matter and helps them to regain some control over her/his life and decisions. In addition, only the survivor can understand the full scope of their situation and make the most informed decisions about their life. Advice, though well intended, can put survivors at even greater risk of violence.

What can I do when I have so few resources and so little time?

First-line support ("LIVES") is the most helpful care you can give. It does not necessarily take a long time, and it does not require additional resources. You can also make referrals to additional services that may offer important support to persons who have experienced GBV.

What if the person decides not to report to the police?

Respect their decision. Let them know if there is someone that they can talk to further about their options, they can also help them report to the police if they change their mind.

What if I suspect violence but the person does not acknowledge it?

Do not try to force the survivor to disclose. Your suspicions could be wrong and the survivor understands best how disclosing violence might affect them. You can still provide care and offer further help such as informational brochures as to where to get help.

Table 2.5.1 provides general tips for what you can do to provide effective first-line support.

Table 2.5 1: Tips for providing first-line support
• Choose a private place to talk with the survivor, where no one can see or overhear you (but not a place that indicates to others why you are there, for example, the use of signage such as “GBV room” is highly discouraged). • Assure the survivor that you will not repeat what she/he says to anyone else, and you will not mention that he/she was there to anyone who does not need to know. If you are required to report the situation, explain in advance what you must report and to whom. • Encourage the survivor to talk without pushing and show that you are listening. • Encourage the survivor to continue talking, but do not force them to talk. You could ask, for example, “Do you want to say more about that?” • Allow silences. If the survivor cries, give them time to recover. • Remember: Always respect the survivor’s wishes.

2.6 First-Line Support: “LIVES”

First-line support involves five elements, as summarized below. The letters in the word “LIVES” can help you to remember them:

Table 2.6.1: LIVES	
Listening	Listen closely, with empathy, and without judging. Practice active listening using open questions.
Inquiring about needs and concerns	Assess and respond to the survivor’s various needs and concerns – emotional, physical, social, and practical (e.g., childcare)
Validating	Show the survivor that you understand and believe them. Assure them that they are not to be blamed.
Enhancing safety	Discuss a plan to protect the survivor from further harm if violence occurs again
Supporting	Support the survivor by helping them to access information, services, and social support

Listening

Listening is the most important part of good communication and the basis of first-line support. It gives the survivor a chance to say what they want to say in a safe and private place to a caring person who wants to help. This is important to emotional recovery and to meeting the practical needs and ensuring the safety of the survivor (see Table 2.6.2).

Table 2.6 2: Active listening dos and dont's	
Do	**Don't**
How you act:	
Be patient and calm. There are so many pressing needs and demands, but the few extra minutes you offer her could make all the difference.	Don't pressure the survivor to tell their story
Your attitude:	
Acknowledge how the survivor is feeling. Let the survivor know that you are hearing what they are telling you, e.g. "I hear how difficult this has been for you"; "It sounds like a very scary situation"	Don't judge what the survivor has or has not done or how she/he is feeling. Avoid phrases such as, "You shouldn't feel that way" or "You should feel lucky you survived" or "Why did you do that?"
What you say:	
Give the survivor the opportunity to say what kind of help they want, if any. To do this, you may ask questions such as, "How can we help you today?" or "What would you like me to do for you today?"	Don't assume that you know what is best for the survivor
Encourage the survivor to keep talking if they wish. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until the survivor has finished before asking questions.
Remember:	
Do:	**Don't:**
Listen and validate their feelings & concerns	Try to convince the survivor to do something you think is right
If you cannot hear or understand the survivor, tell them in a gentle way (this can avoid feelings of being ignored)	Ask questions that force them to re-live painful events
Use plenty of pauses to give the survivor space to talk. Remember that it may be her first time to speak about the abuse or to seek	Ask them to analyse what happened or why it happened

Table 2.6 2: Active listening dos and dont's	
Do	**Don't**
support.	
Acknowledge you are listening, saying "mhm…"	Pressure them to tell their feelings & reactions
When asking questions, remind the survivors that they are free to skip any question. This helps with building trust and ensuring that there is no breach in the ethics.	Be judgmental, not accepting the survivors' belief, choices, and lifestyle
Show your concern, interest, and empathy	• Jump to conclusions about the survivors' concerns • Having a conversation about a problem rather than with a survivor • Do not talk too much, concentrate on listening • Do not overload the survivor with too much information • Never make promises you cannot keep • Do not say they don't need to worry • Do not say things like "cheer up"

When interacting with children or adolescents, take note of the interaction between the caregiver and the child or adolescent. Also pay attention to the body language of the child or adolescent and the caregiver. Consider that the non-offending caregiver may also be part of the LIVES process. The caregiver may be shocked by the disclosure, may also be exposed to violence from the perpetrator, or may feel guilty because he/she was not able to protect the child or adolescent.

Inquiring about needs and concerns

Asking the survivor about their needs and concerns is a way to learn what is most important. It is important to respect their wishes and respond to their needs (see Table 2.6.3).

As you listen to children and adolescents, inquire about their physical, emotional, and social support needs and any safety concerns. They can be raised by the child or adolescent, and/or the non-offending caregiver. Inquiring will have to be adjusted based on the situation and the age/developmental stage of the child or adolescent. Pay attention to words or body language.

Table 2.6 3: Techniques for inquiring about needs and concerns	
Technique	**Examples**
Phrase your questions as invitations to speak	"What would you like to talk about?"
Ask open-ended questions to encourage the survivor to talk, instead of asking questions that can be answered with just "yes" or "no"	"How do you feel about that?"
Reflect the survivor's feelings back to them in your words so they know that you have listened/observed and understood	"It sounds as if you are feeling angry about that" "You seem upset"
Ask for clarification if you do not understand	"Can you explain that again, please?" "Could you tell me more about that?"
Help the survivor to identify and express their needs and concerns	"Is there anything that you need or are concerned about?" "It sounds like you may need a place to stay" "It sounds like you are worried about your children"
Summarize what the survivor has expressed	"You seem to be saying that..."
Things to avoid	
Do not ask leading questions, such as, "I would imagine that made you feel upset, didn't it?"	
Do not ask "why" questions, such as "Why did you do that?" They may sound accusing	

Validating

Validating lets the survivor know that their feelings are normal, that it is safe to express them, and that they have a right to live without violence and fear. It is important that they know they are not to blame and that you believe what she/he says without judgement or conditions. Important things that you can say:

- "It's not your fault. You are not to blame."
- "Help is available." (Say this only if it is true)
- "What happened has no justification or excuse."
- "No one deserves to be hit by their partner or anyone."
- "You are not alone. Unfortunately, many other people face this problem too."
- "You are valuable. Your life and your health are important."
- "I am worried that this may be affecting your health."

Provide information about normal stress reactions to an experience of violence as well as explore and strengthen positive coping methods (see Section 4: Providing Mental Health and Psychosocial Support to Survivors of GBV).

Enhancing Safety

Many persons who have been subjected to violence have fears about their safety and may continue to be in situations that are insecure. If someone has experienced GBV, they may face the risk of further violence from the perpetrator, or from other community members, including family. Male survivors may face significant shame and stigma that prevents them from accessing family or community support. Discrimination, persecution, and the criminalization of same-sex relationships pose significant challenges to the safety of sexual and gender minorities. In cases of GBV, safety risks are often ongoing and require careful attention. Vital forms of support include acknowledging safety concerns, helping a survivor to assess the immediate risks of violence, and planning for safety.

How to assess immediate risk:

Questions to assess immediate risk of violence

Survivors who answer "yes" to at least three (3) of the following questions may be at especially high immediate risk of violence.

1. Has the physical violence happened more often or gotten worse over the past 6 months?

2. Has the person ever used a weapon or threatened you with a weapon?
3. Has the person ever tried to strangle you?
4. Do you believe the person could kill you?
5. Has the person ever beaten you when you were pregnant?
6. Is the person violently and constantly jealous of you?

If the survivor is at high immediate risk, support them by making appropriate referrals, e.g. shelter, police etc.

The health care worker can contribute to the safety of the child or adolescent by:

- assessing whether the child or adolescent and also the non-offending caregiver are safe at home or in his/her immediate environment;
- developing a strategy (together with the child or adolescent and non-offending caregiver) to protect the child or adolescent from further harm.

You can explore jointly with the child or adolescent and the non-offending caregiver strategies to enhance safety. These should take account of the age of the child or adolescent, and the specific circumstances in which they live.

In some instances, it might be appropriate to consider short periods of hospitalization.

Discharge Planning:

Where it is safe to do so, the survivor of GBV 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.

