Standard Operating Procedures

Clinical Management of Rape Sexual Violence and Gender-Based Violence

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FOREWORD

I am happy to launch this first ever Standard Operating Procedure (SOP) for the Clinical Management of Gender-Based Violence (GBV) and Sexual Violence (SV) that will apply to all health facilities in Samoa. This is the first SOP developed by the Ministry of Health as a guide to ensure proper processes and documentation are followed as a response to GBV and SV.

The SOP contributes to the overall vision of the Ministry of Health, "Accelerating Health and Wellbeing for a Healthier Samoa". It supports and complements key Ministry of Health policies and plans and contributes to the implementation of activities for achieving key **Outcome 4, "Improved sexual and reproductive health"** and key **outcome 5, "Improved maternal and child health**" as articulated under Health Sector Plan 2019/20 – 2029/30 and the Ministry of Health Corporate Plan FY2020/21 – 2022/23 as well as the Sexual Reproductive Health Policy 2018 – 2023.

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

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

The Health Facility Readiness and Service Availability report in December 2018 showed that GBV/SV services are available in eight of 14 (57%) facilities. I believe that with the completion of WHO Curriculum for training health care providers on SOP GBV/SV, Samoa will have 100% GBV/SV services available in all health facilities.

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

Faafetai tele

Leausa Samau Toleafoa Dr. Take Naseri

DIRECTOR GENERAL OF HEALTH

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We also acknowledge the WHO Curriculum, 2019 for training health care providers on caring of women and girls subjected to violence. The curriculum aims to build skills and to address providers' attitudes towards survivors of violence, provide first line support as well as providing essential clinical care and refer survivors for further social support.

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

Acronyms

CMR	Clinical Management of Rape
CPO	Child Protection Officer
DGoH	Director General of Health
DDGoH	Deputy Director General of Health
DHS	Demographic Health Survey
DV	Domestic Violence
DVU	Domestic Violence Unit
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
HER	Electronic Health Records
EVAW	Elimination of Violence Against Women
FHSS	Family Health and Safety Study
GBV	Gender-based Violence
GBViE	Gender-based Violence in Emergencies
HCP	Health Care Professional/s
HIMS	Health Information management system
IESG	Inter-Agency Essential Services Guide (Samoa)
IPV	Intimate partner violence
MICS	Multi-Indicator Cluster Survey
MT11	Malietoa Tanumafili 11 Hospital
MOH	Ministry of Health
MWCSD	Ministry of Women, Community and Social Development
Ob/Gyn	Obstetrician/Gynaecologist
PEP	Post Exposure Prophylaxis
PFA	Psychological First Aid
PICTs	Pacific Island Countries and Territories
PTSD	Post-traumatic Stress Disorder
RDH	Rural District Hospitals
RHC	Rural Health Center
RTS	Rape Trauma Syndrome
SOP	Standard Operating Procedure/s
STIs	Sexually Transmitted Infections
SV	Sexual Violence
SVSG	Samoa Victim Support Group
TTMH	Tupua Tamasese Meaole Hospital

INTRODUCTION

Gender-based violence (GBV), sexual violence (SV) including intimate partner violence (IPV) have devastating effects on the lives of women and girls globally as well as in Samoa. As with other Pacific island countries and territories (PICTs), GBV is a major concern to communities and governments, with multi-sectoral actions required to prevent, treat and respond with GBV. Many women experience violence throughout their lives - as girls, while dating, in married life, including during pregnancy. The effects are inter-generational. While the majority of GBV is perpetrated on women, it is recognized that men and boys can also be victim-survivors.

Samoa also experiences many climate-induced emergencies and natural disasters, where the risk of violence, exploitation and abuse is heightened. In addition, restrictions put in place to manage COVID-19 may have major consequences for the provision of, and access to, essential health services for GBV at a time when there is increased need for GBV services, including to meet heightened mental health and psychosocial needs. UNFPA has provided training in Samoa on the 'Minimum Standards for Prevention and Response to GBV in Emergencies (GBViE)' which promotes the safety and wellbeing of women and children in emergencies and practical guidance on how to mitigate and prevent GBViE and facilitate access to multi-sector services for survivors (Annex 8).

The Samoa Family Safety Study (FHSS, 2017) found that over half of the women ever in a relationship (60%) reported that they had experienced physical or sexual violence in their lives by their partner; 46% in the 12 months preceding the interview[1]. The Samoa Demographic Health Survey (DHS) Multi-Indicator Cluster Survey 2019 (MICS)[2] found that 52.3% of women (15-49) had experienced physical violence by their intimate partner in their lifetime; 18.7% in the past 12 months. Of women who had ever experienced physical violence, the most common perpetrator (65.9%) was their mother or step-mother, their father or step-father (53.7%) and current husband/partner (37.5%). Sexual violence by any perpetrator was reported by 21.7% of women in the lifetime; 12.6% in the past 12 months. Of concern, is that 90.8% of children aged 1-14 years had experienced physical punishment and/or psychological aggression by caregivers in the past one month.

While there is no one single overarching policy solely dedicated to gender-based violence (GBV), there are laws and policies that are relevant to the prevention and response of GBV in Samoa. The passing of the Family Safety Act 2013 by Parliament marked Samoa's commitment to end violence against women and girls. The Family Safety Act 2013 states that health service provider, may apply for a Protection Order, in the case where a complainant (or survivor) does not.

In responding to this serious problem of violence, the Government of Samoa through the Ministry of Women, Community and Social Development (MWCSD) completed an Inter-Agency Essential Services Guideline (IESG) to build a strong multi-sector service delivery system, including the health sector. The goal was to equip all agencies to better meet the needs of survivors of GBV in all scenarios, including emergency and non-emergency times. It has been identified that while there are informal procedures applied by health care professionals when responding to reports of domestic violence and child protection, there is no official standard in place to ensure a holistic and survivor-centered response from the health system.

Purpose of the document

This Standard Operating Procedure (SOP) presents clear procedures, roles, and responsibilities for healthcare providers in primary, secondary and tertiary level healthcare facilities in Samoa. The SOP for GBV has been developed in order to eliminate the practices that deprive GBV victims of their

[1] Samoa Family Safety Study, 2017 MWCSD p.35
[2] Samoa Bureau of Statistics, DHS MICS pp19-21.

right to receive comprehensive care which may seriously limit their access to medical services, psychosocial and legal assistance. This document builds on the Samoa Inter-Agency Essential Services Guide (IESG) and clarifies the procedures for the Ministry of Health (MOH) in order to provide a high standard of care to individuals (children and adults) and families.

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

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

This document seeks to clarify the referral processes between these two departments for improved responses to victims/survivors. In addition to MOH and Police, there are several key stakeholders in supporting survivors of GBV and child abuse, in particular the Ministry of Women, Community and Social Development (MWCSD) and Samoa Victim Support Group (SVSG) that will be included in the SOP to ensure clear referral pathways.

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

	Service location	**Responsibilities**	**Documentation**
Ministry of Health	Referral hospitals District Hospital Health Centers (limited to identification and referral)	• Identification of victims (including determining age of child) • Medical assistance • Evidence collection and documentation • Immediate safety planning • Referrals to human and social services • Report for court matters • Information sharing with partner departments and organizations	• Medical History and Examination form • Safety Planning Template • Mandatory reporting to Police for children • Child referral to MWCSD Child Protection Officer • Referrals (see list) • Medical records
Police Domestic Violence Unit	Central Police Station Community Police Posts	• Identification of victims • Detain suspect/perpetrator for 24 hours if safety concerns • Interviewing victims (child/adult) • Gathering and recording evidence • Statements from witnesses • Immediate safety planning including taking victim for Interim Protection Order if needed • Refer to MWCSD for cases involving children, immediately	• Referrals (inc MOH, SVSG, MWCSD) • Police record of incident requiring medical assessment. • Safety Planning Template • History of victim (including previous experiences as victim)

- Refer to Samoa Victim Support Group (SVSG) for temporary shelter, if needed, for children and adults alike
- Refer to Samoa Victim Support
- Report preparation for court matters
- Court attendance

Role and Mandate of the Health Sector

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

In general, the Ministry of Health creates an enabling environment, regulates and sets standards and policy for health service delivery. This is done through an integrated approach in the provision of curative, public health and rehabilitative services. The mandate of the MOH is to provide health care services in all hospitals, district hospitals and community health centers, engage with village committees, provide health promotion, preventative and curative services, provide public health services and provide support services to assist with the implementation of the functions and duties of the Ministry.

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

- Developing national policies, guidelines, standards, protocols and training curricula for GBV service delivery
- Capacity building of health service personnel through training and mentorship on clinical management of GBV/SV
- Providing supportive supervision through the main hospitals and district health providers to ensure quality service delivery on GBV/SV
- Providing health services to GBV survivors
- Referring child survivors of SV/GBV to MWCSD Child Protection Officers (CPO)

This SOP is in line with the Elimination of Violence against Women (EVAW) policy and the National IESG for responding to cases of GBV and is included in the MOH work plan. In Samoa, the IESG has identified that the health sector will use standards and protocols in accordance with WHO GBV Guidelines. A range of responsibilities was identified for the health sector to include:

- Policy role/GBV health service protocol
- Medical care and treatment
- Mental health and psychosocial support services and care
- Sexual and reproductive health services
- Information sharing
- Financial support for GBV prevention and response

Objectives for GBV/SV Standard Operating Procedure

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

The SOP

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

These SOP are applicable to all levels of the health service below. **Of note is that health centres outside of Upolu may not have comprehensive care for sexual assault available.**

MAIN HOSPITALS	DISTRICT HOSPITALS	HEALTH CENTRES
UPOLU		
TTM Hospital Tupua Tamasese Meaole (Apia)	Poutasi District Hospital	Faleolo Health Centre
	Lalomanu District Hospital	Lufilufi Health Centre
	Leulumoega District Hospital	Sa'anapu Health Centre
SAVAI'I		
MTII Hospital Malietoa Tunumafili (Savai'i)	Safotu District Hospital	Vaipouli Health Centre
	Sataua District Hospital	Satupa'itea Health Centre
	Foailalo District Hospital	

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

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

To ensure a competent response, adequate and relevant **training for all front-line staff will be provided to health care professionals (HCPs). The SOP is the foundation of the training and is supported by evidence-based training material from WHO/UNFPA/UNWomen (2019).**

Core Concepts and General Guiding Principles

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

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

- Ensure the **safety** of the victim/survivor and his/ her family at all times
- Respect the **confidentiality** of the affected person(s) and their families at all times; sharing information only on a need-to-know basis
- **Respect** the wishes, rights, and dignity of the victim(s)/ survivor(s) when making any decision on the most appropriate course of action to prevent or respond to an SGBV incident, while also bearing in mind the safety of the wider community as well as the individual concerned.
- Ensure **non-discrimination** in the provision of services.
- Apply the above principles to **children**, including their right to participate in decisions that will

affect them. If a decision is taken on behalf of the child, the **best interests of the child** shall be the overriding principle and appropriate procedures should be followed. Special procedures for working with direct and indirect child survivors of GBV/SV are described in Annex 6.

