Responding to Intimate Partner Violence and Sexual Violence against Women and Girls

CONTENTS

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Foreword

Gender based violence (GBV) is a significant public health challenge in many countries, and Fiji is no exception to it. It is a violation of human rights and has enormous negative impact on the individuals, communities and to societies as a whole.

The Fiji Women's Crisis Centre (FWCC) National VAW prevalence study published in Fiji in 2013 revealed the rates of violence against women and girls in Fiji are amongst the very highest in the World.

The violence against women health guideline for comprehensive case management was designed with an aim to guide health care workers in a uniform way all throughout the Ministry of health and medical services.

The guideline is very comprehensive and easy reference package for any assistance that a health worker will require if attending to a case of Gender based violence and being inclusive of all the laws in Fiji that guide gender based violence issues. Provides guidance on collection of evidence and giving evidence in court and it also links health care workers to all social support services available for victims.

The roles of health care workers are defined from where it starts on receiving a case to where it ends when they have sorted all medical issues and made appropriate referrals to appropriate authorities.

The guideline gives health care workers knowledge and skills to manage and support cases with gender based violence and ensure quality health care services to ensure safety and health for all members of the society.

On that note I acknowledge the team who had worked tirelessly for the development of this document and it is indeed a pleasure to present the "Violence against Women Health Guideline. "

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Suva, Fiji.

UNFPA FOREWORD

The International Conference on Population and Development (ICPD) Plan of Action, and the Fourth World Conference on Women in Beijing and , as well as regional frameworks such as the Pacific Island Leaders' Gender Equality Declaration and the regional Parliamentarians' Moana Declaration all demonstrate governments' commitments to promote women's rights, and to respect women's choices about their bodies and their futures. There has been significant progress in realize these commitments in Fiji, however full implementation requires concerted commitment by government, NGO and development partners.

The Fiji Women's Crisis Centre (FWCC) national Violence against Women (VAW)prevalence study (2013) highlighted high rates of violence against women and girls: 64% of women who have ever been in an intimate relationship have experienced physical and/or sexual violence by a husband or intimate partner in their lifetime, and 24% are suffering from physical or sexual partner violence today. Overall, 72% of ever-partnered women experienced physical, sexual or emotional violence from their husband/partner in their lifetime.

The evidence shows that women who have experienced violence use health care services more often than those who have not. A wide range of health professionals are likely to come into contact with women who have experienced VAW and therefore provide an important entry point for women's access to health care, including accidents and emergencies and reproductive health service providers. With the launch of the Fiji Ministry of Health and Medical Services "i-care campaign" and the medical guidelines, Responding to Intimate Partner Violence and Sexual Violence against Women - Health Guidelines for Comprehensive Case Management, the Fiji health care system is poised to respond to survivors of violence with compassionate care. These guidelines are based on cutting edge technical standards outlined in the global essential services package.

However, according to the Fiji Women Crisis Centre prevalence research, "Almost half of the women who experienced violence (47%) had never told anyone before the survey, with only 4% reporting to doctors or other health workers. (FWCC -2013, page 114.). With stronger health system response including capacity building of health staff, survivors will continue to gain confidence in a timely and consistent health response. The health system, in tandem with a multi-sectoral referral to police and civil society can play an important role in both the prevention and responses to Violence against Women.

UNFPA remains committed to supporting a strong health response to Violence against Women.

Dr. Laurent Zessler,

Director and Representative
United Nations Population Fund
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Acronyms and Abbreviations