How to enhance safety planning:

All survivors, those at immediate risk and others, will benefit from a safety plan. Safety planning means asking key questions and helping the survivor to think through their options. A safety plan does not need to be written down but rather it is a way to mentally prepare for an escalation of violence.

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

The following are elements of a safety plan and questions you can ask the survivor to help them make a plan **(see** Table 2.6.4).

Table 2.6 4: Safety Planning	
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children/others	Would you go alone or who would you take with you e.g., children?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

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***)

Supporting survivors and connecting them with other services

Survivors' needs, in particular children or adolescents, are generally beyond what can be provided in a general clinic or emergency room. Nevertheless, discussing the survivor's needs, informing the survivor about other sources of help, and assisting with getting the additional help wanted is part of a healthcare provider's essential support (see Table 2.6.5). Additional support can come from formal services (e.g., social worker, shelter, etc.) and informal sources (e.g., friends, family, community organisations, etc.).

When making referrals, use the established referral networks and pathways to refer survivors for additional support or services (Annex 1). Whenever possible, give the name of a specific person who can support and assist the survivor at each of the other places, in addition to directions and information on opening hours where applicable.

The child or adolescent and the caregiver should be referred to the Child and Adolescent Mental Health Services to access specialised resources for their health, safety, and social support. A warm referral is strongly recommended.

Table 2.6 5: How to help
o Ask the survivor what issues are most important to them right now. You can ask, “What would help the most if we could do it right away?” o Help them to identify and consider their options. o Discuss the survivor’s social support system. Do they have a family member, friend, or trusted person in the community to talk to? Is there anyone who could help with money?

2.7 Follow-up Support

- With the consent of the survivor, the clinician should refer the survivor to the Medical Social Worker for assessment and counselling as required; if the decision is for the survivor in a medico-legal case to be seen by the psychosocial services outside of the health sector, this should be done in collaboration with the police officer.
- If the survivor is unwilling or unable to engage with other services at this time, the clinician should document this in the health record, 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 survivor is discharged from acute care.
- Explain to the survivor 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 domestic violence intervention centres
- Social services departments
- Helplines for survivors of GBV
- Shelters for survivors of GBV
- Crisis centres and/or shelters
- Counselling and emergency hotlines
- Social Workers, Psychologists, Counsellors
- Non-governmental organizations, including church groups
- Other key agencies in your area

Where necessary, the health care provider should provide support by making warm referrals to service providers; for example, in high-risk cases, if the survivor needs and requests support, contact could be made with the police and with the helpline/shelter unit.

2.8 LIVES CC: LIVES for Children, Adolescents, and their Caregivers

Two additional components have been included to account for the specific needs of children and adolescents who experience abuse. The acronym "LIVES CC" (LIVES for **C**hildren, adolescents, and their **C**aregivers) can remind you of these key components in responding to children and adolescents where abuse has been identified.

1. **Child and Adolescent Friendly Environment**

There are various barriers that make it difficult for children and adolescents who have experienced abuse to access services. These include stigma, administrative barriers, lack of awareness about the existence of services, and lack of transport options. It is important to make efforts to overcome these barriers and to make it easier for children and adolescents to obtain the health services they need.

Health care providers can help to make services more child and adolescent-friendly, by:

- making their workspace appealing and "friendly" to children and adolescents;
- being non-judgemental and considerate in their dealings with children and adolescents;
- having the competencies needed to deliver the right health services in the right way to children and adolescents;
- making children and adolescents aware of where they can obtain the health services they need.

2. **Caregiver Support**

Non-offending caregivers can play an important role in helping the recovery of children and adolescents who have experienced child abuse. A child or adolescent's disclosure of abuse can have strong emotional effects on the non-offending caregiver and may have a big impact on the way the entire family functions. Therefore, it is important to support both the caregiver's ability to support the child or adolescent and to support the caregiver themselves.

- Talk to the non-offending caregiver separately from the child or adolescent, if appropriate.
- Ask the non-offending caregiver how they can be supported.
- Provide them with emotional support to help them cope with the situation.
- Non-offending caregivers may have been victimized in the past and may also show symptoms of extreme stress. If possible, provide them with the assistance they need through psychosocial support or mental health services.
- Ask them about perceived safety at home for the child or adolescent, and themselves.
- Provide them with information about the examination and care, long term consequences of child abuse, how to be more supportive of the child or adolescent, and the implications of disclosure on the wider family.
- Some children may display problems sleeping, increased anger, or regressive behaviours. Provide parenting guidance to deal with these behaviours.
- When sending the child or adolescent home, explain to them the follow up steps that will be required and what they should look for in terms of signs and symptoms and medication.

Remember:

Children or adolescents who have been abused must be referred to the Child and Adolescent Mental Health Services.

SECTION 3: PROVIDING PHYSICAL CARE FOR SURVIVORS OF GBV

Summary: Providing Physical Care for Survivors of GBV

- On arrival at the health facility, all survivors of GBV should be firstly assessed for life threatening injuries and conditions, and should be managed as per standard operating procedures.
- Antibiotics to prevent wound infection, tetanus toxoid for booster vaccinations and medications for relief of pain should be readily available. In the case of a minor (under 16 years of age), an adult surrogate should be present.

History taking

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.

Physical examination

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

Collection of forensic specimens

- It should be noted that biological specimens are usually not viable beyond 72 hours.
- All specimens must be identified by date and time, the name of the survivor, 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 survivor, the date, place of collection and the full name of the police officer, his/her badge number and division).

Investigations and Treatment of the Survivor of Sexual Violence

Investigations

- 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 Venereal Disease Research Laboratory (VDRL), HIV, Hepatitis A, B and C tests. Tests need to be done one week after the initial visit and then repeated in three months.
- Other tests may be required based on the condition of the survivor.

Treatment

- Communicate side effects clearly, but without inducing fear.
- Consider the impact of the traumatic event.
- For young children, adherence counselling needs to involve caregivers.
- They should return to the clinic if side-effects do not go away in a few days, if they are unable to take the drugs as prescribed, or have any other problems

Treatment Protocols

- Treatment of the female survivor where rape is suspected should be with emergency contraceptives; ensure that the correct age-appropriate dosages are given to child/adolescent survivors.
- 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.
- Individuals subjected to sexual violence should be offered immunization for Hepatitis B.

Prophylaxis against Pregnancy (to be given within 120 hours of the assault)

- Low dose ethinyl estradiol-norgestrel: 4 tablets orally, then 4 tablets in 12 hours or
- Ethinylestradiol-levonorgestrel (Ovral): 2 tablets orally then two tablets in 12 hours or
- Postinor: 1 tablet to start then one tablet 12 hours later OR 2 tablets of Postinor 2 as a single dose

These doses apply to girls who are post menarche or those in the beginning stages of puberty (Tanner 2).

Prophylaxis against STIs

For prophylaxis against gonorrhea:

- Ceftriaxone: 125 milligrams to 250 milligrams intramuscularly as a single dose or Ciprofloxacin: 500 milligrams orally as a single dose or
- Spectinomycin: 2 grams intramuscularly

For prophylaxis against chlamydia:

- Azithromycin: 1 gram orally do not give to pregnant women or
- Doxycycline: 100 milligrams orally twice daily for seven days or
- Erythromycin: 500 milligrams orally twice daily for seven days

For prophylaxis against trichomoniasis:

- Metronidazole: 2 grams orally as a single dose

For prophylaxis against bacterial vaginosis:

- Metronidazole: 500 milligrams twice daily for 7 days

For prophylaxis against HIV (<u>to be given within 72 hours of the assault</u>)

- Tenofovir: 300 milligrams orally daily for 28 days and Lamivudine: 150 milligrams AND Dolutegravir: 50 milligrams (or Efavirenz 600 milligrams) orally daily for 28 days
- For children and adolescents, where adult formulations/dosing are not appropriate, Abacavir/Lamivudine and Atazanavir/Ritonavir (or Lopinavir/Ritonavir) should be used.

3.0 Providing Physical Care for Survivors of GBV

On arrival at the health facility, all survivors of GBV should be firstly assessed for life threatening injuries and conditions, and should be managed as per standard operating procedures. Survivors with less severe injuries can usually be treated on site. In those cases, physical care often includes cleaning and treating any wounds as necessary. Antibiotics to prevent wound infection, tetanus toxoid for booster vaccinations and medications for relief of pain should be readily available.

The survivor of GBV may sustain injuries that are severe and life-threatening, warranting admission at a secondary care facility. Such a survivor should be assessed, stabilised, and prepared for transfer. The receiving facility should be notified of the arrival of the survivor and make preparations for the admission of the survivor. For specific guidance, see Policy and Procedure Manual for the Referral and Transfer of Patients (2016).