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

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

Human Resources

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

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

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

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

- Refer safely and appropriately.

Minimum staffing levels of Health care professionals trained in CMR at health facility level:

District and Community Health Centres

All front-line staff to be trained in the SOPs – Doctors and Nurses and assistant clinical staff.
A GBV focal point will be identified for each health facility. Focal point for GBV and SV will be a Midwife, Senior Nurse or Nurse Manager at each rural health facility; and the Principal Clinical Nurse, Senior Nurse and Head of Unit (Doctor) for main hospitals, TTM and MT11.

Hospitals:

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

GBV/SV Focal Points:

Doctors of OB-GYN, Head Midwife, Registered nurses and enrolled nurses.
Emergency Room Doctor, Head Nurse
Head Nurse or Paediatrics Head of Unit (doctor)
Mental Health: Psychiatrist, Head Nurse, Counsellors, Social Workers
Public Health – Nurse managers, Senior nurses and Midwives in rural health districts. Doctors in district hospitals.
MCH/FP/STI Program Coordinators – Principal Nurses, Principal SRH and Senior Officer.
Samoa Family Health Association – Registered Nurses and assistants.
General Practitioners/Private Specialists
District Health Centre- Head Doctor and Head Nurse

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

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

Responsibilities and Accountabilities at each level of care

Facility level	Minimum Standards for medical management of survivors	Reporting/recording requirements for health facilities	Minimum staffing at health facilities
District Hospitals (DH) Community Health Centres (Savai'i and Upolu)	Manage injuries as possible Provide first-line support Identify GBV/SV Detailed history, general examination, documentation by GBV focal point (**excluding genital-anal examination**) Provide first doses of EC and STI treatment (and PEP if indicated) Refer direct and indirect child survivors to TTM Gynae clinic, MWCSD Child Protection/Case Management Officer for care and protection planning, SVSG for temporary shelter, if needed, for children and adults alike	Fill in Medical History and Examination Form and keep on file safely locked (if hard copy). Code Maintain a GBV and laboratory register - HIMS Refer to post rape care facility at hospital or counseling as indicated Follow up	Nurses/midwives trained as GBV focal points Doctors can do examination in District Hospital – if trained Refer to Ob/Gyn in TTM Refer for trauma counseling if needed to Mental Health services (TTM or DH if available)
Hospital facilities (where full post rape care facilities can provided) TTM	Manage injuries Detailed history, examination and documentation Refer genital-anal examination to Ob/Gyn (or Urology for male) Provide EC & STI prophylaxis/ treatment (and PEP if indicated) Provide counseling for trauma, HIV testing and PEP adherence Refer direct/indirect child survivors to MWCSD CPO	Fill in Medical Examination form and maintain GBV register Ensure follow up management of survivors Complete Forensic examination form for Public Safety unit and possible legal case	Medical doctor and nurses trained in clinical case management of rape (Ob/Gyn) Trained trauma counselor

FACILITY MINIMUM STANDARDS

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

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

The HCPs who do the triage and registering should be mindful of the **need to maintain confidentiality and privacy**. Survivors of violence should be prioritised and not be made to wait in public waiting rooms. At hospitals, survivors should be directed to the designated gynaecological room unless the patient is in a critical condition.

A **dedicated space** for survivors is critical for the provision of CMR. The dedicated space where survivors will be assessed must provide auditory and visual privacy. The space should be equipped in line with Psychological First Aid guidelines. The room should be provided with information on assessing the victims which includes job aids, copy of SOP, flow chart of both adult and child (female and male) survivor's pathways to be posted clearly on the wall.

Outer islands and hospitals

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

Health Centres and Hospitals

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

CMR KIT

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

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

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

Checklist of equipment, medicines and other supplies for examination and care of women subjected to violence

Examination equipment and laboratory products

- ☐ examination couch (with curtains or screen if needed for privacy)
- ☐ secure record storage cabinets
- ☐ light source (lamp or torch)
- ☐ speculum
- ☐ pregnancy testing kits
- ☐ rapid tests for HIV, syphilis
- ☐ urinanalysis kits
- ☐ test strips for vaginal infections
- ☐ forensic evidence collection kits (depending on forensic laboratory capability), including:
  - swabs & container for transporting swabs
  - microscope slides
  - blood tubes
  - urine specimen containers
  - sheets of paper(drop sheet)
  - paper bag
  - plastic bags for specimens
  - tweezers
  - scissors
  - comb
- ☐ digital camera to document injuries

Medicines

- ☐ supplies for wound care
- ☐ analgesics
- ☐ anti-emetics
- ☐ emergency contraception
- ☐ antiretroviral drugs for post-exposure prophylaxis for HIV prevention
- ☐ drugs for treatment or prophylaxis for sexually transmitted infection
- ☐ hepatitis B vaccination
- ☐ tetanus toxoid

Administrative supplies

- ☐ a protocol/SOP for care
- ☐ job aids (for example, flow charts, algorithms, pictograms)
- ☐ consent forms
- ☐ documentation forms (for example, medical intake forms, police forms for forensic evidence, medico-legal certificates)
- ☐ referral directory
- ☐ communication materials

Disposables

- ☐ sheets, blankets and towels
- ☐ in case the woman's clothes are soiled or torn or taken for evidence collection
- ☐ sanitary pads

Identifying violence: Raise the subject

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

Be alert and consider violence when…

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

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

Some examples of opening questions:

These questions are now a regular part of my consultations for female patients

I now ask these questions routinely because I have found that many of my female patients live with violence at home

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

Follow up with indirect questions

How is your relationship? or How much tension is there in your relationship?
Sometimes people we care about hurt us. Has that happened to you?

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

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

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

What to do if you suspect violence, but she doesn't disclose it:
• Do not pressure her. Give her time to decide what she wants to tell you • Tell her about services that are available if she chooses to use them • Offer information on the effects of violence on women's health and their children's health • Offer her a follow-up visit

Preparation for Clinical Care

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

- Health service providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by DV/IPV in order to improve diagnosis / identification and subsequent care[3].

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

- Asking women about violence must be linked to an effective response, which include a **PFA and first-line supportive response**, appropriate medical treatment and care and referral within the health system itself or externally.
- In Samoa it is found that sometimes survivors come with/or are brought by their family to the health centre with the aim to seek justice. However, it is important that the focus for the HCP is on the survivor's needs. The HCP's role is to provide healthcare and support to the survivor, through survivor-centered care.
- All child survivors must be referred to Police, MWCSD, Victim support and human services where necessary and the Paediatric Department of the Ministry of Health.
- When reporting over the radio - use codes (as developed for HIV) to maintain confidentiality. It is important that radio communication must be used with confidentiality, or else use telephone and emails.

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

Health Centres and Hospitals:
If the survivor is found to be medically stable, bring the patient to the dedicated space.

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

Apply PFA using first line approach to support and **address survivors' emotional, physical, safety and support needs** (Annex 1).

Establish informed consent by explaining confidentiality, available services and options[4]

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

LIVES
- Listen
- Inquire about needs and concerns
- Validate
- Enhance safety
- Support

Remember:
- Forcing or pressuring the survivor to answer questions or hurrying through the procedure can re-traumatize the survivor.
- Always present as calm and not rushed.
- Let the survivor stay in control.
- Avoid any distraction or interruptions.

Explain benefits of undertaking a comprehensive medical history and examination:
- For diagnostics and provision of adequate treatment
- To create a record of the incident that will be kept safe in a lockable filing cabinet or electronic system with copy provided to the survivor if requested
- To document the injuries in the event that survivor may decide to pursue criminal justice.

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

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

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

Additional care for physical health after sexual assault

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

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

First, ***L**isten, **I**nquire, **V**alidate* (first-line support). Then:

* Take a history and conduct the examination
* Treat any physical injuries
* Provide emergency contraception
* Prevent sexually transmitted infections (STIs)
* Prevent HIV
* Plan for self-care

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

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

Medical History

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

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

Components of Standardised Medical History

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

Components of Standardised Obstetric- Gynaecological History

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

Assess mental health status

Women experiencing violence should be assessed for mental health problems (symptoms of acute stress/Post-Traumatic Stress Disorder (PTSD), depression, alcohol and drug use problems, suicidality or self-harm) and be treated accordingly, using the mhGAP[5] intervention guide which covers WHO evidence-based clinical protocols for mental health problems. Mental health care should be delivered by health service providers with an understanding of violence against women.

- **If at risk – refer according to Samoa mental health protocols**

Information about the assault

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

Purpose of the interview

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

Good practice for interviewing survivors about the incidence

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

Consideration for Male Survivors (Men and Boys)

- Men and boys are often less likely to disclose – ask for gender preference of HCP.
- May be targeted in order to destroy their masculine identity.
- Men and boys are vulnerable in prisons.
- May be forced to witness or participate in sexual violence against others.

[5] The **mhGAP Intervention Guide** (**mhGAP**-IG) for mental, neurological and substance use disorders for non-specialist health settings, is a technical tool. See https://www.who.int/publications-detail/mhgap-intervention-guide---version-2.0

- The same procedures for obtaining consent, taking a history, conducting the physical examination (although the genital examination will be different) and ordering diagnostic laboratory tests should be followed for men and boys.
- Men and boys may be extra sensitive to touch.
- Refer to Urology or Medical or Surgical (Male Doctor/Male Nurse for initial assessment) departments, depending on injuries.

'Top-to-toe' Examination

The examination may be undertaken for urgent triage by nurses/midwives in community health centres and by medical doctors in the District Hospitals (if trained). Only medical doctors can write medical reports for court. Refer if non-urgent to TTM. Midwife, Senior Nurse or RN can do the initial assessment in rural health facilities before top to toe examination by the GBV/SV focal point. A doctor is accompanied by a Registered Nurse or Midwife or RN.

Good practice for top-to-toe examination

- A chaperone should accompany the HCP if the survivor prefers.
- Verbally confirm that the survivor is giving consent for each step of the examination. Allow withdrawal of consent.
- Assist survivor to maintain dignity, provide a sheet or gown.
- Practice universal precautions.
- Collection of specimens (swab for semen) during the course of the examination.
- Be systematic (head to toe; genital-anal by Ob/Gyn).
- Document everything thoroughly (use pictograms).