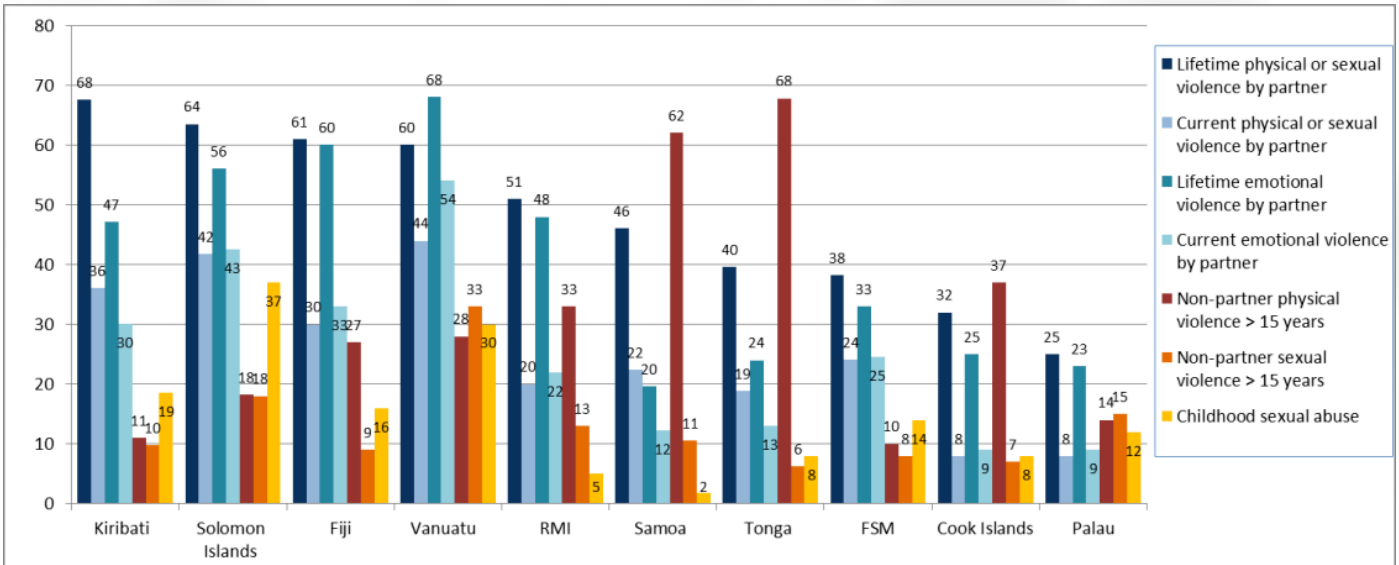
AIDS	Acquired Immunodeficiency Syndrome
CSW	Commission on the Status of Women
DALY	Disability-adjusted life year
DEVAW	Declaration on the Elimination of Violence against Women
DV	Domestic violence
EECA	Eastern Europe and Central Asia
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HRBA	Human rights based approach
ICPD	International Conference on Population and Development
IEC	Information, education & communication
IPPF	International Planned Parenthood Federation
IPV	Intimate partner violence
M&E	Monitoring & Evaluation
PEP	Post-exposure prophylaxis
PTSD	Post-traumatic stress disorder
SOP	Standard Operating Procedures
STI	Sexually transmitted infections
SV	Sexual violence
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
	UN Women United Nations Entity for Gender Equality and the Empowerment of Women
VAW	Violence against women
WAVE	Women against Violence Europe
WHO	World Health Organization

Introduction

It is well documented that Gender-Based Violence (GBV) is a significant public health challenge in many countries. It is a violation of basic human rights and has enormous negative impacts on individuals, communities, and societies as a whole. GBV affects the safety, dignity, and health of people as well as economic well-being and the security of nations.

Gender-based violence includes Violence against Women (VAW). Globally, it is estimated that 35% of women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime. Approximately 30% of women who have been in a relationship, report that they have experienced some form of physical or sexual violence by their partner. (WHO 2013) It is estimated that the prevalence of lifetime intimate partner violence (IPV) and sexual violence (SV) in the Pacific ranges between 60-80%.

Figure 1: Prevelance of Violence against Women, by type (percent; Ages 14-49 and 18-49)



Source: UNFPA, 2014

The Fiji Women's Crisis Centre (FWCC) national VAW prevalence study published in Fiji in 2013 revealed that the rates of violence against women and girls are among the very highest in the world: 64% of women who have ever been in an intimate relationship have experienced physical and/or sexual violence by a husband or intimate partner in their lifetime, and 24% are suffering from physical or sexual partner violence today. This includes 61% who were physically attacked and 34% who were sexually abused in their lifetime. Rates of emotional abuse are also high: 58% of ever-partnered women experienced emotional violence in their lifetime, and 29% in the previous 12 months before the survey. Overall, 72% of ever-partnered women experienced physical, sexual or emotional violence from their husband/partner in their lifetime, and many suffered from all 3 forms of abuse simultaneously. (FWCC, 2013)
In addition, 69% of women have been subjected to one or more forms of control by their husband or partner, and 28% were subjected to four or more types of control. For example, 39% of women (2 in 5) have to ask permission from their husbands before seeking health care for themselves and 57% of the respondents reported that their husband or partner insists on knowing where they are at all times. Women living with intimate partner violence are also subjected to economic abuse: more than 1 in 4 ever-partnered women (28%) had husbands/partners who either took their savings or refused to give them money. (FWCC, 2013)
The high proportion of women who have experienced very severe physical attacks is alarming: 44% or more than 2 in 5 ever-partnered women have been punched, kicked, dragged, beaten up, choked, burned, threatened with a weapon, or actually had a weapon used against them

There is a high rate of non-partner violence against women and girls: overall, 31% were subjected to physical and/or sexual assault since the age of 15 by someone other than their husbands and partners. This includes 27% who were physically abused and 9% who were sexually abused. Among those who were sexually abused, 3.5% were raped and 6.8% were attempted rapes; some women have suffered from both rape and attempted rape since age 15. 16% of all women were sexually abused when they were children under the age of 15 years. (FWCC, 2013)

Source: Somebody's Life, Everybody's Business, FWCC, Suva, 2013

[1]Against Women, adopted by the United Nations General Assembly in 1993, defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life".2 It encompasses, but is not limited to, "physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women and forced prostitution; and physical, sexual and psychological violence perpetrated or condoned by the state, wherever it occurs." (source: Declaration on the elimination of violence against women. New York, United Nations, 23 February 1994 (Resolution No. A/RES/48/104).