The assessment of survivors of sexual violence is discussed in section 3.4.

3.1 History Taking

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 survivor during the history taking and physical examination:

- Always interview the survivor 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 survivor that any information shared will be confidential. The limits of confidentiality should be explained.
- Reporting requirements mandated by law should be explained e.g., child abuse
- Be empathetic, supportive, and non-judgemental in your initial response. This can determine whether the survivors disclose further information that can be helpful to offer appropriate and survivor centred support.
- Affirm that the survivor has made an important step.
- Reassure the survivor that you (the clinician) believe them, that the abuse is not their fault and that they have a right to safety. It is important to not insist that a survivor answer questions or disclose information that may compromise their safety.
- Use language and terminology that is appropriate to age, culture, educational level, and non-stigmatizing. Trained interpreters (sign language, foreign language, etc.) 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 survivors 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.

It is critical that the survivors 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 survivor and document this. Notify the Senior Medical Officer, Medical (Officer) Health, Consultant on duty, and other appropriate stakeholders as necessary.

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

3.2 Conducting the Medical Examination

Physical examination

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

In the case of a minor (under 16 years of age), an adult surrogate should be present.

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

Remember:

- Take your time and work systematically
- Document all findings carefully and clearly
- Explain what you are going to do before doing it
- Ask often if the survivor has any questions

Conduct a head-to-toe examination, including a 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 the case of pre-pubertal girls, a speculum examination should **not** be performed.

Table 3.2.1 is a checklist for important steps in the physical examination of a survivor of GBV.

Table 3.2 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 eardrum
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 survivors with life-threatening or severe conditions for emergency treatment. Review immunization history and provide immunization as appropriate. In cases of sexual assault, please see section 3.4; the timeliness of post-rape care is of utmost importance and should take priority.

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

3.3 Conducting the Mental Status Examination

The physician should assess the survivor's mental status as part of the medical examination. There may be presentations 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 needs of the survivor.

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

Conduct a brief assessment of the survivor and consider the list in Table 3.3.1 as a checklist for the important steps in the mental status examination of a survivor of GBV.

Table 3.3 1: Screening Checklist for Mental Status Examination

Indicator	**Questions?**
Appearance and behaviour	Is there evidence of neglect in the survivor's appearance? Are clothing and hair cared for or in disarray? * Is the survivor distracted or agitated? Is the survivor 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 survivor calm, crying, angry, anxious, very sad, elated, without expression?
Speech	Is the survivor silent? How does the survivor speak (clearly, coherently or with difficulty)? Too fast/too slow? Is the survivor confused?
Thoughts	Does the survivor have thoughts about self-harm? Are there bad thoughts or memories that keep coming back? Is the survivor 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 survivor 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)*

3.4 Assessment of Survivors of Sexual Violence

Survivors of sexual violence, including survivors of rape, require an immediate and timely medical response to manage injuries, and administer medication to prevent or treat sexually transmitted infections and prevent unwanted pregnancies. Treatment within 72 hours is preferable, particularly to administer post-exposure prophylaxis for HIV and other sexually transmitted infections, and pregnancy prevention care (up to 120 hours). Survivors may present much later than 72 hours and require other treatment.

Clinical care for rape survivors must be readily available, and healthcare staff should be able to provide clinical services to the survivor, including performing and documenting a physical exam, providing treatment, and referring to other services (e.g., case management and psychosocial support) according to the survivor's wishes. Healthcare staff should provide survivor-centred care based on the GBV Guiding Principles, including informed consent, confidentiality, respect, and non-discrimination. Female health staff should be present where possible.

Remember:
It is critical that the survivor provide permission to conduct the physical examination and therefore the process of informed consent should be undertaken prior.

The examination of the survivor of sexual violence is a very sensitive process. It is also a forensic examination and will require collection of forensic evidence once the survivor has consented and/or as required by law.

Ensure the survivor is comfortable and kept informed throughout the examination about the process in understandable language for their age group. The clinician should ensure, in particular, that where the survivors are children or adolescents, they are given age-appropriate information. Persons 16 years and older can consent to a medical examination; the child below the age of 16 can determine who they want in the room.

During the medical examination of a survivor of sexual assault, 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. The child or adolescent survivor should be able to have a say in the gender of the officer that is present.

History Taking

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 survivor's activities prior to the assault;
- How many attackers had sexual or physical contact with the survivor;
- The nature of any violence and whether a weapon was used, and, if so, what type of weapon;
- Whether the survivor lost consciousness at any point in time;
- Whether the survivor 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 survivor 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 survivor's body it occurred;
- Whether an object was used to penetrate the survivor and, if so, what type of object and where did penetration occur;
- Whether the survivor 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 survivor has used a tampon or sanitary napkin since the assault.

Examination of the Survivor of Sexual Violence

Sexual violence is very traumatic. Survivors may be very sensitive to being examined or touched. The health worker needs to proceed slowly and ask often if they can proceed. It is important to allow the survivor to set the tone and reject specific stages of the assessment. This should not affect the quality and type of care provided.

Before you proceed

- Help the survivor feel as comfortable as possible.
- Let them know when and where you will touch them.
- Help the survivor to lie on their back with legs bent, knees comfortably apart.
- Place a sheet over the survivor's body. It should be drawn up at the time of the examination.

Physical examination

- Where the collection of forensic specimens is indicated, the physician should wear powder-free gloves and change them often to prevent cross-contamination; standard gloves can be used otherwise.
- The survivor's clothing is removed (packaging is indicated where forensic specimens are being collected).
- The general physical examination is carried out followed by an oral and genito-anal 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 survivor, and only if necessary for investigation (for example, if the survivor had loss of consciousness or used mind-altering drugs).

Collection of forensic specimens

- 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 survivor, 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 survivor, the date, place of collection and the full name of the police officer, his/her badge number and division).

3.5 Investigations and Treatment of the Survivor of Sexual Violence

Investigations

- 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 Venereal Disease Research Laboratory (VDRL), HIV, Hepatitis A, B and C tests. Tests need to be done one week after the initial visit and then repeated in three months.
- Other tests may be required based on the condition of the survivor.

Treatment

Treatment Adherence: It is very difficult to attain adherence. Given the stigma associated with sexual abuse, the first visit to the health care provider may be the only visit and therefore the only opportunity to provide adherence counselling.

- Communicate side effects clearly, but without inducing fear.
- Consider the impact of the traumatic event.
- For young children, adherence counselling needs to involve caregivers. For adolescents, engage them in developing an adherence plan, with age-tailored messages and respecting their autonomy (e.g., ascertaining whether they wish to engage caregivers).

Discuss the following points:

- It is important to remember to take each dose, so it is helpful to take it at the same time every day, such as at breakfast and dinner. Taking the pills at regular intervals ensures that the level in the blood stays about the same.
- An alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can help remember.
- If they forget to take the medicine on time, they should still take it, if it is less than 12 hours late.

- If it is more than 12 hours late, they should wait and take the next dose at the regular time.
- They should not take two doses at the same time.
- They should return to the clinic if side effects do not go away in a few days, if they are unable to take the drugs as prescribed, or have any other problems.

Treatment Protocols

- Treatment of the female survivor 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 and as per the guideline documents for the treatment of survivors of sexual assault.

Prophylaxis against Pregnancy (to be given within 120 hours of the assault)

For pregnancy prophylaxis, with consent, administer the following:

- Low dose ethinyl estradiol-norgestrel: 4 tablets orally, then 4 tablets in 12 hours, or
- Ethinylestradiol-levonorgestrel (Ovral): 2 tablets orally then two tablets in 12 hours, or
- Postinor: 1 tablet to start then one tablet 12 hours later OR 2 tablets of Postinor 2 as a single dose

These doses apply to girls who are post menarche or those in the beginning stages of puberty (Tanner 2).

Prophylaxis against STIs

For prophylaxis against gonorrhea:

- Ceftriaxone: 125 milligrams to 250 milligrams intramuscularly as a single dose or Ciprofloxacin: 500 milligrams orally as a single dose, or
- Spectinomycin: 2 grams intramuscularly

For prophylaxis against chlamydia:

- Azithromycin: 1 gram orally (**do not give to pregnant women),** or
- Doxycycline: 100 milligram orally twice daily for seven days, or
- Erythromycin: 500 milligrams orally twice daily for seven days

For prophylaxis against Trichomoniasis

- Metronidazole: 2 grams orally as a single dose

For prophylaxis against bacterial vaginosis

- Metronidazole: 500 milligrams twice daily for 7 days

For prophylaxis against HIV (to be given within 72 hours of the assault) which is to be done after the appropriate counselling, with consent administer the following:

- Tenofovir: 300 milligrams orally daily for 28 days and Lamivudine: 150 milligrams AND Dolutegravir: 50 milligrams (or Efavirenz 600 milligrams) orally daily for 28 days

For children and adolescents, where adult formulations/dosing are not appropriate, Abacavir/Lamivudine and Atazanavir/Ritonavir (or Lopinavir/Ritonavir) should be used.