Step 1

- *General appearance and demeanour.*
- *If appropriate, start with the survivor's hands; this will reassure the survivor (note that male survivors may be extra sensitive to touch).*
- *Take the vital signs - pulse, blood pressure, respiration and temperature.*
- *Inspect both sides of both hands for injuries.*
- *Observe the wrists for signs of ligature marks.*

Step 2

- *Inspect the forearms for defence injuries. Defensive injuries include bruising, abrasions, lacerations or incised wounds.*
- *Bruising can be difficult to see, and thus tenderness and swelling is of great significance.*
- *Any intravenous puncture sites should be noted.*

Step 3

- *The inner surfaces of the upper arms and the armpit or axilla need to be carefully observed for signs of bruising.*
- *Survivors who have been restrained by hands may display fingertip bruising on upper arms.*
- *Note that when clothing has been pulled, red linear petechial bruising may be seen.*

Step 4

- *Inspect the face.*
- *Look in the nose for signs of bleeding.*
- *Gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising.*

- *The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa. Look for broken or missing teeth as a result of violence.*
- *Petechiae on the hard/ soft palate may indicate asphyxiation (penetration).*
- *Check for a torn frenulum and broken teeth. Collect an oral swab, if indicated.*

Step 5

- *Inspect the ears.*
- *Inspect area behind the ears (for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp).*
- *Use an otoscope to inspect the eardrum for rapture, bleeding /hematoma.*

Step 6

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

Step 7

- *The neck area is of great forensic interest as bruising on the neck can indicate a life-threatening assault.*
- *Imprint bruising may be seen from necklaces and other items of jewellery on the ears and on the neck.*
- *Suction-type bruising from bites should be noted.*

Step 8

- *The breasts and trunk should be examined with as much dignity and privacy as possible.*
- *Start with the back. It is possible to expose only the area that is being examined.*
- *The shoulders should be viewed separately.*
- *Subtle bruising and more obvious bruising may be seen in a variety of places on the back.*
- *Breasts are frequently a target of assault and are often bitten and so may reveal evidence of suction bruises or blunt trauma.*
- *If the breasts are not examined, the reasons for not doing so should be documented.*

Step 9

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

Step 10

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

Step 11

- *Examine the back of the legs with the survivor standing.*
- *The buttocks can be inspected with the survivor standing[6].*
- *Alternatively, the survivor may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock. The latter method may be the only option if the survivor is unsteady on her feet for any reason, but it does not afford such a good view of the area.*

Document

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

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

Genital-Anal Examination (Annex 5)

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

Consider language – adjust for cultural and age preferences. For example:
'I'm now going to have a careful look at your private parts/where babies come from/….'.
'I'm going to touch you [here] in order to look a bit more carefully'
'Please tell me if anything feels tender/is hurting'

Good Practice

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

[6]Use gown to maintain a feeling of privacy and dignity.

Step 1 - Female

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

Step 1 - Male

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

Step 2 -Female

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

Step 3 - <u>Speculum exam is to be undertaken at the Hospital only</u>

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

Step 4 Female/Male

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

Step 5 Female/Male

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

Injuries

Female genito-anal injuries related to penetration

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

Male genito-anal injuries related to sexual violence

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

Special considerations for male rape survivors

- Men and boys are also at risk of rape (see also Annex 6) and the role of health-care professionals is the same for male survivors, and first line support remains important care to provide (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 beyond his control.
- The physical examination can be sensitive for male survivors, and it is important to follow the general guidelines as above.

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

Treatment/prescriptions

Emergency contraception[7]

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

[7] *WHO Clinical Handbook for full details, pages 49-51*

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

Facts about emergency contraception pills

2 kinds of pills are commonly used for EC:

- **Levonorgestrel-only** works better and causes less nausea and vomiting than combined. referred dosage: 1.5 mg levonorgestrel in a single dose.
- **Combined estrogen-progestogen.** Use if levonorgestrel-only pills not available. Dosage: 2 doses of 100 µg ethinyl estradiol plus 0.5 mg levonorgestrel, 12 hours apart.

Any woman can take EC pills. There is no need to screen for health conditions or test for pregnancy.

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

Emergency contraception counseling points

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

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

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

Instructions

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

Emergency copper IUD

- Can be used for EC up to 5 days after unprotected intercourse.

- More effective than EC pills.
- The higher risk of STIs following rape should be considered if using a copper IUD.
- Good choice for very effective long-acting contraception if a woman is interested in the IUD and could be referred for it immediately.

Post-exposure prophylaxis for sexually transmitted infections[8]
Women survivors of sexual assault should be offered prophylaxis for the most common sexually transmitted infections and hepatitis B vaccine following national guidance.

HIV post-exposure prophylaxis
The prevalence of HIV is very low in Samoa, however clinicians may consider offering HIV post-exposure prophylaxis (PEP[9]) for survivors presenting within 72 hours of a sexual assault, if there are concerns about HIV status of perpetrator. Use shared decision-making with the survivor, to determine whether HIV PEP is appropriate and follow national guidelines for prophylaxis.

Forensic Evidence

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

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

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

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

Good Practice

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

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

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

Terminology for documenting injuries

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

[8] *WHO Clinical handbook for further details, section 2.3, pages 52-54*
[9] *WHO Clinical Handbook for further details, section 2.4, pages 55-57*

- The site of the contusion does not necessarily correspond with the impact point.
- Bleeding into soft tissue will follow fascial planes (i.e. battle sign, raccoon eyes).
- It can be difficult to see or demonstrate in dark-skinned individuals.
- If present, a contusion always indicates blunt force; however, blunt force may not always produce a contusion (i.e. severe internal abdominal damage following blunt force application, but with no external bruising.)

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

A **laceration** is a tear in tissue caused by blunt force such that the tissue is crushed, stretched, sheared, or avulsed. They commonly occur over bony prominences. They are characterized by strands of 'bridging' tissue within the wound depths.

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

Use detailed, objective medical language in your description.

Do:
- Position/ location (document in clock format)
- Negative findings (write intact or unremarkable)
- Describe all wounds in detail:
- T – Tear/Laceration
- E – Ecchymosis[10]
- A – Abrasion
- R – Redness
- S – Swelling

Do not
- Use abbreviations
- Draw lines – state "normal" or "not injured"
- Leave empty spaced
- Leave empty spaces

Safety Planning

A core aspect of CMR is to assist with the safety and security of the survivor. Safety planning is taking practical steps for identifying survivors in danger and implementing safety strategies before the violence escalates. **The violence often escalates when a survivor is seeking to leave the abuser.** The HCP assessing the survivor is responsible for discussing a plan to protect the survivor from further harm. See Annex 6 for specific child-centered approaches.

Assess survivor's safety and consider:

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

[10]Discoloration of the skin resulting from bleeding underneath.

Safety plan

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

Assess immediate risk of violence

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

Questions to help assess immediate risks

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

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

Safety planning

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

Safety Planning	
Identifying danger	What are the warning signs? When do you take action? (see Cycle of Violence[11])
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, phone numbers, keys, money, clothes, or other things with you when you leave?
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get access to money in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Reporting – Forms

- After obtaining consent (Annex 4), details about the alleged assault must be documented in specified forms (Annex 5).
- In instances where the Police supply a form, fill in the information needed accordingly.
- Forms should be signed by the HCP/Doctor who undertook the assessment.
- Keep the forms in a secure location in a locked cabinet or with a code if an electronic record.

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

Good Practice

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

Follow-up Care & Referrals

Referrals from other departments or NGOs:

Minimize the number of times that the survivor is asked to repeat her story as this can be retraumatizing for the survivor.

Police/Referring Department should share the report/statement to prevent a situation where the survivors have to repeat her story.

Treating Dr/HCP should review any information.

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

Good Practice

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

Referral (see Annex 7)

Maintaining confidentiality when referring a patient within the health system is critical. It is important that the safety of the patient is carefully considered when referring to other agencies and departments. Annex 7 provides contact details of agencies for referral. A number of accommodation and support services are available in Samoa for survivors, and women should be consulted about their views for appropriate referrals.

The Ministry of Women, Community and Social Development (MWCSD) core function is to serve the public in regard to domestic issues, especially those related to social and cultural affairs. The MWCSD is the mandated government agency to develop national strategy, policies and actions to prevent and respond to all forms of GBV in the communities both in emergency and non-emergency situations. The MWCSD co-ordinate the Inter-agency Taskforce on Prevention of/Responding to GBV Policy/strategy development, early intervention and case management, monitoring and evaluation of the IESG for responding to GBV.

Church and Faith based organisations and district /village groups are increasingly engaging in GBV work: around prevention and early intervention activities, spiritual empowerment, imposing village rules especially around domestic violence, providing psychological first aid, counselling and support.

Other NGOs provide services that health workers need to understand in order to refer appropriately. The Samoa Victim Support Group has a Child Protection policy 2019 revised version to assist victims of crime by providing integrated, personalized and professional service to ensure that they are supported to be safe and in control of restoring their lives, through quality services. SVSG is the main temporary shelter service provider in Samoa, however, in cases involving children it is important that temporary shelter should be the last resort. Family and community-based solutions should be considered first and all other options exhausted.

The SVSG mission is to be recognized as the leading community organization in Samoa that:

- provides access to an integrated, personalized and professional service to all survivors of crime and those in need;
- advocates for the rights and interests of survivors of crimes and those in need;
- supports those at risk of becoming victims of crime;.
- advocates for violence free families and communities;
- provides safe and secure shelters for survivors;
- champions the interests and rights of persons with disabilities;

The Police are important to have as an ally, in particular the Domestic Violence Unit (DVU) who act as focal points for GBV within the Police. The DVU ensures the safety and security of the survivor and have a clear role in the pathway to perform their specific responsibilities: prevention, enforcement, rehabilitation and reintegration, training of human resources and developing policies to support continuous learning/skills development for staff.

The Ministry of Health and the Police Force should meet regularly to review practices and coordinate interventions. The MOH can support joint capacity development by including Police in basic GBV and SV training. It may be useful to set up a Taskforce for the SOP on GBV made of relevant senior officials.

Health Information System

It is important to record the prevalence of GBV and SV seen by all health facilities including TTM hospital without breaking confidentiality. A coding system is developed to report GBV and SV cases that are reported to health facilities. These information are captured in the Tupaia app to generate reports for decision making and further recommendation.
The information recorded during GBV/SV patient's consultation must be recorded in the prescribed forms or input in the Tupaia app. This will also include treatments provided to the patient and further referral to relevant social services as it relates to the Referral Pathway in this SOP.

The ICD coding must be recorded on the victim's hospital record, in order for DHS to track costs associated with medical treatment of survivors of violence. ICD Code T74 is used for confirmed adult and child abuse, neglect and other maltreatment. ICD Code T76 is used for suspected adult and child abuse, neglect and other maltreatment.

The health facility GBV/SV focal person must fill information related to the patient for further referral. It is reflected from the Refferal Pathway that patient should be referred to the Mental health and psychosocial services for further follow up and assessment once discharged from the hospital.