Respondents who identified as being transgender were more likely than men to have been verbally or physically abused in the previous twelve months. Among participants who identified as being transgender, 48% of them had been reported of verbally abused in that time period while 28% had been physically abused. Approximately 20% of homosexual men had experienced forced sex at their sexual debut with another male. 38% of them reported being forced to have sex in the last six months. (MENFiji, 2012)

Country's response to VAW

The Fiji government along with the civil society has a strong commitment to respond to the issue of intimate partner violence and sexual assaults. The documentation of the national response includes:

a. National commitments to gender equality

- Constitution of Fiji and in particular section 26 which guarantees equality regardless of sex, gender, pregnancy, marital status, health status, gender identity and expression
- People's Charter for Change, Peace and Progress, 2008
- Roadmap for Democracy and Sustainable Social-Economic Development, 2009-2014
- Women Plan for Action, 2010-2019
- Domestic Violence Decree, 2009; and No Drop Policy, 1995
- Child Welfare Decree 2010
- Family Law Amendment Decree, 2003
- National Policy of Sexual Harassment in the Workplace, 2008
- Gender Equality and Social Inclusion Strategy, 2012
- National Gender Policy 2014

b. National commitments to inclusion of people disabilities

- Constitution, People's Charter for Change, Peace and Progress, 2008
- The Fiji National Council for People with Disabilities Act, 1994
- The National Policy on Person Living With Disabilities, 2008-2018
- Signature of the United Nations Convention on Persons Living with Disabilities

Note: Fiji is also a member of the Secretariat of the Pacific Community (SPC). A number of the regional agreements and commitments have been endorsed over recent years.

The development of this guideline is part of the Health Sector Response on Prevention of VAW as well as the Fiji National Gender Policy, 2014. It is also the outcome of a comprehensive exercise, involving all key stakeholders which was led by the Ministry of Health Fiji, with technical assistance from UNFPA Pacific Sub Regional Office. This guideline have been sourced and adapted from the Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia, WAVE and UNFPA 2014.

The target audiences for this document are primarily the health care providers who directly manage the case. The document is also aimed for the secondary audiences which are the key people who are involved within the referral system. Healthcare facilities and providers may be the first or only point of contact outside the home for VAW survivors. Therefore, health providers are required to provide information and assistance before violence escalates, raise society's awareness to VAW as a public health problem, and counsel survivors and their families.

The comprehensive care of survivors of violence, within the health sector, will include the provision of high-quality medical and psychosocial care and support services, with clear linkages to the community, police and legal referral systems. The services aim to serve anyone in need including men, women, boys and girls, persons with a disability, same sex couples, and transgender. However it is acknowledged that most survivors of violence are likely to be women and girls.

The document primarily focuses on the clinical case management; however it is also aimed at assisting clinicians, nurses, and all health care providers to understand and appreciate comprehensive VAW programming responses and referrals. The Health Guidelines for Comprehensive Case Management will support healthcare staff in providing high-quality and comprehensive services to survivors and the community. It also serves as a guide for healthcare managers and providers to identify and mobilize the required resources, supplies and medicines for VAW service delivery points.

This document needs to be read in conjunction with other guidelines to provide a broader picture of whole of specific response in Fiji. For example the Juveniles Act, the Child Welfare Decree, the HIV Decree, the Mental Health Decree, and the Domestic Violence Decree are all relevant to the advancement of gender equality in Fiji.

Fiji Legal Framework

There are two decrees directly relevant to IPV and SV. There is the Domestic Violence Decree 2009 and the Child Welfare Decree (2010). The Interagency Guidelines (IAG) on Child Abuse, Neglect and Abandonment (December 2013) refer to domestic legislation and international commitments related to Child Protection in Fiji:

Domestic Legislation

The primary legislation that relates to the care and protection of children are:

- Constitution of the Republic of Fiji, 2013
- Child Welfare Decree, 2010
- Crimes Decree, 2009
- Domestic Violence Decree, 2009
- Sentencing and Penalties Decree, 2009
- Juvenile Act, 1974
- Adoption of Infants Act, 1978
- Employment Relations Promulgation 2007
- HIV Decree 2011
- Mental Health Decree
- Family Law Act and Family Law Amendment Decree

International Commitments

- Universal Declaration on Human Rights (ratified 1948)
- United National Convention on the Rights of the Child (ratified 1993)
- United Nation Convention on the Rights of Persons with Disabilities (signed 2006)
- International Labour Organization (ILO) Convention 182 on the Worst
- CEDAW

Domestic Violence Decree 2009

Objectives:

- To eliminate, reduce and prevent domestic violence
- To protect victims of domestic violence
- To implement CEDAW
- To provide a legally enforceable framework for domestic violence

Section 11

- When exercising jurisdiction under this Decree the court must regard the safety and well- being of the victim to be of the utmost and paramount importance.

Restraining Orders (RO):	The following people can make an application for RO: • A legal practitioner for any party • A party • A police officer • Director Social Welfare • A welfare officer • Public Trustee • Any person whom the court can allow to appear on behalf of a victim in the interests of justice

Section 19 provides for the following:

- The victim
- The victim's care giver
- A child through any adult parent or guardian
- A police officer
- The Director Social Welfare or any welfare officer appointed under s 37(2) Juv Act
- The Public Trustee
- Any other person in the interests of the safety or well-being of the victim

Section 20: Ex-Parte Interim Order (it is when an order is granted on the basis of the application of one party and does not provide the other party)

- Ex-parte (on hearing from only the victim) occurs where the court is satisfied that delay would or might entail a risk of harm or undue hardship.