3.6 Self-Care for the Survivor

Discuss with the survivor and/or caregiver the examination findings, what they may mean for their health, and any treatments provided. Invite them to voice questions and concerns and ensure to explain wound care.

For sexually active survivors, if it is a case of sexual assault, advise the survivor to refrain from sex until STI prophylaxis/treatment is completed. Condoms should be used consistently if the survivor is unable to refrain.

All survivors, including children and adolescents and their non-offending caregivers, should be encouraged to return to the facility if they have any concerns regarding their physical (or mental) health.

SECTION 4: PROVIDING MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR SURVIVORS OF GBV

Summary: Providing Mental Health and Psychosocial Support for Survivors of GBV

Assessing mental health and providing psychosocial support

General healthcare staff should do the following: `

- Offer first-line support and basic psychosocial support to all survivors of GBV. This support may be sufficient for those experiencing transient signs of psychological stress. In an emergency setting where a healthcare provider may see a survivor only once, this type of support may be the most important help you can give.
- Assess the survivor for mental health problems if symptoms are severe enough to affect day- to-day functioning and do not diminish over time. Offer to link them to a social worker, counsellor or psychologist who may have more training and/or more time to provide appropriate care.

Basic psychosocial support:

- Provide information about normal stress reactions to an experience of violence. This can bring relief to survivors and help them to cope better.

Signs that a survivor may need specialized mental health support:

• If a survivor does not show signs of improved coping or recovery, or shows deterioration.
• If a survivor is not functioning and not able to care for self or children.
• If a survivor is believed or known to have a mental health condition.
• If a survivor talks of suicide or indicates she may be a risk to herself or others.
• If a survivor requests specialized mental health services

Cautions in providing mental health and providing psychosocial support services

- Do not routinely prescribe benzodiazepines for insomnia.
- Do not prescribe benzodiazepines or antidepressants for acute distress.

4.0 Providing Mental Health and Psychosocial Support for Survivors of GBV

Survivors of GBV can present a wide range of reactions, symptoms, and difficulties. It is important to keep in mind that a survivor's reaction is usually a temporary and natural response to an abnormal event. The effects of GBV depend on individual, family, economic, socio-cultural, and environmental factors, including but not limited to their relationship to the perpetrator, and personal and social coping and support mechanisms; the nature and context of the violence; and the level of social stigma or family and community support and acceptance.

Protective factors that may minimize psychological impact include having access to support and resources to meet needs and receiving psychosocial and emotional support. Most survivors recover with basic psychosocial support, although some may experience severe and enduring symptoms that require specialized support. Staff should allow the survivor to determine what they wish to share, and whether they would like further psychosocial and/or mental health support.

Combatting the mental and psychological effects of GBV

The impact of violence varies from person to person. Many survivors of GBV experience long-lasting psychological and social effects due to the silence and stigma surrounding GBV, a lack of family and community support and appropriate response services, internalized shame, and a lack of power and resources to escape continued perpetration of GBV. Psychosocial support is therefore a critical emergency intervention. It is a central component of both short and long term care.

As a critical intervention that contributes to survivors' safety, healing and recovery, psychosocial support interventions can range from basic support by first responders, such as

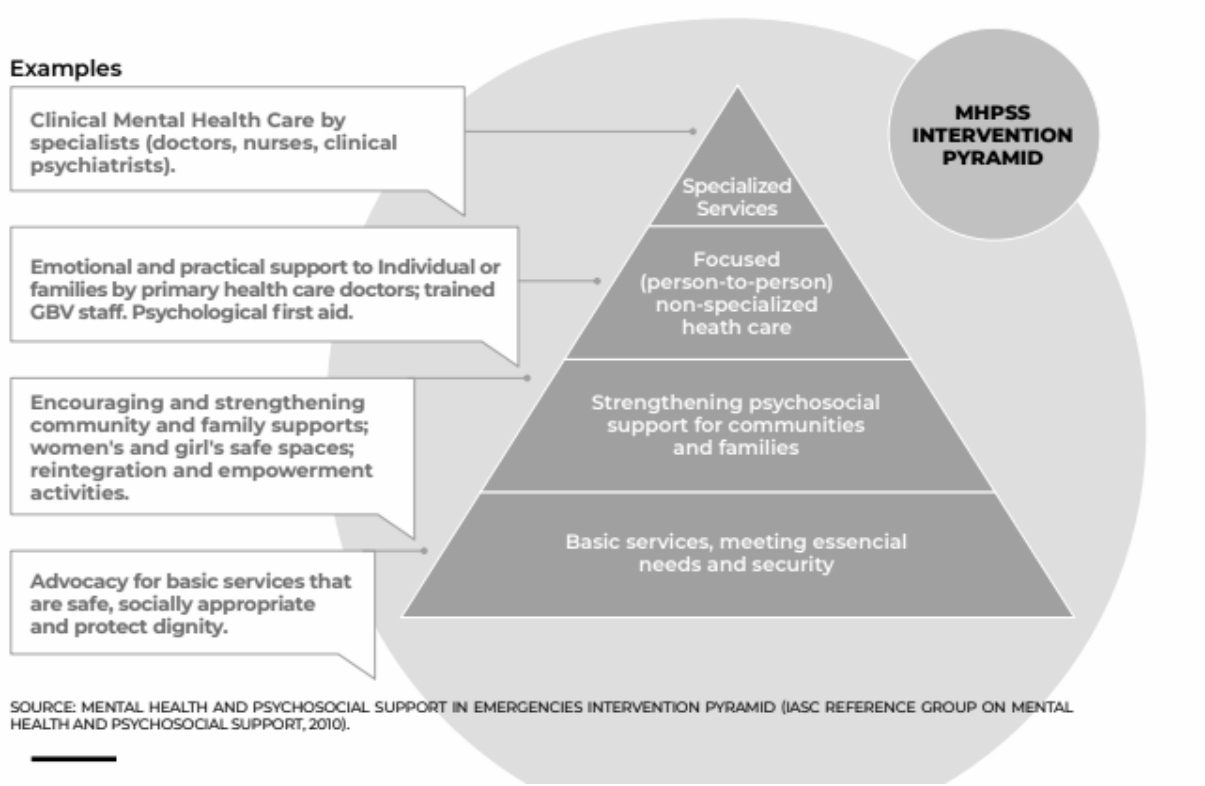
psychological first aid to survivors and families, to more focused case management support, including psychological interventions provided by non-mental health specialists.

Quality psychosocial support services are survivor-centred and age-appropriate, build resilience, and support positive coping mechanisms. These services are not limited to what can be provided by the health team and include community-based interventions. They should include opportunities for social networking and solidarity-building among survivors. Services are focused on healing, empowerment, recovery, and case management. Emotional support, social and community re-engagement, self-sufficiency to reduce vulnerability (skills training, income generating grants); food and non-food items support, safe spaces, and sensitization and awareness-raising to increase awareness about GBV and services available for survivors are part of the suite of psychosocial support services.

Psychosocial group support activities should not focus exclusively on female survivors. GBV referral pathways should support men and adolescent boys to access mental health and psychosocial support care through health facilities and to join relevant community support groups and life skills programmes, according to the survivors' wishes. Sexual violence can cause significant and long-lasting impacts on the mental health and psychosocial well-being of adult male survivors who should be supported to access survivor-centred care through trained health, mental health and psychosocial service providers.

Mental health and psychosocial support (MHPSS) is located between the protection and health sectors and describes support that seeks to protect or promote psychosocial well-being and mental health. The word 'psychosocial' captures how psychological well-being is directly linked to one's social surroundings, including community, family, and cultural networks. Mental health and psychosocial support (MHPSS) includes four layers of service provision that become more specialised as they progress (Figure 4.1).

Figure 4 1: Mental Health and Psychosocial Support Intervention Pyramid



Layer 1: Basic services and security should be survivor-centred and should not increase the risk of sexual exploitation and abuse. In emergency responses, e.g., during natural disasters such as hurricanes, etc., there may be a particular gap as regards healthcare for survivors of rape and intimate partner violence. At this layer, there are ideally referral services available to link survivors to essential needs and/or other types of support, depending on their unique needs. Health care workers should be cognizant of the risk of GBV in emergency settings, provide the needed services and take additional actions as necessary e.g., engagement with other service providers.