A note must be made on the victim's hospital record/ medical file that the attendance at the health facility site is the result of an incident of violence as well as if a *GBV/ Sexual Violence / Child Abuse Medical Examination and Treatment Form* (as required) are completed and who these have been referred to. Reports from GBV/SV will be aggregated by sex, age, district, etc. as reflected in the Medical history and Examination form for Sexual assault. Reports are generated on monthly or quarterly basis.

The HIS template includes number of GBV/SV cases reported to health facilities and to be categorised as "Physical violence" and "sexual violence". This will be collected on quarterly basis by the HIS, M&E division.

Glossary of Terms

Child	In accordance with the Convention on the Rights of the Child a "child" is defined as a person below the age of 18 years.
Gender[12]	Refers to the socially constructed characteristics of women and men–such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed. The concept of gender includes five important elements: relational, hierarchical, historical, contextual and institutional. While most people are born either male or female, they are taught appropriate norms and behaviours – including how they should interact with others of the same or opposite sex within households, communities and workplaces. When individuals or groups do not "fit" established gender norms they often face stigma, discriminatory practices or social exclusion–all of which adversely affect health. It is important to be sensitive to different identities that do not necessarily fit into binary male or female sex categories.
Gender equality[13]	Refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration – recognizing the diversity of different groups of women and men. Gender equality is not a 'women's issue' but should concern and fully engage men as well as women. Equality between women and men is seen both as a human rights issue and as a precondition for, and indicator of, sustainable people-centered development. Gender inequality therefore refers to the absence of such rights, responsibilities and opportunities.
Gender-based violence[14]	An umbrella term for any harmful act that is perpetrated against a person's will; it is based on socially ascribed (gender) differences between male and female. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.
Informed consent	This means explaining all aspects of the examination to the patient in a manner they can fully understand. Particular emphasis should be placed on the matter of the release of information to other parties, including the police and other parties. This is especially important in settings where there is a legal obligation to report an episode of violence (and hence details of the examination) to relevant authorities. It is crucial that patients and parent/caregivers understand the options open to them and are given sufficient information to enable them to make informed decisions about their care. This is a fundamental right of all patients but

[12] Gender Fact sheet N°403 August 2015 http://www.who.int/mediacentre/factsheets/fs403/en/ accessed 11, May 2017
13 Gender mainstreaming: strategy for promoting gender equality. Office of the Special Advisor on Gender Issues and Advancement of Women (OSAGI); 2001 (http://www.un.org/ womenwatch/osagi/pdf/factsheet1.pdf, accessed 11, May 2017)
14 Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery IASC Inter-Agency Standing Committee 2015
(https://interagencystandingcommittee.org/working-group/documents-public/guidelines-integrating-gender-based-violence-interventions accessed 11 May 2017)

	has particular relevance in this setting where patients may have been subjected to a personal and intrusive event against their will. It is also important to ensure that a patient has a sense of control returned to them when in medical care. Above all, the wishes of the patient must be respected (WHO 2003).
Perpetrator	A person who directly inflicts or supports violence or other abuse inflicted on another against her/his will.
Psychological first aid (PFA)	A set of skills that helps someone to provide basic stabilizing psychological support in the aftermath of a traumatic event.
Sexual Assault	The term sexual assault refers to sexual contact or behaviour that occurs without explicit consent of the victim. Some forms of sexual assault include: • Attempted rape • Fondling or unwanted sexual touching • Forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body Penetration of the victim's body, also known as rape
Sexual violence	Any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object**.**
Sexual Violence	Sexual violence is defined as: any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats – for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is sought. It may also occur when the person aggressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation. Sexual violence includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus.
Survivor/victim	Survivor/victim refers to people who have experienced/are affected by violence. The term survivor is usually preferred by those working on violence against women to emphasize that women affected by violence have agency and are not merely passive "victims" in the face of violence. The term victim is, however, used in criminal justice. For the purposes of this document, they are used interchangeably.

Language – Translation into Local Languages

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

Glossary	Translation
Anal/anus	Alā feau
Breasts	Susu
Clitoris	Kitolisi o le tamaita'i (fatu pi)
Confidentiality	Malupuipuia ma saogalemu faamatalaga
Hymen	Afuafu o le alafanau o le tamaitai
Informed consent	Maliega fa'amauina/tusitusia
Labia	Laukapipi (vaega pito i fafo o le totoga sa o le tamaitai)
Masturbation, touching sex organs	Fufu poo le tago pe pa'i i vaega o totoga (lotelote totoga sa)
Oral penetration by penis	Feusuaiga e faaoga ai le gutu
Penetration of rectum by object	Faaogaina o se mea faitino e tui/momono i Itotonu o le ala feau
Penetration of rectum by penis/finger	Faaaogaina o le poti poo le tamatama'ilima e momono I totonu o le alafeau
Penetration of vagina by object	Faaaogaina o se mea faitino e momono I le ala fanau
Penetration of vagina by penis/finger	Faaaogaina o le poti/pi a le alii/ tamatama'ilima e momono I le ala fanau
Penis	Poti (pi a le alii poo le tama)
Rape	Faamalosi e fai se feusuaiga Feusuaiga fai faamalosi (toso teine)
Scrotum	Fua polo/polo
Sexual assault	Aafiaga o le soifua ini faiga faamalosi. Faao'olima mataga e ala I feusuaiga
Testicle	Fuamiti (fua fanau o le alii)
Vagina	Ala fanau

ANNEXES

Annex 1: Psychological First Aid Fact Sheet

Annex 2: What is first-line support? (LIVES)

Annex 3: Pathway for initial care after assault

Annex 4: Consent Form

Annex 5: Medical History and Examination Form for Sexual Assault

Annex 6: Responding to Direct and Indirect Child Survivors of SV/GBV (UNICEF)

Annex 7: Gender based violence referral contacts

Annex 8: Role of health care professionals for GBV in Emergencies

Annex 1: Psychological First Aid for Health care professionals

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

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

PFA is NOT

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

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

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

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

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

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

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

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

- Ask the person in distress if you can help and move to a quiet space to protect their privacy. If the woman is with her partner, talk to her alone in case she is experiencing intimate partner violence (IPV). Prioritize her safety and security always.
- Offer basic immediate comforts like tissue, water, or a blanket.
- Put all of your focus on the person. Clear your mind of judgments and assumptions, especially in cases of gender-based violence.
- Don’t rush to talk or start interviewing the person. Sit quietly with the person.

  - If you know the situation you can refer to it. For example, experiencing violence can be a terrifying and stressful experience. How are you coping?
  - If you don't know the situation, you can state your concerns and invite the person to tell you their needs. For example, I have seen you are not yourself, you look sad and worried. Is there something I can help with?
- Use appropriate body language (relaxed posture, lean in slightly, face the survivor, open arms, soft eye contact).
- Ask only necessary questions.
- Use "encouragers" like nodding your head, saying I see or go on.
- Use silence to allow the person space to think and talk.

- Use comforting statements like:
  - You are not alone. Other people have experienced this too.
  - You are doing your best. You had a terrible situation and you tried to make the best decision you could.
  - Many people who have this experience feel like you do. This is a common reaction to what happened.

- If listening to a GBV survivor, provide immediate emotional comfort. Tell the survivor it is not her fault. Believe her.
- Identify high-risk cases.

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

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

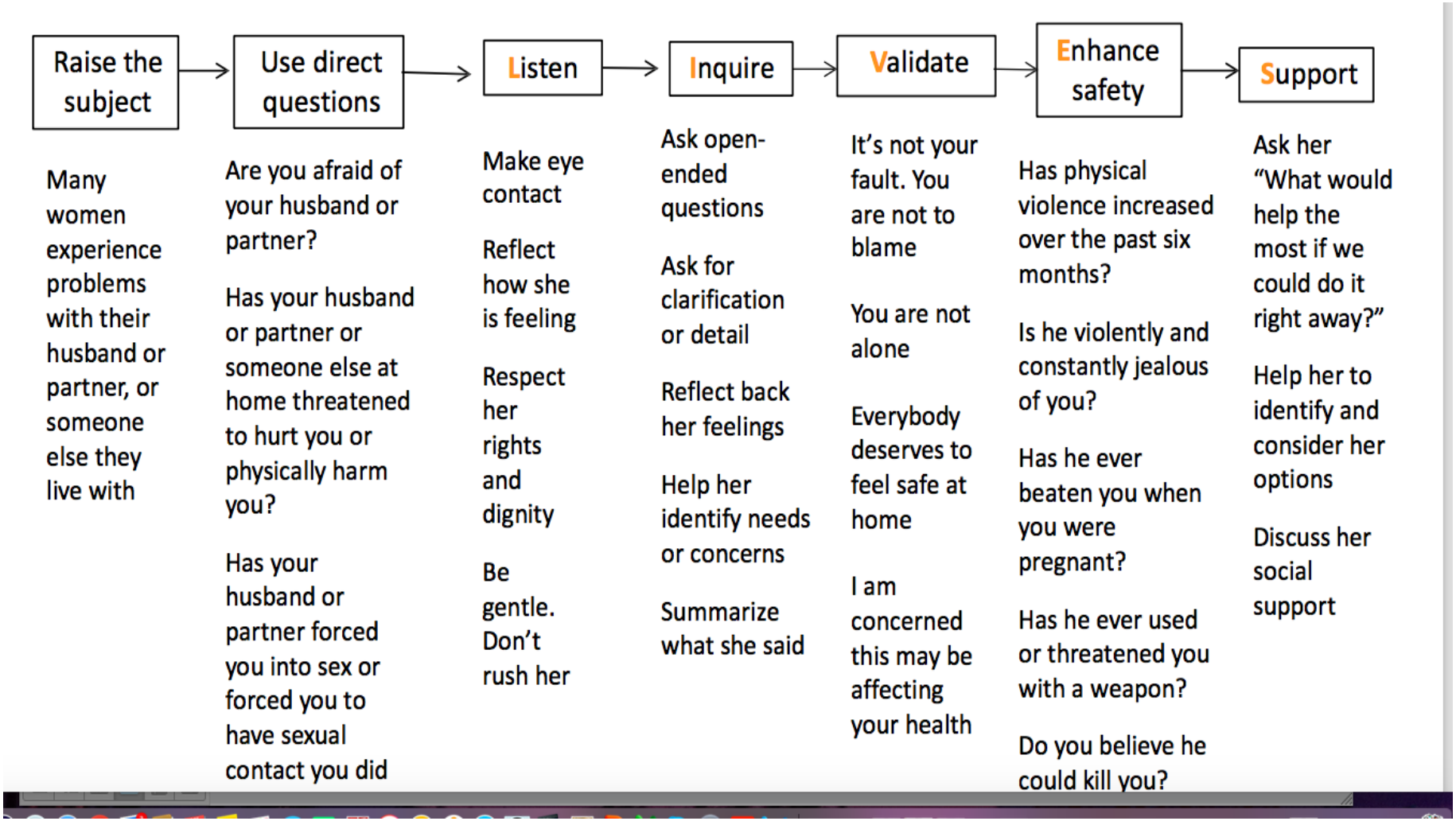
- Connecting people with others- community, friends, family, religious leaders, volunteers, recreational or educational groups, livelihood programs.
  Linking those in crisis to the appropriate tools can build their resilience to recover from negative events and resume normal life.