However, once an Interim Order is granted;

- The court must adjourn for an inter-parte date (for hearing both sides of the story)
- The interim order remains unless specifically discharged or suspended by the court

Restraining Orders:-

- Take effect immediately
- Continues until varied, suspended or discharged by any court exercising the jurisdiction

Child Welfare Decree 2010 (CWD)

Purpose of the CWD:

- To promote and protect the health and welfare of children through mandatory reporting.
- To emphasize the duty of care of professionals handling cases of possible child abuse.
- To protect the confidentiality and integrity of cases of possible child abuse.

Definitions:

Terminology	Definition
A child	is a person under the age of 18yrs.
A designated medical officer	is a doctor appointed under section 16 of the CWD.
Director	is the Director of Social Welfare
Permanent Secretary	is the PS Women and Social Welfare
Professional	is a health professional (Medical & Dental Practitioners Decree) a welfare officer, police officer under the Police Act or a legal prac titioner. Latest Amendment: Teachers are now also included as a 'professional'.

Best Interests of the Child Principles:

- Every child has the right to protection from harm or likely harm.
- Families have the primary responsibility for the physical, psychological and emotional well-being of their children.
- The preferred way of ensuring such well-being is through the support of the family and extended family.
- Powers exercised under the Decree must respect the rights of people affected and the views of the child and parents.
- A child must be informed of decisions made under the Decree as appropriate to age and understanding.

Relevant Provisions to Ministry of Health:

a) **Section 4** - Immediate Mandatory reporting occurs where:
(a) the professional becomes aware or reasonably suspects during practice that a child has been, is being or is likely to be harmed; and
(b) as far as he or she is aware no other professional has notified the Permanent Secretary for Social Welfare.

(b) **Section 5** - How Notice is to be given:

- In writing or
- By fax or
- By email or
- By other reliable means of communication
- Where necessary verbal notice may be given, subject to section 6.

Contents of report -

- Child's name
- Child's date of birth
- Place of residence of the child
- Name of Parents
- Where the parents live or may be contacted
- Details of harm or likely harm
- The professional's name address and telephone number
- The reason for report
- Type of injuries

c) **Section 5** (2)
• The professional may seek other information about the harm or likely harm.

d) **Section 6** - Follow Up Notice
• Section 6 (1) where a professional has given verbal notice under section 4, he or she must within 7 days after giving the verbal notice, provide the Permanent Secretary written notice about the harm or likely harm.
• Section 6 (2) the follow up notice must include the information set out in s5 (1) (a) to (g) including the time that the notice was given.

e) **Section 8**
Provision for the protection of professionals acting in good faith from liability when disclosing information regarding section 4.

f) **Section 9 (1)**

Confidentiality: The professional must not disclose the identity of the person giving the information. Except if:
(1) permitted by the Decree
(2) in the course of performing a function under the Juvenile Act
(3) by way of giving evidence in a legal proceeding.

g) **Section 10** (1) Care and Treatment Order

- Powers of medical officers where the child is at a health centre, surgery or other place.
- Where the child has been harmed or is at risk of harm.
- And the child is likely to leave or be taken from the facility and harmed if there is no immediate action.
- The designated medical officer may order that the child be held at a health centre or surgery.

- THE ORDER MUST BE WRITTEN

Content of Care and Treatment Order

- Details of the child's condition.
- Reasons for the Order
- Name of the Health facility where the child is held.
- The time of making the Order.

h) **Section 10 (3)**
• The doctor must explain the Order to the child if the child is of an age where this is appropriate.
• The designated doctor must give a copy of the Order to the person in charge of the health facility with reasons for why the order has been sought.

i) **Section 11**
Procedure
• Within 48hrs the child must be released into the custody of a parent or guardian.
• If for the safety and well-being of the child, he/she cannot be released into the custody of a parent or guardian, the case needs to be referred to the Permanent Secretary or Director of Social Welfare to exercise powers under the Juveniles Act.
• Or transferred to another health facility.
• A Care and Treatment Order may be extended to 96 hours after consultation with another designated medical officer who agrees to the extension.
• The parents or guardian must be advised of the extension.
• There can only be one extension arising from one set of circumstances.

Offences under CWD:

Section 9(2)

• Any professional who other than as permitted under the Decree discloses the identity of the person giving information, is guilty of an offence and liable to a default fine of $5000.00.
• Section 17 – A professional who fails to give a notice under ss.4; 5 and 6.
• Section 18 – A professional who refuses to or fails to give the requested notice under s.7(1) and (2) and who has been warned by Permanent Secretary of the possibility of prosecution when he or she requests the information.
• Section 18 (b) – any person who removes a child under an Order.
• Any person who keeps a child in his or her custody knowing the child is subject to a Care and Treatment Order.
• Penalty is a maximum fine of $10,000 and/or 18 months imprisonment.