Layer 2: Community and family supports focus on increasing awareness of GBV and reducing stigma at the community and family levels. It is important to note that GBV survivors should not be targeted directly for participation in these psychosocial activities. However, it is likely that beneficiaries may disclose incidents of GBV in safe spaces, making it essential that referral pathways to more focussed, non-specialised or even specialised services are available. Health educators/health care providers can raise awareness in various community settings.

Layer 3: Focussed, non-specialised support is conducted through case management. These supports are typically for GBV survivors who have come forward seeking additional support. These focussed, non-specialised supports could include group-based psychosocial sessions or counselling, as well as additional livelihood and educational reintegration interventions. The medical social worker has a key role to play once acute issues have been addressed.

Layer 4: Specialised services are at the top of the MHPSS intervention pyramid and include psychological evaluations by trained professionals. The fewest number of GBV survivors will need to access these types of services, compared to services at lower levels of the pyramid. However, it is important to note that survivors at this level should retain access to psychosocial support activities at lower levels, including safe spaces and reintegration activities.

Table 4 1: Mental Health Support

Some survivors may experience persistent symptoms and emotional distress. If a survivor continues to experience problems with mood, thoughts or behaviour, and is unable to function in their daily life, they may have more severe health problems. It is important that service providers are able to recognize when a survivor requires more specialized mental health services and can help them obtain such care. All service providers should be familiar with the services available to survivors in their area of operation, and able to make safe and confidential referrals based on informed consent. Clinical treatment for mental health disorders requires specialized services delivered by qualified mental health professionals. Staff should not attempt to provide specialized mental health care without proper qualifications.

Service providers must understand the consequences of GBV and be able to provide compassionate support to survivors whether or not survivors disclose details.

Signs that a survivor may need specialized mental health support:

- If a survivor does not show signs of improved coping or recovery or shows deterioration.
- If a survivor is not functioning and not able to care for self or children.
- If a survivor is believed or known to have a mental health condition.
- If a survivor talks of suicide or indicates she may be a risk to herself or others.
- If a survivor request specialized mental health services

Assessing mental health and providing psychosocial support

General healthcare staff should do the following: `

- Offer first-line support and basic psychosocial support to all survivors of GBV. This support may be sufficient for those experiencing transient signs of psychological stress. In an emergency setting where a healthcare provider may see a survivor only once, this type of support may be the most important help you can give.
- Assess the survivor for mental health problems if symptoms are severe enough to affect day-to-day functioning and do not diminish over time. Offer to link them to a social worker, counsellor or psychologist who may have more training and/or more time to provide appropriate care.

Basic psychosocial support:

- Provide information about normal stress reactions to an experience of violence. This can bring relief to survivors and help them to cope better.
- Healthcare providers should let survivors know the following:
  - Most survivors who have been exposed to violence experience symptoms of emotional distress. These reactions are normal and common in people who have gone through a stressful and frightening experience. In most cases, these reactions to an experience of violence will improve over time and they will likely feel better, especially if they receive (practical and emotional) support from others.

Cautions in providing mental health and providing psychosocial support services

- Do not routinely prescribe benzodiazepines for insomnia.
- Do not prescribe benzodiazepines or antidepressants for acute distress.

Identify and address current psychosocial stressors

Identify and discuss issues that are causing stress and having an impact on the survivor's life. Ask:

- What is your biggest worry these days?
- What are your most serious problems right now?
- How are these problems or worries affecting you?

Assist them to manage stressors. Explore and strengthen the survivor's social support and coping methods:

- Teach stress-management techniques, such as relaxation exercises.
- Work with them to identify potential solutions and coping strategies. In general, do not give direct advice. Encourage the survivor to find their own solutions by supporting them with brainstorming ideas together, asking questions and exploring available support options.
- Discuss possible referrals to relevant agencies and community resources.

Explore and strengthen positive coping methods:

A survivor's experience of violence can make it more difficult to engage in day-to-day tasks. Talk to them about their lives and activities and about how they are coping. Ask:

- How has (the violence) been affecting you?
- How do you deal/cope with these problems day by day?
- Explore positive coping strategies that are feasible for them, in a supportive and non-judgemental manner.

Encourage them to:

- build on their strengths and abilities (e.g. ask what is going well currently and how they have coped with difficult situations in the past);
- continue activities, especially ones that they used to find interesting or pleasurable;
- engage in relaxing activities to reduce anxiety and tension (e.g. walk, sing, pray, play with children);
- spend time with friends and family who are supportive and avoid isolating themselves;
- try to engage in regular physical activity;
- try to keep a regular sleep schedule and avoid sleeping too much; and
- avoid using self-prescribed medications, alcohol, or illegal drugs to try to feel better.

Linkage to Social Support:

Community based interventions can make an important difference to survivors and, with the survivor's consent, referrals can be made accordingly (see Annex 1 - referral directory).

Stress reduction and relaxation exercises:

Stress-reduction techniques can be used to manage stress and anxiety. Make sure you demonstrate the techniques and practise together with them during the session. Encourage them to practise at home when they feel stressed (see Annex 2 - Exercises to help reduce stress).

Suicide and self-harm:

Some healthcare providers fear that asking about suicide may provoke the person to commit it. This is not correct. On the contrary, talking about suicide often reduces an individual's anxiety around suicidal thoughts and helps them to feel understood and may encourage them to seek help.

You can start with general questions such as:

- "What are your hopes for the future?"

If the survivor expresses hopelessness, ask if they currently have – or have a history of – thoughts or plans to commit suicide or to harm themselves. If so, there is an immediate risk of harm or suicide; refer them immediately to a mental health specialist. They should not be left alone until you can ensure that they are in appropriate care.

General principles

Be cautious when involving family members and caregivers in mental health assessment and care. Family members and caregivers are often involved in the care and support of people with mental health problems and can be an important source of support. However, some caregivers or family members may be unsupportive, may not keep information confidential, or may be perpetrators of IPV or sexual violence. It can be helpful to involve supportive and "non-offending" family members if the survivor consents.

- **Involve the survivor as much as possible**. Even if the survivor's functioning is impaired and supportive family members are present, always involve the survivor in the discussion as much as possible.

- **Explain the limits of confidentiality**. Let the survivor know that you will maintain confidentiality, except when you perceive a risk to them (e.g., suicide or self-harm) or to others, or if there are legal requirements.

- **Ensure that the information provided is clear**. Repeat information, allow time for questions, and consider providing written information on specific mental health conditions.

Consider pre-existing mental health conditions

Pre-existing mental health conditions should be considered when making assessments and planning care for survivors of GBV.

Important notes:

- Every community will have people with pre-existing mental health problems, which may be exacerbated or reoccur if they experience IPV or sexual violence.
- Persons with mental health and substance abuse problems may be at a greater risk of GBV, so there may be a disproportionate burden of pre-existing mental health and substance abuse problems among survivors.
- If a person has suffered from mental health problems (e.g., depressive disorder or substance use disorder) before experiencing violence, they will be much more vulnerable to suffering from them again.
- Similarly, having a history of exposure to violence (e.g., childhood sexual abuse, IPV, war-related trauma, etc.) should be considered in the mental health assessment and treatment planning process.

SECTION 5: RESPONSE TO SURVIVORS AND VULNERABLE POPULATIONS WITH SPECIFIC NEEDS

Summary: Response to survivors and vulnerable populations with specific needs

Children and Adolescents

- Their care needs and recovery and healing plans should be managed by the Child and Adolescent Mental Health team.
- Reporting of children in need of care and protection to the Children's Registry or other designated authority is mandatory under the Child Care and Protection Act.
- Given their age, the risks of early pregnancy, lack of decision-making power and limited access to information and services, special attention must be given to removing barriers and facilitating access to services for adolescent girls.
- Adolescents 16 years and older can independently consent for contraception and medical interventions.

Males

- Male survivors of rape are likely to underreport the incident, because of shame and stigma.
- The psychological trauma and emotional after- effects for men are similar to those experienced by women.
- Offer care that is survivor-centred, non-stigmatizing and non-discriminatory.

LGBT Persons

- Often professionalism is the key: treating survivors in a non-discriminatory and non-judgmental manner.
- Testing for HIV and STIs and requesting follow up tests, months later, is crucial to an effective treatment.
- Ensure referral for psychosocial support services.

Victims of Trafficking in Persons

- It is not recommended that any authorities be called regarding the possibility of human trafficking without the consent of the survivor.