For more information about PFA refer to the following resources:

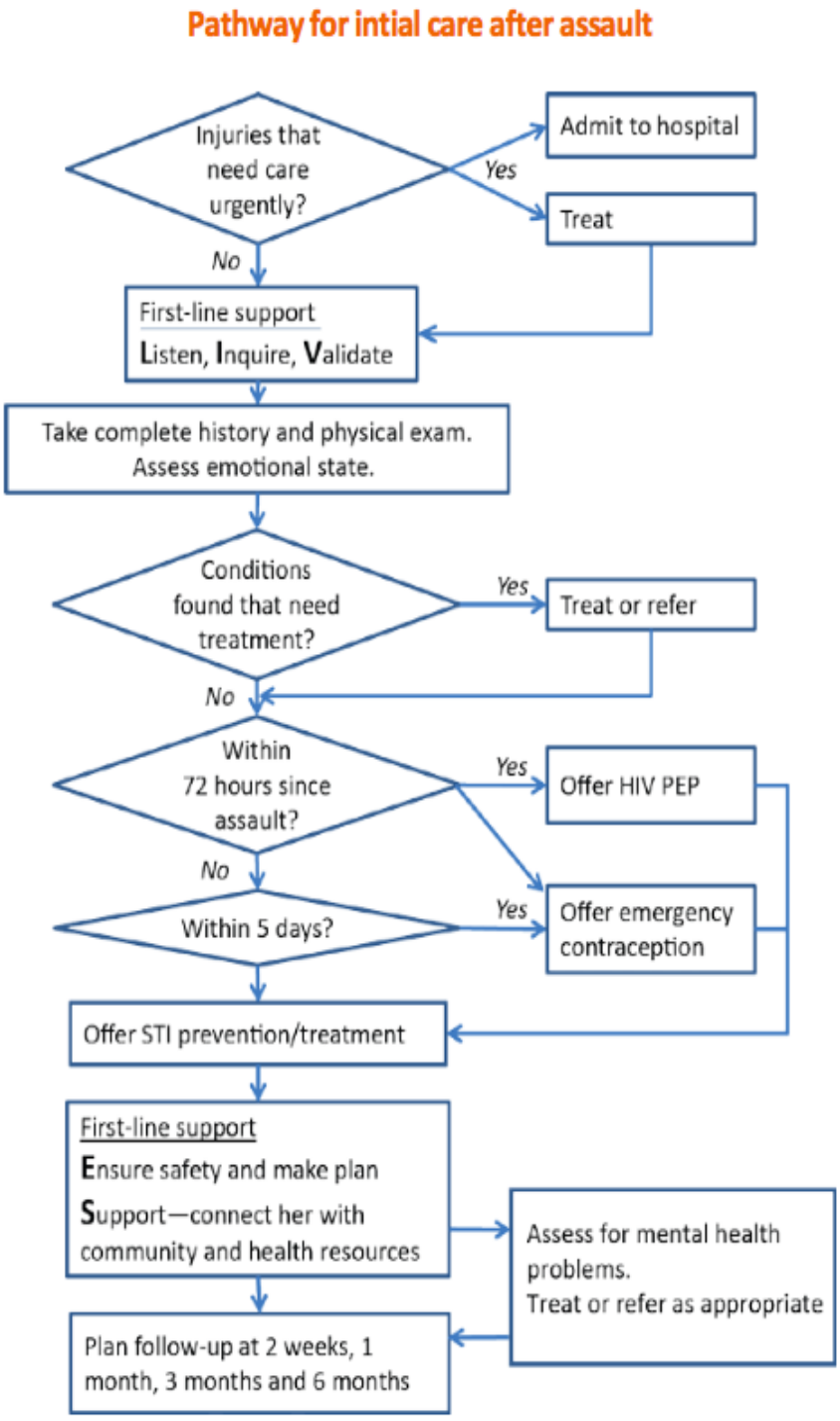
Psychological First Aid: Guide for Field Workers. 2011. *WHO, War Trauma Foundation and World Vision International* http://www.who.int/mental_health/publications/guide_field_workers/en/

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

Annex 2: What is first-line support? LIVES



Annex 3: Pathway for initial care after assault



Annex 4: Consent

Name of facility -

Note to the health worker:

After providing the relevant information to the patient as explained on page 40 (notes on copleting the consent form), read the entire form to the patient (or his/her parent/guardian), explaining that she can choose to refuse any (or none) of the items listed. Obtain a signature, or a thumb print with signature of a witness.

I, - , (print name of survivor)

authorize the above-named health facility to perform the following (tick the appropriate boxes):

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

I understand that I can refuse any aspect of the examination I don't wish to undergo.

Signature: -

Date: -

Witness: -

Annex 5: Medical History and Examination Form for Sexual Assault

CONFIDENTIAL **CODE:**

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

1. GENERAL INFORMATION

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

2. GENERAL MEDICAL INFORMATION

Existing health problems
Do you have any ongoing health problems? ☐Yes ☐No If "yes", what health problems?
Do you have any allergies? If so, to what?
Are you taking any medicines, herbs or potions?
Vaccination status
Have you been vaccinated for: tetanus? ☐Yes When? _____ / _____ / _____ DD MM YY

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

3. DESCRIPTION OF INCIDENT

Date of incident: _____ / _____ / ____ DD MM YY	**Time of incident:**
Could you tell me what happened, please? Has something like this happened before? ☐Yes ☐No If "yes": When was that? _____ / _____ / ____ DD MM YY Was the same person responsible this time? ☐ Yes ☐ No	

Physical violence	**Describe type and location on body charts**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	
Drugs/alcohol involved	

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

Actions after assault

After this happened, did you

Vomit?	☐ Yes	☐ No
Urinate?	☐ Yes	☐ No
Defecate?	☐ Yes	☐ No
Brush your teeth?	☐ Yes	☐ No
Rinse your mouth?	☐ Yes	☐ No
Change your clothes?	☐ Yes	☐ No
Wash or bathe?	☐ Yes	☐ No
Use a tampon or pad?	☐ Yes	☐ No

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method? ☐ IUCD ☐Pill ☐Injectable ☐ Implant ☐ Sterilization ☐ Condom ☐ Other _____
Were you using this method when the incident happened? ☐Yes ☐No
Menstruation and pregnancy
When did your last menstrual bleeding start? __ / ___ / __ DD MM YY Were you menstruating at the time of event? ☐Yes ☐No

Do you think you might be pregnant?☐Yes ☐No If “yes”, number of weeks pregnant: ____ weeks
Have you ever been pregnant? ☐Yes ☐No If “yes”, how many times? _____ times
History of consenting intercourse (only if samples taken for DNA analysis in assault case)
When was the last time you had sex willingly? ____ / ___ / ____DD MM YY Who was it? (for example, husband, boyfriend, stranger)

5. HEAD-TO-TOE PHYSICAL EXAMINATION

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

Eyes and ears	Neck
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

6. GENITAL AND ANAL EXAMINATION

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

7. MENTAL STATE

1. Appearance	☐ casual dress, normal grooming and hygiene ☐ other (describe):	
2. Attitude	☐ calm and cooperative ☐ other (describe):	
3. Behavior	☐ no unusual movements or psychomotor changes ☐ other (describe):	
4. Speech	☐ normal rate/tone/volume w/out pressure ☐ other (describe):	
5. Affect	☐ reactive and mood congruent ☐ normal range ☐ labile tearful blunted	☐ depressed constricted flat ☐ other (describe):
6. Mood	☐ euthymic ☐ anxious ☐ irritable elevated	☐ depressed ☐ other (describe):
7. Thought Processes	☐ goal-directed and logical ☐ disorganized	☐ other (describe):
8. Thought Content	☐ delusions phobias ☐ obsessions/ compulsions	☐ other (describe):
9. Perception	☐ no hallucinations or delusions during interview ☐ other (describe):	
10. Orientation	Oriented: ☐ time ☐ place ☐ person	☐ self ☐ other (describe):

Self harm risk:	
Ask: Have you had thoughts about hurting yourself?	☐ Yes ☐ No
Ask if they have any plans on when, where and how they intend to harm themselves?	
Ask for Any history of self harm? If yes-when? what method? premeditated? Intention?	
Risk of self harm	☐ Low ☐ Moderate ☐ High

Aggression/violence risk:	
Has the individual made threats? Against whom?	
Is the patient hostile or angry?	☐ Yes ☐ No
Does the individual carry a weapon?	☐ Yes ☐ No
Thoughts of violence	☐ Yes ☐ No
Risks of harm to others	☐ Low ☐ Moderate ☐ High

11. Memory/ Concentration	☐ short term intact ☐ long term intact ☐ distractable/ inattentive	☐ other (describe):
12. Insight/Judgement	☐ good ☐ fair ☐ poor	

Acute stress/PTSD risk	
Are you distressed by certain places, people, situations etc that remind you of the incident?	☐ Yes ☐ No
Are there bad thoughts or memories or dreams that keep coming back?	☐ Yes ☐ No
Are you seeing the event over and over in your mind?	☐ Yes ☐ No
Avoiding thoughts, feelings, or conversations about the incident	☐ Yes ☐ No
Avoiding activities and places or people who remind you of it	☐ Yes ☐ No
Irritability or outbursts of anger	☐ Yes ☐ No
Reckless or self-destructive behavior	☐ Yes ☐ No
Problems concentrating	☐ Yes ☐ No
Feeling on guard	☐ Yes ☐ No
Easily startled?	☐ Yes ☐ No
Problems sleeping	☐ Yes ☐ No

8. INVESTIGATIONS DONE

Type and location	Examined / sent to laboratory	Result

9. EVIDENCE TAKEN

Type and location	Sent to / stored	Collected by / date

10. TREATMENTS PRESCRIBED

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

11. COUNSELLING, REFERRALS, FOLLOW-UP

<table>
<tr><td colspan="2">Client plans to report to police OR has already made report?

☐Yes ☐No</td></tr>
<tr><td>Client has a safe place to go?
☐Yes ☐No</td><td>Has someone to accompany her/him?