Commencement Date – Section 1: 1st – 6th September 2010.

Objectives of the Clinical Guideline

The guidelines primarily aim to ensure that those who experience VAW receive holistic, effective, and comprehensive care. The objectives of the document are:

- To provide technical guidance to health care providers on comprehensive medical management and referral for VAW survivors, to both adults and children

- To ensure standardized medical management of VAW survivors including collection, storage and processing of forensic evidence

- To strengthen linkages between the health facilities and communities to increase timely and effective use of comprehensive VAW services

- To provide common understanding to HCWs on GBV

CHAPTER

1

Understanding gender-based violence

1. Definition (Fiji, 2014; WHO, 2013, and National Gender Policy 2014)

Terminology	Definition/description
Sex	Sex refers to the biological and physiological differences between men, women and inter-sex.
Gender	Gender refers to socially constructed identities, attributes and roles that a society sees appropriate for women and men. It is socially constructed and a learnt behavior, e.g. In Fiji Housework is considered as a women's job.
Gender Based Violence	Gender based violence is any act (including threats of such act) that results in, or is likely to result in, physical, sexual, emotional or psycho logical harm to women, and which results from power inequalities that are based on gender roles in which a perpetrator gains power and exerts control over the other person. Emotional/psychological abuse accompanies all physical and sexual abuse, but can and is also inflicted on women without any accompanying physical or sexual assault.
Gender Discrimination	Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.
Gender Equality	Gender equality means that women and men have equal conditions for realizing their full human rights and potential to contribute to political, economic, social and cultural development, locally, nationally and inter nationally, and to benefit from the results.
Gender Equity	Fairness of treatment for women and men, according to their respective needs. This may include equal treatment or treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities. Women in Fiji come from various back grounds and have different realities: race, ethnicity immigration and visa status, disability, rural/urban/outer islands, socioeconomic circumstanc es, age and sexual identity. Thus in Fiji context, equality should be ap plied to all people living in urban/rural, ethnicity indo-fijian/itaukei women, social/economic status women from diverse backgrounds, trans women etc. Improving health outcomes for all women requires a focus on women with least access to health resources and who are most at risk for poor health
First-line support	This refers to the minimum level of (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health-care (or other) provider. It shares many elements with what is being called "psychological first aid" in the context of emergency situations involving traumatic experiences
Intimate partner	A husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover.

Intimate partner violence	Behaviour by an intimate partner that causes physical, sexual or psycho logical harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife/spouse battering. Dating violence is usually used to refer to intimate relationships among people, which may be of varying duration and intensity, and do not involve cohabiting.
Sexual violence	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 (WHO 2002, cited in WHO 2013). Acts of sexual violence include: - rape, other forms of sexual assault; - unwanted sexual advances or sexual harassment (including demands for sex in exchange for job promotion or advancement or higher school marks or grades); - trafficking for the purpose of sexual exploitation; - forced exposure to pornography; - forced pregnancy, forced sterilization, forced abortion; - forced marriage, early/child marriage; - female genital mutilation; - virginity testing; and - incest.
Sexual assault	A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. 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 and oral penetration
Shelter	Also known as a safe house or refuge, this is usually a place, often at a secret location, where women can flee from abusive partners
Violence against women	A broad umbrella term, defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life". It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation
Physical violence	Physical force that results in bodily injury, pain, or impairment. The severity of injury ranges from minimal tissue damage, broken bones to permanent injury and death. Acts of physical violence include: - slapping, shoving, pushing, punching, beating, scratching, choking, biting, grabbing, shaking, spitting, burning, twisting of a body part, forcing the ingestion of an unwanted substance; - restraining a woman to prevent her from seeking medical treatment or other help; and using household objects to hit or stab a woman, using weapons (knives, guns).

Emotional/verbal violence	Emotional abuse includes non-physical behaviors such as threats, insults, constant monitoring or "checking in," excessive texting, humiliation, intimidation, isolation or stalking.
Rape	The physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration. (WHO 2002, WHO 2013) From Crimes Decree in Fiji 2009, rape is defined as follows—207: (1) Any person who rapes another person commits an indictable offence. Penalty — Imprisonment for life.
	(2) A person rapes another person if— *(a)* the person has carnal knowledge with or of the other person without the other person's consent; or *(b)* the person penetrates the vulva, vagina or anus of the other person to any extent with a thing or a part of the person's body that is not a penis without the other person's consent; or *(c)* the person penetrates the mouth of the other person to any extent with the person's penis without the other person's consent. (3) For this section, a child under the age of 13 years is incapable of giving consent.

Note:
It is important to note that violence can also be perpetrated against men and boys. For instance, boys may become subjected to sexual abuse by family members or trafficked for the purpose of sexual exploitation.