- This constraint does not apply to children and adolescents

Emergency Settings

- Conditions related to emergencies, e.g. the use of shelters or movement restrictions, may exacerbate the risk of many forms of GBV.
- All agencies involved in emergency response have a responsibility to protect those affected by GBV.
- Sexual and reproductive health services and commodities, including post-rape care services, should be available and accessible in a timely manner.

5.0 RESPONSE TO SURVIVORS AND VULNERABLE POPULATIONS WITH SPECIFIC NEEDS

Children and Adolescents

Child Survivors

Children are more vulnerable than adults to abuse, due to their age, size, and limited participation in decision-making. Healthcare service providers, teachers, parents, caregivers, and others should be aware of the signs and symptoms of child abuse and, specially, sexual abuse, as girls and boys will often remain silent. Services should be provided in a non-discriminatory manner, with the informed assent and/or consent of the child or of their caregiver. The best interests of the child and their immediate care and safety should be the primary consideration in all decisions. Children should be interviewed and treated in an environment where they feel safe, using child-friendly communication techniques. They should participate in decisions that affect their lives, as appropriate to their age and maturity. Although children are resilient, they vary in how they are affected by abuse; their care needs and recovery and healing plans should be managed by the Child and Adolescent Mental Health team.

Adolescent girl survivors

Given their age, the risks of early pregnancy, lack of decision-making power and limited access to information and services – including health care – special attention must be given to removing barriers and facilitating their access to services. For example, parents should be informed of the potential long-term sexual and reproductive health implications of denying contraception and medical treatment to adolescent girl survivors of gender-based violence and should be aware of the life-threatening health consequences of early pregnancy. It is important to ensure that female health service providers are available to provide counselling and treatment to adolescent girl survivors that is age-appropriate, accessible, non-judgmental, and non-discriminatory. Girls who are at risk of pregnancy resulting from rape should be offered emergency contraception. Adolescents 16 years and older can independently consent for contraception and medical interventions.

Key reminders

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.

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. 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. Report as required under the Child Care and Protection Act. Ensure that the environment/health facility is child/adolescent friendly.

Pregnant Women and Girls

Women and girls who experience sexual violence while pregnant may face a higher risk of complications such as miscarriage, pregnancy-induced hypertension, premature delivery, and infections, including hepatitis and HIV.

The health service provider should ensure that the medical drugs that are prescribed for the clinical management of rape have no side effects (or contraindications) for the pregnancy. Additionally, risks of physical, sexual, or emotional abuse may increase during pregnancy and result in greater health complications.

Males

Men and boys also experience GBV, but this is not always acknowledged or well understood. Sexual violence inflicted on men can be used to disempower, dominate, and undermine traditional concepts of masculinity. Entrenched social, cultural, and religious norms, including taboos around sexual orientation and masculinity, may stigmatize male survivors, evoke feelings of shame, and prevent men and adolescent boys from reporting incidents or seeking services.

Sexual violence can cause significant and long-lasting impacts on the physical, mental, and sexual health and well-being of male survivors and their families. It is important that multi-sectoral services including healthcare, psychosocial services, safety and security mechanisms, and legal assistance are available to all survivors. Male survivors have specific needs regarding treatment and care that should be addressed by healthcare providers, who must be trained to identify indications of sexual violence in men and boys, and offer care that is survivor-centred, non-stigmatizing and non-discriminatory (see Box 5.1).

Table 5 1: Special considerations for male survivors of sexual assault

- Men and boys are also at risk of rape; the role of the health-care provider is the same for female and male survivors, and first-line support remains important care that you can give (see LIVES).
- Male survivors of rape can be as likely as women to underreport the incident, because of shame and stigma. While the physical effects differ, the psychological trauma and emotional after- effects for men are similar to those experienced by women.
- When a man is raped anally, pressure on the prostate can cause an erection and even orgasm, which can contribute to feelings of shame and self-blame; reassure the survivor that, if this has occurred during the rape, it was a physiological reaction and was beyond his control.
- The physical examination can be sensitive for male survivors, and it is important to follow the general guidelines in Section 3: Providing Physical Care for Survivors of GBV.

LGBT Persons

Healthcare providers should provide care in an empathetic manner. Often professionalism is the key: treating survivors in a non-discriminatory and non-judgemental manner, testing for HIV and STIs and requesting follow up tests, months later, is crucial to an effective treatment.

Ensure referral for psychosocial support services within the health sector and/or referrals to community-based LGBT organisations offering “safe spaces”.

Victims of Trafficking in Persons

The Trafficking in Persons (Prevention, Suppression and Punishment) Act defines Human Trafficking as the transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Healthcare workers may be the only outside communication these victims have. The role of the health care worker in providing care for these victims includes close attention to the following considerations:

- Providing trauma sensitive care and support for the decision to disclose
- Safety management
- Obtaining consent for reporting to authorities

Specific Signs/Red Flags to identify cases of trafficking in persons

- Signs of physical and/or sexual trauma
- Injuries in various stages of healing
- Evidence of lack of care for previous conditions
- Discrepancy between the history, presentation, and pattern of injury
- Marked discrepancy between stated age – older or younger than visual appearance
- Subordinate, hyper-vigilant or fearful
- Accompanied by overprotective companion/guardian
- Foreign accent
- Extreme anxiety/tearfulness or lack of emotions
- Recurrent sexually transmitted infections
- Developmental regression e.g., bedwetting
- Multiple or frequent pregnancies

When assessing these survivors, the clinician should do so in a private setting. If needed, an independent translator who speaks the survivor's language should be made available. However, an individual suspected of perpetrating Human Trafficking should not be the translator.

There should be an emphasis on survivor safety and confidentiality in interviewing potential victims of human trafficking. The clinician should ask only questions that are relevant to the assistance being provided and avoid asking questions that are curiosity based. It is not recommended that any authorities should be called regarding the possibility of human trafficking without the consent of the survivor, considering potentially legitimate concerns regarding the well-being of victims and their loved ones. On the other hand, this constraint does not apply to children and adolescents who require immediate placement into a place of safety.

Procedure after obtaining consent

- Call out cascade - Trafficking in Persons Unit; Child Development Agency (if relevant)
- Point person(s) in hospitals - Senior Medical Officer, Senior Nurse/Director of Nursing, Internist, Social Worker
- Arrange admission to ward to avoid processing through the Accident & Emergency Department.
- Designate specific hospitals if needed (Regional or Parish hospitals)
- Designate specific rooms, e.g., side rooms – if available
- Security will be in place for victim by the Police
- Three-day turnaround time for admission to shelter if survivor deemed medically fit

5.1 Emergency Settings

An emergency is any situation in which the life or well-being of civilians is affected by natural disaster, conflict or a public health threat has been or will be a risk unless immediate and appropriate action is taken, and that demands an extraordinary response and exceptional measures. Conditions related to emergencies e.g., the use of shelters or movement restrictions, may exacerbate the risk of many forms of GBV.

Prevention and mitigation of, and the response to, GBV are classified as essential, life-saving interventions in these settings. All agencies involved in emergency response have a responsibility to protect those affected by GBV. This includes supporting survivors, and those at risk, to access clinical care and support services, whether onsite or through referrals. Sexual and reproductive health services and commodities, including post-rape care services, should be available and accessible in a timely manner.

Effective coordination with emergency management coordinators/focal points, and between health and child protection actors to ensure the provision of health care to GBV survivors and collaborative support to children and adolescent survivors of sexual abuse is particularly important. Local/community partners, in particular those involved in the emergency response, also play a vital role in measures to prevent, mitigate and respond to GBV.

SECTION 6: DOCUMENTATION AND MEDICO-LEGAL REPORTING

6.0 Documentation and Medico-Legal Reporting

6.1 Documentation

Documentation is an important part of providing sensitive, ongoing care, as it provides a reminder of what was discussed and addressed and/or to alert another provider at later visits. Documentation is stored and managed as per the standard protocols for the handling of medical records to ensure confidentiality and maintaining survivor privacy. Documentation of injuries is also important if the survivor decides to report to the police. To document injuries appropriately, take the following steps:

- Tell the survivor what you would like to write down and why. Ask if this is okay and follow their wishes. If there is anything that the survivor does not want written down, do not record it.
- Enter in the medical record any health complaints, symptoms, and signs, as you would for any other survivor, including a description of his/her injuries. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured them.
- Do not write anything where those who do not need to know can see it; for example, on an X-ray requisition card or a bed chart.
- Be aware of situations where confidentiality may be broken. Be cautious about what you write on what document, where you are doing the writing, and where you leave the records.
- Remember, you have been entrusted with private and sensitive information. Your actions could easily put the survivor at further risk. Keep the survivor informed and respect their wishes.