☐Yes ☐No</td></tr>
<tr><td colspan="2">Counselling provided:</td></tr>
<tr><td colspan="2">Referrals made (for example, housing, mental health care, support group):

To: Purpose:</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Follow-up agreed with client? ☐Yes ☐No

Date of next visit: _____ / _____ / _____ DD MM YY</td></tr>
</table>

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

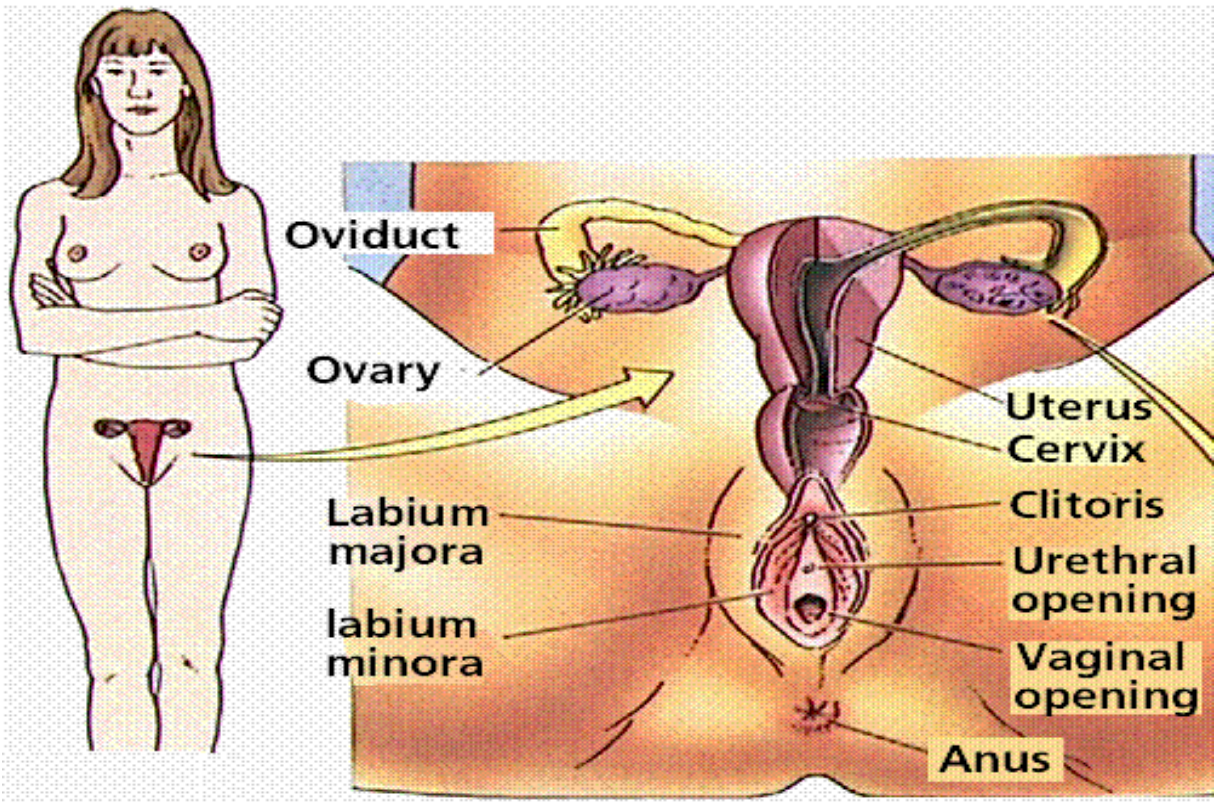
Title: _____

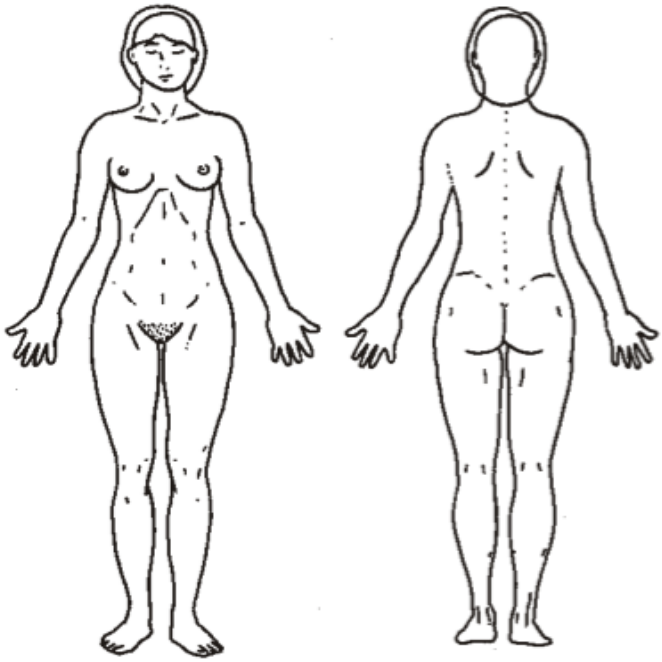
Printed name: _____

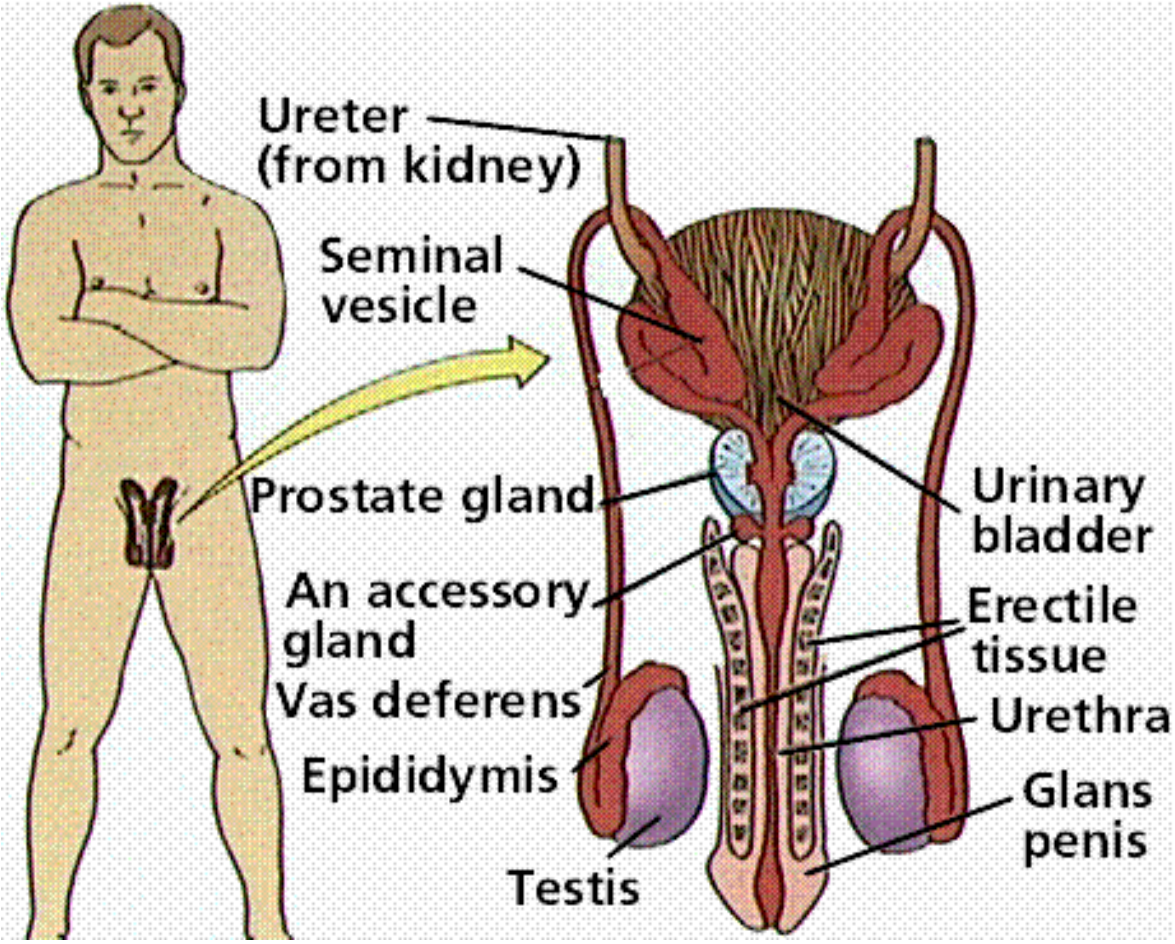
Signature: _____

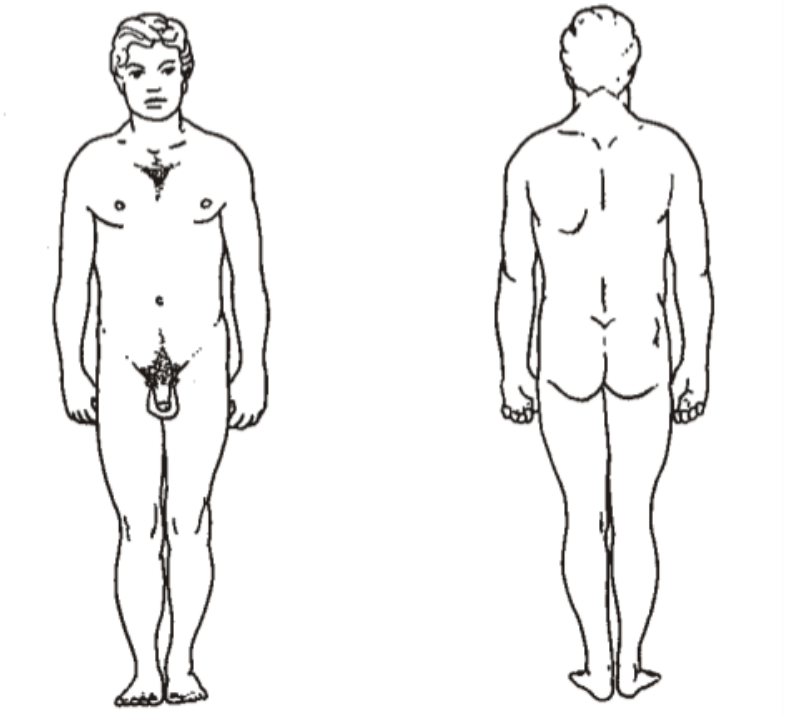
Date: _____ / _____ / _____

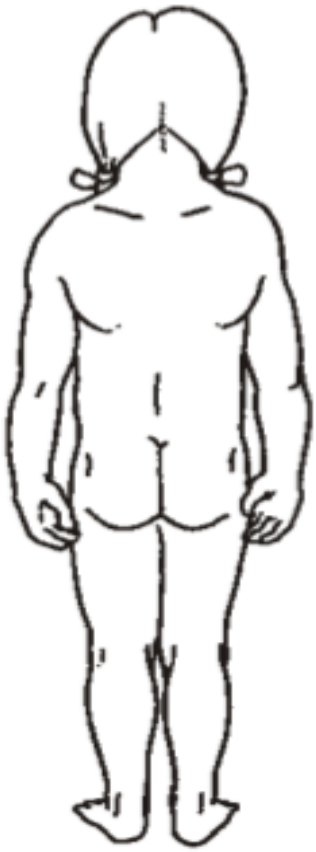
DD MM YY

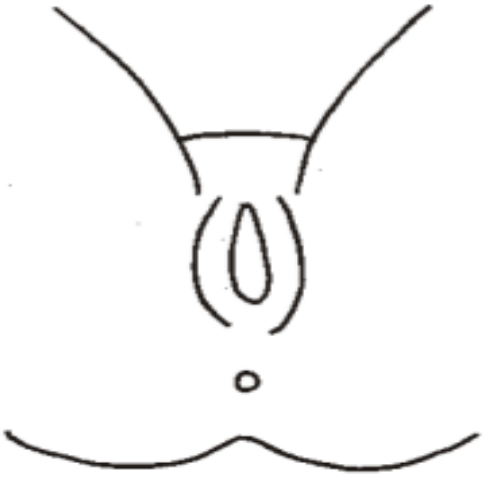

Oviduct
Ovary
Uterus
Cervix
Clitoris
Labium majora
Urethral opening
labium minora
Vaginal opening
Anus