2. Gender –based Violence in Humanitarian Settings.

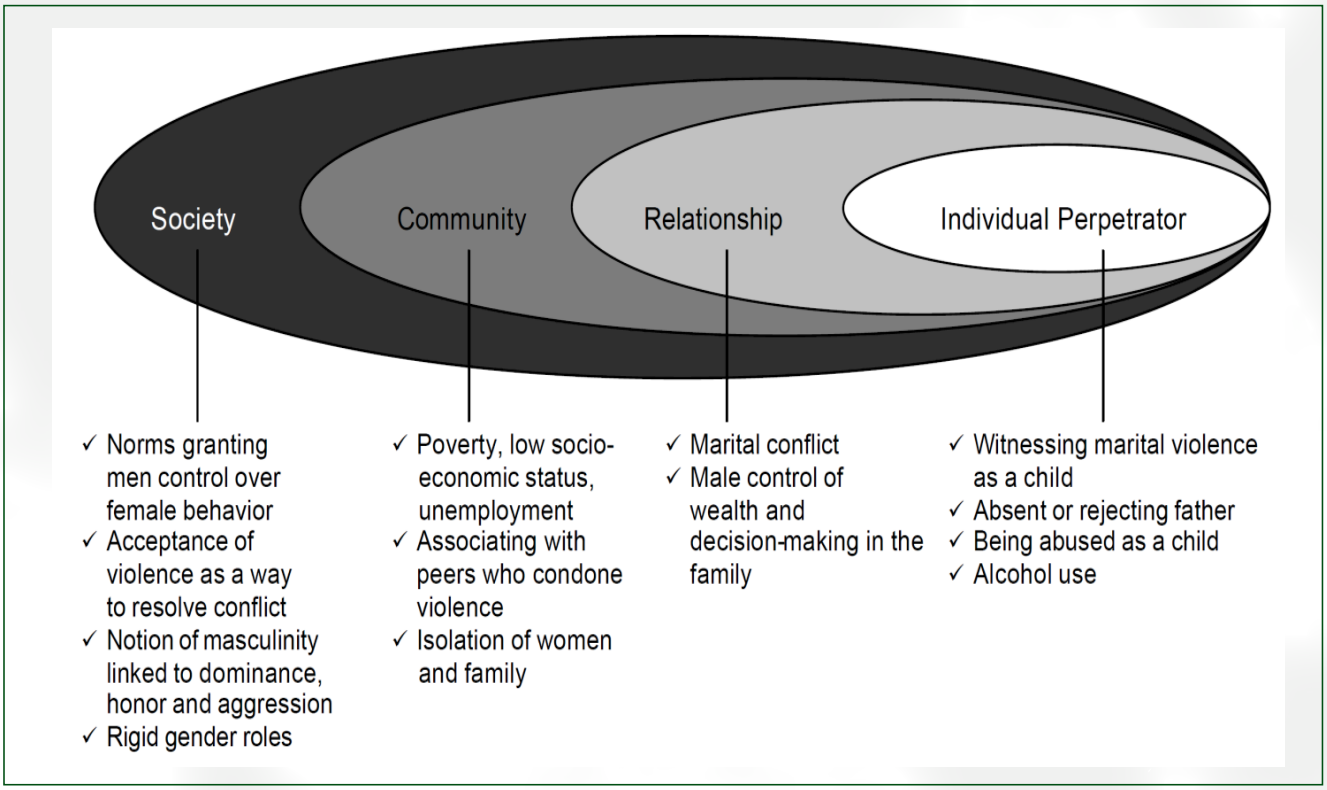
During a crisis, such as natural disaster, institutions and systems for physical and social protection may be weakened or destroyed. Police, legal, health, education, and social services are often disrupted; many people flee, and those who remain may not have the capacity or the equipment to work. Families and communities are often separated, which results in a further breakdown of community support systems and protection mechanisms. Gender-based violence is problematic in the context of complex emergencies and natural disasters, where civilian women and children are often targeted for abuse, and are most vulnerable to exploitation, violence, and abuse simply because of their gender, age, and status in society.

Establishing a coordination mechanism for sexual violence at the outset of the emergency will help to ensure are more responsible and responsive action from the earliest stages of the emergency to the more stable phase and beyond. Survivors/victims of GBV need assistance to cope with harmful consequences. They may need health care, psychological and social support, security, and legal redress. At the same time, prevention activities must be put in place to address causes and contributing factors to GBV in this setting. The overall aim of coordinated action from actors from many sectors an agency is to provide accessible, prompt, confidential, and appropriate services to survivors/ victims according to a basic set of guiding principles and to put in place mechanisms to prevent incidents of sexual violence. (IASC 2005)

3. Contributing factors of gender-based violence

There are multiple factors which contribute to violence against women: it is often a combination of several of these contributing factors which increase the risk of a man committing violence and the risk of the woman experiencing violence.
The underlying cause of GBV is gender inequality and unequal power distribution.
The diagram below provides a framework for understanding the risk factors which may contribute to VAW and children.

Figure 2: Ecological Framework for Understanding Violence against Women (Source: Heise 1998)



Source: Pan American Health Organization, Women, Health and Development Program, Fact Sheet: Social Responses to Gender-Based Violence.

These contributed factors can be present at different levels: the individual, the relationship, the community and the structural level. (Heise 1998, WHO 2005)

- **Individual-level:** biological and personal history factors that increase the risk of violence. For example, a low level of education, young age (early marriage) and low-economic status/income have been associated as risk factors for both experiencing and perpetrating intimate partner violence.