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 assessments, interventions, and referrals
- Non-disclosure by survivor of relevant information such as previous medical history

Use body maps, or photographs where necessary, to supplement written descriptions.

6.2 Medico-Legal Reporting

Medico-legal reporting should ideally happen only with the consent of the survivor to advance a legal case or in the cases of mandatory reporting.

In the absence of mandatory reporting for adults, and if the survivor does not wish to report to police/justice, there is no need to collect medico-legal information (including evidence) when it cannot be used; this may cause unnecessary trauma. Inform the survivor that forensic evidence can usually be collected up to 5 days after sexual assault and advise of what the collection process involves. If more days have passed since the assault, it may be too late to collect forensic evidence, but with the survivor's consent, a full physical examination can still be done and well documented, which may be useful in a legal case. Only medico-legal evidence that can be collected, stored, analysed, and used should be gathered. If the survivor decides not to report, respect their decision.

Reporting of children in need of care and protection to the Children's Registry or other designated authority specifically: Office of The Children's Advocate (OCA); the Child Protection and Family Services Agency (CPFSA); the Centre for the Investigation of Sexual Offences and Child Abuse (CISOCA); and the Police is mandatory under the Child Care and Protection Act. The Act states that a 'prescribed person' (that is, a physician, nurse, dentist, other health, or mental health professional; or an administrator of a hospital or other public medical facility) who has information which causes the person to suspect that a child is likely to be abandoned, neglected, physically or sexually ill-treated, or otherwise in need of care and protection and does not make a report to the Children's Registry or other relevant authority "commits an offence and shall be liable upon conviction to a fine not exceeding $500,000, or to imprisonment not exceeding six months or both" (CCPA, 2004, Section 6 (4)).

Preparing the Medical Report

A medical report is prepared upon the request of the survivor, legal guardian, or the courts. The medical report is usually prepared and signed by a senior medical officer in the health care facility. The report may or may not be used for legal purposes, that is, it may or may not be a medico-legal document.

The preparation of the medical report is as important as the examination and the collection of evidence. It is the proof that the survivor was examined and that specimens were collected. The physician is charged then to ensure that care is taken during the process of preparing the report.

In court proceedings, the notes from the physician will be read by forensic experts, law enforcement officials and members of the legal fraternity, whose ability to read and understand the written document is paramount to the processing of the case.

No detail of the examination process should be excluded from the report. The report should be legible and should avoid the use of medical jargon. In specific reference to survivors of sexual violence, the report should not make reference to the terms 'alleged rape', 'suspected rape', 'claims to have been raped' or 'no evidence of rape or sexual assault noted'. Sexual assault is not a diagnosis; it is to be determined not by a medical doctor but by a court of law. A reasonable concluding assessment might be, 'the examination is compatible with the history given' or 'the findings are in keeping with a history of sexual assault'.

Preparing the Medical Certificate

Unlike the medical report, the medical certificate is a medico-legal document. It is the duty of the physician who has conducted the examination to prepare and sign the medical certificate when requested. A certificate format should be provided by the police either at the time of the initial examination or within days afterwards.

Preparing for Court

A case of GBV for which a forensic examination was done and a medical certificate prepared may involve the physician appearing in court to give evidence. When this occurs, the physician is advised to prepare thoroughly beforehand. Preparation may begin by contacting the prosecutor (Crown Counsel) attached to the case to discuss their expectations in marshalling the evidence before the court. Check on court dates a week prior, to ensure that no changes to the schedule are envisaged. Before going to court, the doctor should review the medical and forensic records associated with the case and conduct an extensive literature review, as necessary (see Table 6.2.1).

Table 6.2 1: Writing Reports and Giving Evidence in court: guiding principles for health care workers

WRITING REPORTS	GIVING EVIDENCE
1. Explain what you were told and observed.	1. Be prepared.
2. Use precise terminology.	2. Listen carefully.
3. Maintain objectivity.	3. Speak clearly.
4. Stay within your field of expertise.	4. Use simple and precise language.
5. Distinguish findings and opinions.	5. Stay within your field of expertise.
6. Detail all specimens collected.	6. Separate facts and opinion.
7. Only say or write what you would be prepared to repeat under oath in court.	7. Remain impartial.

SECTION 7: INJURY SURVEILLANCE

7.0 Injury Surveillance

The interpersonal violence landscape is rapidly changing as violence prevention has increasingly become a national focus and an international priority. There is a 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 survivor 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 survivor and/or family or legal guardian in an effort to compile data on the survivor's injuries and their locales. This information is fed into the electronic database system. Entering survivor information for injuries and locales should cover information as outlined Table 7.1.

Table 7.1: Data Collection

Information required	Description
1. Survivor's name, address, demographics and next of kin information:	1. Survivor's name must be recorded in full, including middle name(s) 2. Survivor'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. 3. Survivor demographics are required for statistical analysis, especially for the social and economic implications brought on by these injuries. 4. 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 survivors who are unresponsive). a. Survivor's Surname (helps to identify each record as unique) b. Date of Birth (along with "Age", establishes true age) c. Gender (key demographic indicator) d. Survivor/Incident Location Address (including community codes)

Table 7.1: Data Collection	
2. Type of injury survivor suffered and Injury related questions to ascertain the cause and characteristics of injuries:	a) Violence Related Injuries: i. Circumstances of Injury 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 v. Causation from Severe Adverse Environmental Effects (SAEE) (e.g., storm, hurricane, earthquake, another natural disaster) 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 vii. Causation by a Multi-Victim Road Traffic Crash Event

Table 7.1: Data Collection	
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 next are the flowcharts outlining the process for reporting and documentation of injuries at sentinel sites, beginning with survivor assessment upon arrival (see Figures 7.1 and 7.2)

Figure 7.1: Flowchart – Jamaica Injury Surveillance System (JISS)