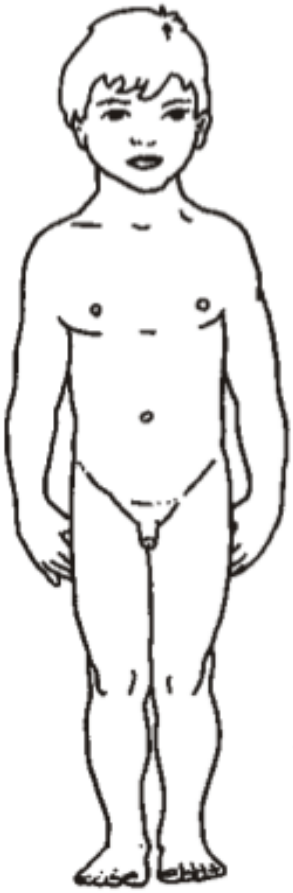


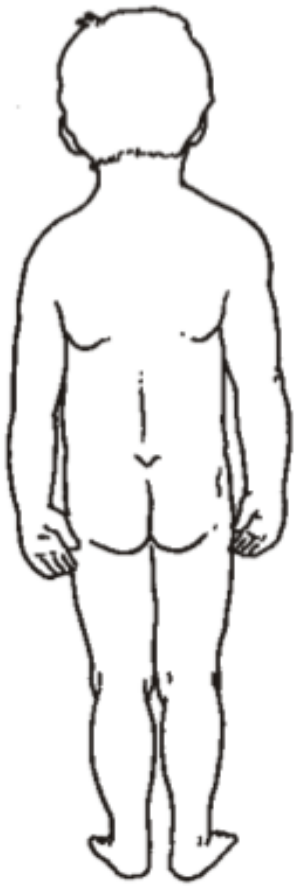

Ureter
(from kidney)
Seminal
vesicle
Prostate gland
An accessory
gland
Vas deferens
Epididymis
Testis
Urinary
bladder
Erectile
tissue
Urethra
Glans
penis

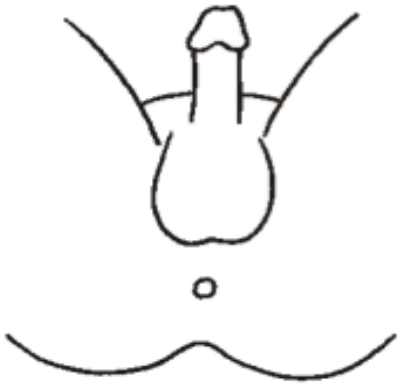












Annex 6: Responding to Direct or Indirect child survivors

There is a strong correlation between violence perpetrated against children and violence perpetrated against adult women in the home.[15] Gender-based violence (GBV) affects children, either directly through experiencing sexual violence, or physical or emotional abuse from an intimate partner or household member, or oftentimes indirectly through the witnessing of domestic violence (DV) between parents, or between a parent and her/his partner. In other instances, children may be the direct inadvertent recipients of GBV, such as being beaten when attempting to protect/shield their family members from abuse. Under the UN Convention on the Rights of the Children (UNCRC), Governments and their officers have a special responsibility to protect children from all forms of violence, to support parents in their child-rearing responsibilities, and to intervene to protect children when they are at risk of or have experienced harm (Articles 19, UNCRC). Any child who witnesses GBV is exposed to ***emotional abuse***, which has lasting adverse impacts on girls' and boys' mental health and overall well-being. ***Child survivors, by virtue of their age and vulnerability, require specialised treatment and support, different from adult survivors.***

Health workers are most likely to be the first point of contact for a child[16], female or male, who has experienced abuse or neglect either directly or indirectly as a result of a GBV/Sexual Violence (SV)/DV incident. A health worker may learn of a girl or boy who has been abused or neglected in many ways:

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

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

- ✓ First and foremost, take the necessary steps to ensure the child's safety; for example, separating or preventing direct contact between the child and the alleged perpetrator of child abuse; ensuring the child/adolescent is accompanied by a safe and trusted adult; contacting the police for assistance etc.
- ✓ Provide child-sensitive medical treatment for injuries and any follow up medical care needed
- ✓ Report or refer any child suspected of, or known to have, experienced child abuse or neglect to the Child Protection authority under the MWCSD.
- ✓ Where necessary for an investigation and likely to result in evidence, conduct a child-sensitive forensic medical examination, collect forensic evidence, prepare a medical report, and testify in court as needed.
- ✓ In all their actions, health workers are to ensure that the best interests of the child/adolescent takes priority.[17]

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

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

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

Health workers can incorporate open-ended screening questions[18] when completing intake processes with children and adolescents. When you are asking a child about something that could be awkward, uncomfortable, embarrassing, shameful, or sensitive, **open-ended questions** give you the best chance of getting the whole story. For example – "I notice that you have a bruise. How did it happen?" … "Tell me more about that"; or "You seem to get angry when I asked you that question…then pause to allow child to respond."

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

Physical Abuse:

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

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

Sexual Abuse:

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

Neglect:

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

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

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

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

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

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

- Maximize efforts to have the child undergo only one examination in order to minimize trauma.
- Offer a choice in the sex of the examiner, whenever possible.
- Conduct the history and medical examination in a room that is safe, private, quiet, and child-friendly.
- Make sure that there is another safe adult present during the examination.
- Allow the child to choose who is present in the room whenever possible. Ensure that the adult support person is not a witness to the abuse, the alleged perpetrator or a person who is sympathetic to the alleged perpetrator.
- Minimize the need for the child to repeatedly describe the incident, as this can be re-traumatizing. Limit questions to what is required for medical care. Where possible, obtain details of the child abuse incident from the police other service providers involved in the case, or the accompanying

parent/caregiver/adult, rather than having the child repeat what happened to her/him multiple times to different people

- Use language and terminology that is appropriate to the child's age, developmental stage and that is non-stigmatizing. Reassure the child they are not to blame for their experience of abuse or neglect.
- Clearly explain confidentiality and any limitations, including the mandatory reporting requirement for health workers who become aware of a situation or act which may amount to child neglect, abuse, maltreatment and exploitation. Explain that the health worker is obligated to share with the child protection authority (MWCSD) information that will facilitate an investigation and identify perpetrators or victims of child neglect, abuse, maltreatment and exploitation.[19]
- Respect the wishes of children (e.g. not forcing them to give information or be examined) while balancing this with the need to protect their best interests and safety. In situations where a child's wishes cannot be prioritized, the reasons should be explained to the child before further steps are taken.
- Seek informed consent from the child or their non-offending parent/caregiver as appropriate. If the child is under the legal age of consent for obtaining clinical care, it is still best to seek their "assent" by explaining the procedure and why it is needed, in simple child-friendly terms, and seeking the child's permission. In situations where a child's wishes cannot be prioritized, the reasons should be explained to the child.
- If parents/caregivers refuse any required preventive or necessary medical exam and treatment for their child, regardless of their religious and moral beliefs, recourse may be made to a court to order the parents/caregivers to provide the child with the required treatment.[20]
- Conduct a comprehensive assessment of the child's physical and emotional health in order to facilitate appropriate treatment and/or referrals.
- During the examination, explain what will be done in child-friendly language and prior to each step.
- Demonstrate trustworthiness by following through on anything told to the child or caregiver and providing emotional support.
- Minimize delays while conducting the examination in accordance with the child's wishes (for example, not rushing the child through the examination).
- Clearly explain what to expect after the exam and provide instructions for follow-up.

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

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

[19] Refer to the IESG

[20] Refer to the IESG

Annex 7: Referral Contacts

Services provided	Who to refer to Location	Contact Info	Responsibility to follow-up
Shelter/housing Social welfare case management	Samoa Victim Support Group	Email: svsginsamoa@gmail.com Telephone 685 – 27904, 685 -25392	Samoa Victim Support Group Ministry for Women, Community and Social Development. (MWCSD)
	Ministry of Women, Community and Social Development	MWCSD Tooa Salamasina Community Center, Sogi Apia Telephone: 685 27752 Facsmile: 685 23639 Email: mwcsd@mwcsd.gov.ws	
	Ministry of Police & Prisons	Domestic Violence Unit, Telephone 22222 Ext 150	
Crisis Center	Ministry of Justice, Courts and Administration	Ministry of Justice, Courts and Administration, Apia Samoa Telephone: 685 22671, 22672, 22673 Email: mjca.gov.ws Website: www.mjca.gov.ws	MWSCD
Rehabilitation and Probation services	Ministry of Justice, Courts and Administration	Ministry of Justice, Courts and Administration, Apia Samoa Telephone: 685 22671, 22672, 22673 Email: mjca.gov.ws Website: www.mjca.gov.ws	MWSCD
Financial Aid	Samoa Victim Support Apia	Email: svsginsamoa@gmail.com Telephone 685 – 27904, 685 -25392	MWCSD
Legal Aid	Ministry of Justice, Courts and Administration	Ministry of Justice, Courts and Administration, Apia Samoa Telephone: 685 22671, 22672, 22673 Email: mjca.gov.ws Website: www.mjca.gov.ws	MOPP, MWCSD
Support Groups	Samoa Family Health Association Motootua, Apia	Email: info@sfha.ws Phone number : 685 26929	MoH, SFHA, SVSG
	Samoa Victim Support Group	Email: svsginsamoa@gmail.com	