- **Relationship-level** factors contribute to the risk of VAW at the level of relationships including peers, intimate partners and family members. For instance, men having multiple partners are more likely to perpetrate intimate partner violence or sexual violence. Such men are also more likely to engage in risky behaviours with multiple sexual partners by refusing condoms, exposing themselves and their intimate partners to a higher risk of HIV and STI's.

- **Community-level:** refer to the extent of tolerance towards VAW in contexts at which social relationships are embedded, such as schools, workplace or the neighborhood. In Fijian communities, violence against women is considered to be normal and accepted, and women are not encouraged to report.

- **Society-level** factors include the cultural and social norms that shape gender roles and the unequal distribution of power between women and men. Intimate partner violence occurs more often in societies where men have economic and decision-making powers in the household and where women do not have easy access to divorce and where adults routinely resort to violence to resolve their conflicts

Note: Certain religious, cultural, and social norms and beliefs are also constituted factors for harmful practices resulting in violence against women.

4. The dynamics of violence in intimate partner relationships

Women survivors of violence presenting in a health care setting may often not disclose their experiences. Even in case where a patient discloses that she has experienced violence from an intimate partner, she may not be willing to leave the abusive relationship. The women cannot leave because of their financial status, family responsibility, religious and community obligations and stigma.
Understanding the dynamics of violent intimate relationships can help health professionals to maintain a supportive and non-judgemental, which is an important prerequisite of an effective health system response to VAW. Negative attitudes towards women in general and towards survivors of violence in particular can inflict additional harm to women.

a.) The cycle of violence

The course of a violent relationship can be divided in to three phases:

First phase	Tensions gradually build up. The woman tries to appease with her partner, generating a false sense of being able to control his aggression and prevent violence.
Second phase	An episode of physical, sexual and psychological violence which ends when the perpetrator stops the abuse temporarily. (Walker 1987, Stark 2000, WHO 2005). Women also spiral out in this cycle – " Return and Go.."
Third phase	The perpetrator apologizes and promises to change his violent behaviour. He may show especially loving and gentle behaviour; this makes the woman believe that there is a "good" side to her violent partner, which she can retain through adjusting to his behavior by modifying her own. (Walker 1987, Stark 2000, WHO 2005)

In many situations, the cycle of violence is being repeated; over time, the phases of aggression increase in regard to both, severity and duration, and phases become shorter. (BMWFJ 2010)
In some situation, women are still remaining in violent relationships due to the following reasons: (WAVE 2006)

- the life of the survivor is threatened
- the survivor cannot escape or thinks that escape is impossible
- the survivor is isolated from persons outside
- the captor(s) show(s) some degree of kindness to the survivor(s).
- and many more…

In Fiji situation, almost half of the women do not ask for help as they think the violence was normal or not serious. Humiliation or embarrassments and fear of losing custody of the children were the main reasons that prevent women from seeking help.