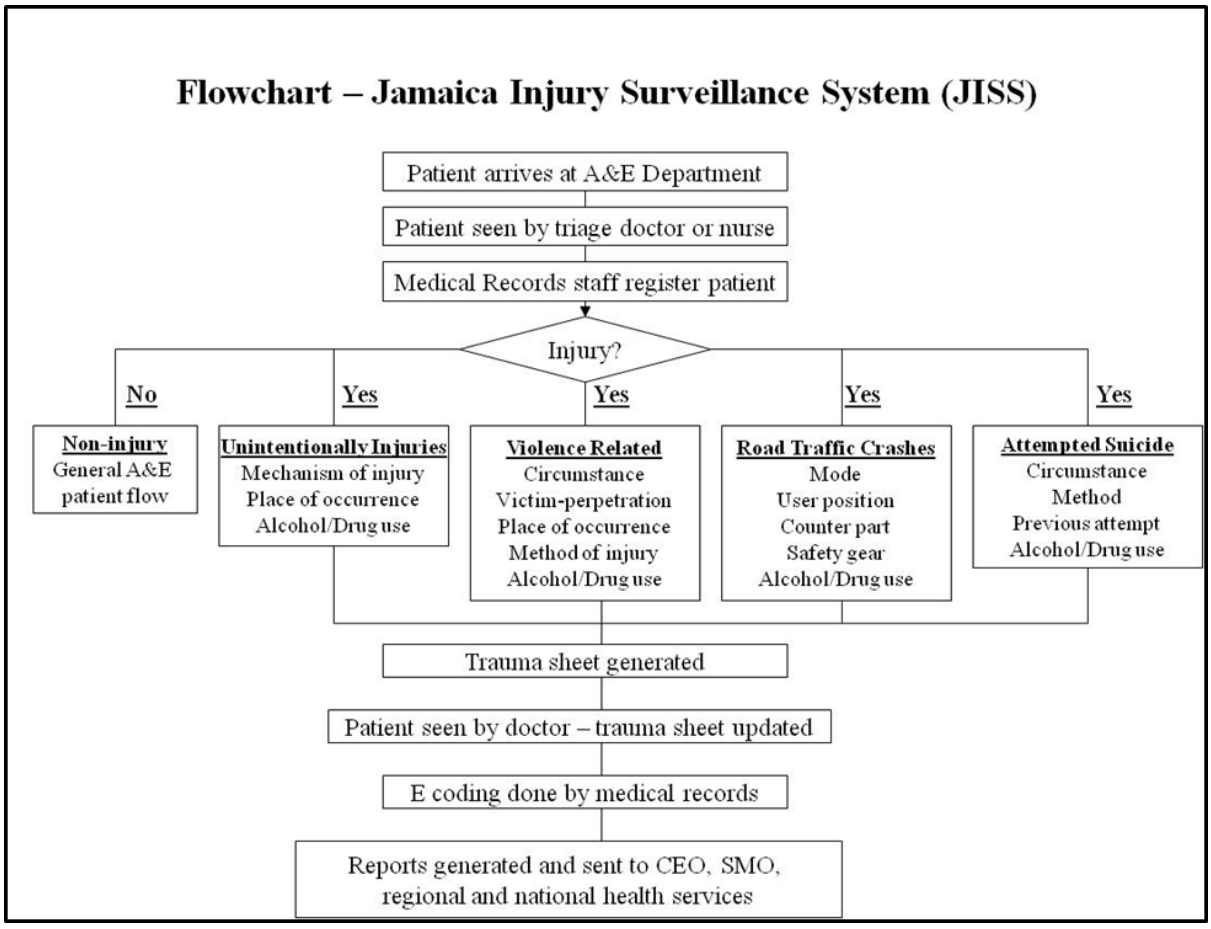
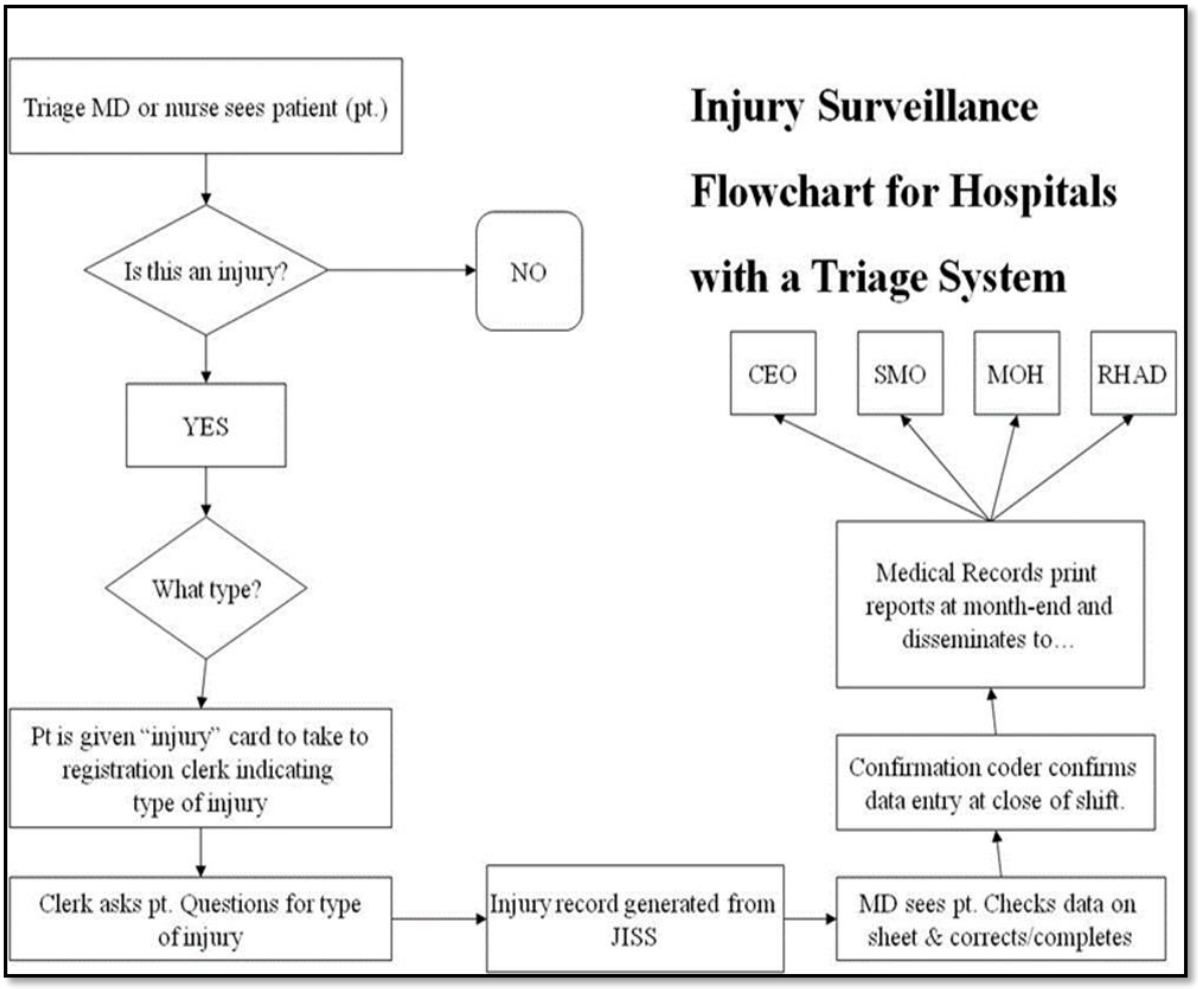


Figure 7.2: Injury Surveillance Flowchart for Hospitals with a Triage System



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).*

ANNEX 1: REFERRAL DIRECTORY

NATIONAL HELPLINES

For 24-hour helpline, crisis counselling, referral to other services including safe shelters:	Bureau of Gender Affairs: • Call or WhatsApp (876) 553-0372 (24/7) • Call for free (888) NOABUSE also (888) 662 2873 (Monday - Friday 8.30 AM - 4 PM) Woman Inc • Call: 876-929-2997 Child Abuse Helpline / To report child abuse to CPFSA • Call for free 211
The Domestic Violence Intervention Centres are there to secure the safety of survivors of domestic violence, conduct investigations and referral to professionals and hold perpetrators accountable. For emergencies:	DVI Care Centres from 8 AM to 7 PM Monday to Saturday • DVI Centre 876-224-4274-5 (at any time) • Police intervention: 119

MAIN DIRECTORY OF SERVICES FOR SURVIVORS OF GBV

The Domestic Violence Intervention Centres are there to secure the safety of survivors of Domestic violence, conduct investigations and referral to professionals and hold perpetrators accountable:	DVI Care Centres from 8 AM to 7 PM Monday to Saturday • For emergencies DVI Centre 876.224.4274-5 (at any time) • Police intervention: 119
In case of sexual assault and rape, visit the nearest hospital within the 72 hours for effective prevention of HIV and other sexually transmitted infections or pregnancies. For investigations on sexual assaults and offences on adults and children report to:	CISOCA 3 Ruthven Road, Kingston 10 Deputy Superintendent 876-926-7318; 876-926-4079 For any health services find here the full list of health facilities and hereafter where to find the public hospitals closest to you.
If specialized mental health services are needed:	Bellevue Hospital 16 1/2 Windward Road, Kingston 2 876-928-1380-7
Specialized sexual and reproductive health services, including in case of risks of unplanned pregnancies, HIV or other STIs:	Jamaica Family Planning Association (FamPlan) 65 East Street, Kingston 876-922-8724
For Screening and treatment for HIV and STIs, contact your nearest health centre.	For any health services, find here the full list of health facilities and hereafter where to find the public hospitals closest to you.
For legal support	Jamaicans for Justice 876-755-4524 complaints@jamaicansforjustice.org
The Family Court or Parish Court to obtain a protection order:	Family Court 552 Duke Street, Kingston 876-922-0000; 876-922-6183 876-967-2546

For counselling:	Victim Service division 47e Old Hope Road Kingston 5 876-946-0663
Organizations that can further assist marginalized populations:	Jamaica Council for Persons with Disabilities 876-968-8373 Combined Disabilities Association 5 Ripon Road, Kingston, 876-929-1177 Jamaica Association for the Deaf 91 Dumbarton Avenue 876-926-7709 Jamaica Society for the Blind 111 ½ Old Hope Road, Kingston 6 876-927-675 Caribbean Vulnerable Communities Coalition 876-631-7299; 876-631-7219 Jamaica AIDS Support for Life 876-952-0021-2; Monday to Friday from 10 am to 4 PM Jamaican Network for Seropositives 876-929-7340 For LGBTQI+ Equality for All 876-620-7698; 876-620-7727 TRANSWAVE Jamaica 876-669-4671

ANNEX 2: EXERCISES TO HELP REDUCE STRESS

1. *Slow breathing technique*

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

2. *Progressive muscle relaxation technique*

- In this exercise, you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to three (3) while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to three (3), and then relax and breathe out slowly.
- Hold your leg and thigh muscles tight…
- Hold your belly tight…
- Make fists with your hands…
- Bend your arms at the elbows and hold your arms tight…
- Squeeze your shoulder blades together…

- Shrug your shoulders as high as you can…
- Tighten all the muscles in your face….
- Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times. Now, go the other way…inhale to the left and back, exhale to the right and down. Do this 3 times.
- Now bring your head up to the centre. Notice how calm you feel.

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