		Telephone 685 – 27904, 685 -25392	
Counseling	Ministry of Health, Apia - Mental Health & Psychosocial services - Doctors and Nurses Case Management/Child Protection Unit, Division for Social Development	Ministry of Health, Moto'otua, Apia Samoa Telephone 21212 Mental Health Services Ext. 602 & 603 Ministry of Women, Community and Social Development, Tooa Salamasina Community Center, Sogi Apia Telephone: 685 27752, 27753	MOH, Ministry of Police and Prison (MoPP) - MoH
Mental Health Care	Ministry of Health, Mental Health and Psychosocial Services	Email: @health.gov.ws Ministry of Health, Moto'otua, Apia Samoa Telephone 21212 Ext. 602 & 603	MoH
Primary Care	Ministry of Health, Public Health Services in rural facilities	Public Health Facilities in urban and rural areas Main contact number: 21212 and 68100	Ministry of Health, Public Health Services in rural facilities
Child Care	Ministry for Women, Community and Social Development.	Ministry of Women, Community and Social Development, Tooa Salamasina Community Center, Sogi Apia Samoa Telephone: 685 2772, 2773	MWCSD, MOH, MoP
	Samoa Victim Support, Apia	Email: svsginsamoa@gmail.com Telephone 685 – 27904, 685 -25392	SVSG, MOPP, MoH

Annex: 8 Role of health care professionals for GBV in emergencies

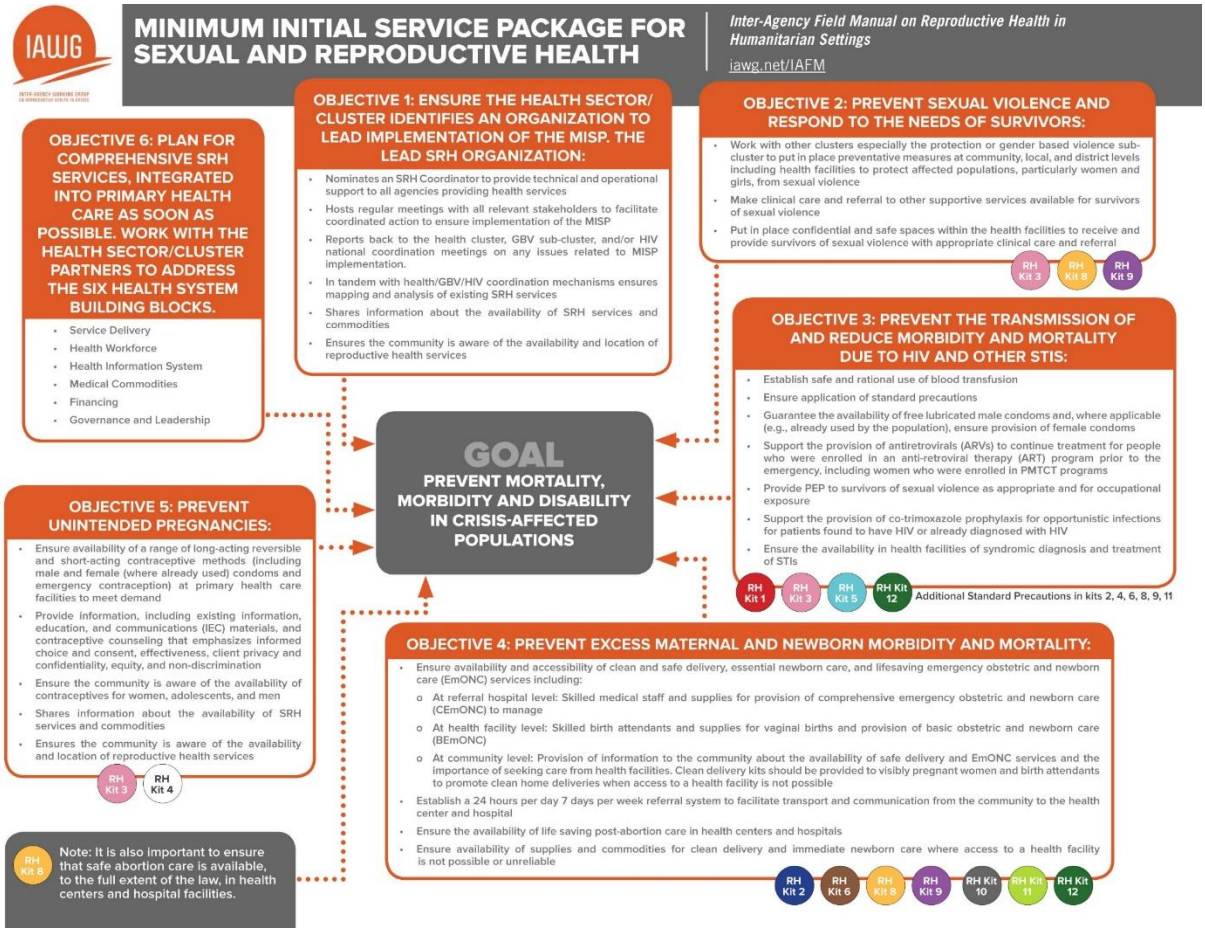
This Annex provides supplementary information for health workers to consider in providing clinical and medical care to GBV survivors during humanitarian situations.

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

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

2. MISP Cheat Sheet https://cdn.iawg.rygn.io/documents/MISP-Reference-English.pdf?mtime=20200322131753&focal=none

   Health providers can use this quick reference tool to recall the minimum actions required to prevent sexual violence and respond to the needs of survivors as contained in Objective 2 of MISP. The "cheat sheet" also highlights the importance of ensuring availability of RH Kit 3 (Post Rape Treatment Kit), RH Kit 8 (Management of Complications of Miscarriage and Abortion), and RH Kit 9 (Repair of Cervical and Vaginal Tears).

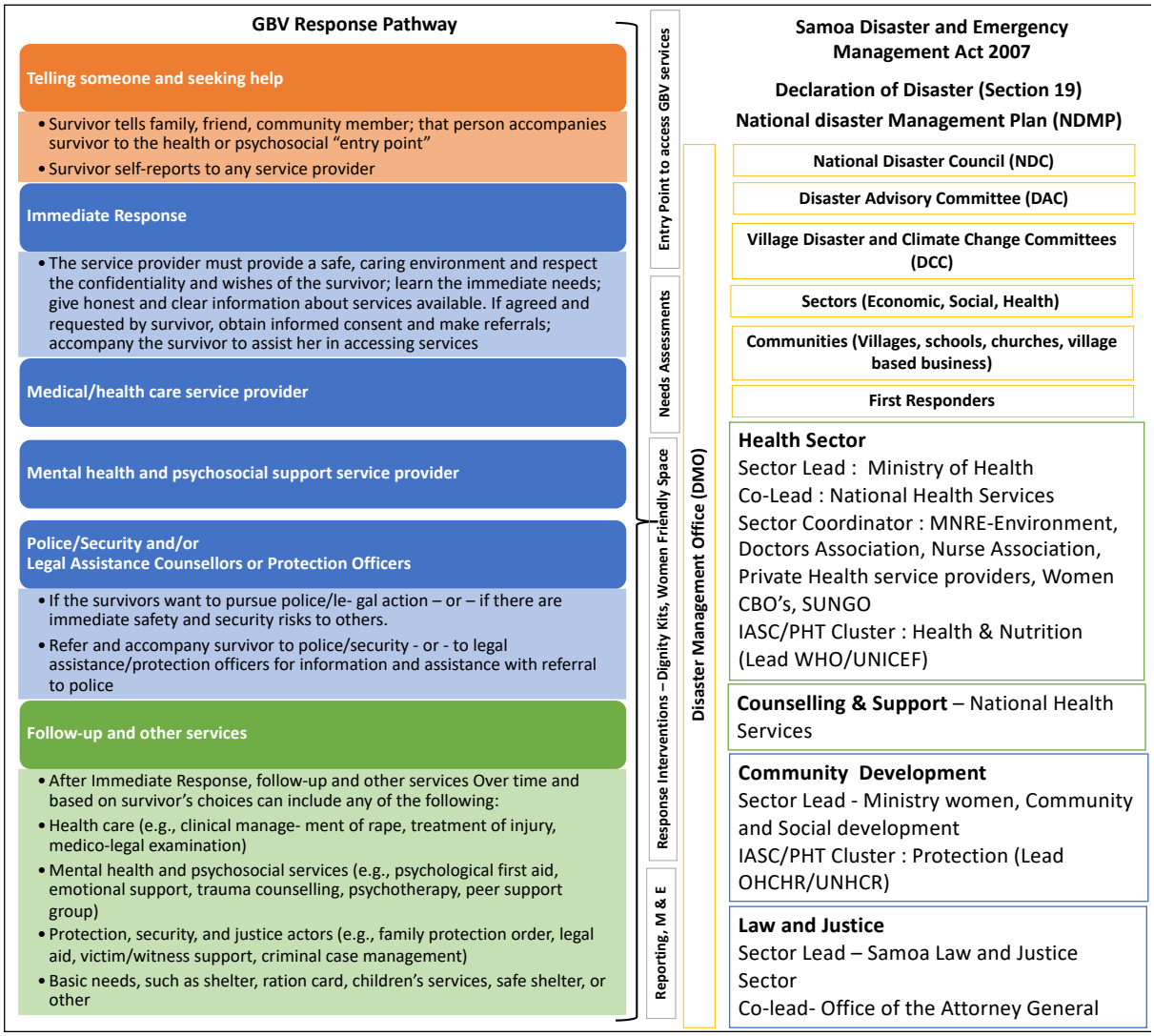


- Inter-agency Minimum Standards for GBV in Emergencies Programming : Standard 4 Health Care for GBV Survivors - Key Actions for health care for GBV survivors provide the standards that GBV survivors ought to receive from their health care workers (p.27 https://gbvaor.net/gbviems/)

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

3. Gender-based violence referral pathway for emergencies/disasters –

- The risk of GBV is increased in emergencies and all humanitarian actors have a responsibility to reduce the risk of GBV through prevention, mitigation and response actions (IASC -Guidelines for Integrating GBV Intervention in Humanitarian Action https://gbvguidelines.org/en/).
- The Samoa Disaster and Emergency Management Act 2007 and National disaster Management Plan (NDMP) governs disaster response and includes under the Protection of Life, security and physical integrity including monitoring and reporting gender based violence.
- Health Sector is responsible for the health management of gender based violence and violence against women during preparedness and response.
- The Samoa Inter-Agency Essential Services Guide for Responding to Gender-based Violence and Child Protection (2021) GBV referral pathways may need to be adjusted to the specific disaster and include NDMP coordination structures




Condom & Lubricant supply


MESSAGE FOR YOUTHS AND YOUNG PEOPLE
Available Family Planning Methods