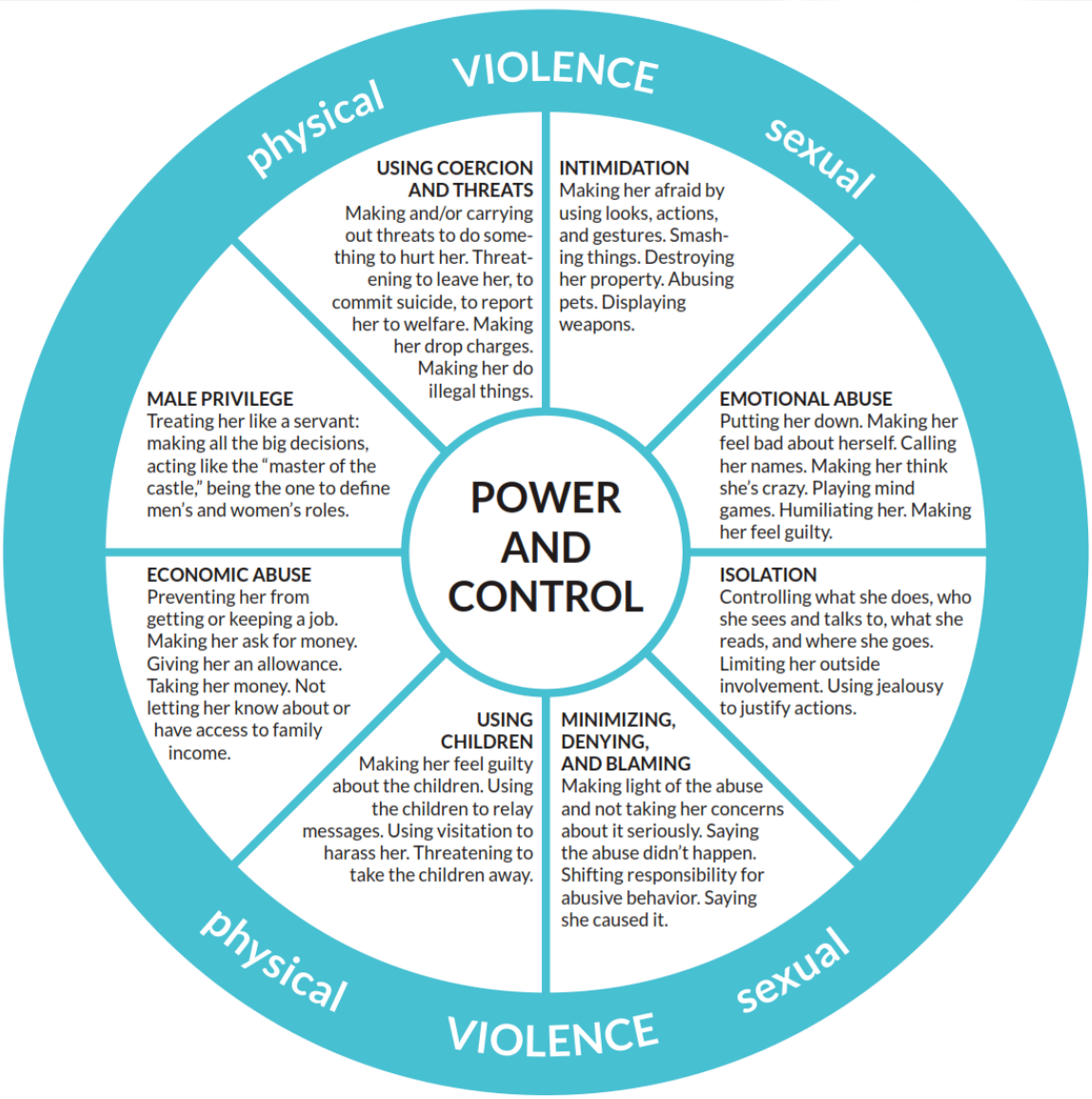
5. The Power and Control

Power and control in abusive relationships is the way that abusers exert physical, sexual and other forms of abuse to gain control within relationships. Sometimes, one person seeks complete power and control over their partner and uses different ways to achieve this, including resorting to physical and emotional violence. The perpetrator attempts to control all aspects of the victim's life, such as their social, personal, professional, health and financial decisions.

The Power and Control Wheel offers a framework for understanding the manifestations and mechanisms of power and control in an intimate relationship. (WHO 2005)

The wheel consists of eight spokes that summarize the patterns of behaviours used by an individual to intentionally control or dominate his intimate partner: using intimidation; using emotional abuse; using isolation; minimizing, denying and blaming; using children; using male privilege; using economic abuse; and using coercion and threats. These actions serve to exercise "power and control" – these words are in the centre of the wheel. The rim of the wheel is made of physical and sexual violence – this violence holds it all together. (UNFPA/WAVE 2014)

Figure 3: The Power and Control Wheel
(Adapted from Domestic Abuse Intervention Center Duluth, MN 218/722-4134. http://www.ncdsv.org/images/powercontrolwheelnoshading.pdf)



6. Gender-based violence and intersectionality: multiple discrimination

The manifestations of violence against women are shaped by gender inequalities.
It is important to acknowledge that women are not an identical group. They may be coming from difference class, migrant or refugee status, age, sexual orientation, marital status, ethnicity, disability or HIV status. Health professionals should be aware of these factors with gender and understand the specific risk and/or needs of women belonging to one or more marginalized groups. Specific strategy is needed to improve outreach and access of women belonging to these groups to health care.
(Please refer to Fiji National Gender Policy)

a. Women and persons with disabilities

Women with disabilities experience discrimination and stereotypical attitudes because they are both women and persons with disabilities. Some factors expose both men and women with disabilities to a greater risk of violence, compared to persons without disabilities. In addition, women with disability experiences different than men with disability. This difference is largely shaped and determined by gender. As a consequence, women with disabilities are more likely to experience violence compared to both, men with disabilities and women without disabilities. (OHCHR et al, 2011)

The factors that increase the likelihood that an individual with a disability will be perceived as an easy target for abuse includes:

- Persons with disabilities may rely on others to meet basic needs
- Social isolation results in limited exposure and lack of information about personal relationships and opportunity to disclose if sexual assault/abuse occurs
- Some people with disabilities have had limited opportunity to interact and develop social skills
- Lack of social credibility to report or disclose sexual violence.
- Sexual assault survivors that are deaf, have speech difficulties or a limited vocabulary
- Lack information about sexuality, sexual abuse and personal safety strategies
- Generally, society is not comfortable with people with disabilities having sexual desires, feelings and needs
- The large number of persons with disabilities in institutional settings and the physical and emotional contact of caregivers results in power imbalances between the staff and residents. This imbalance of power increases risks for sexual assault, abuse and exploitation.

Violence Against Women with Disabilities—Screening (Nosek MA et al, 2003 and Nosek MA et al, 2004)

Screening for abuse in all clinical and counseling settings is the best strategy for offering women with disabilities a way to get help to resolve violence in their lives.
For women with disabilities, there are many barriers to finding and obtaining help to resolve violence in their lives. One of the biggest barriers is the stigma associated with revealing a violent relationship or situation. This, combined with the stigma of having a disability and the stereotype of being weak, vulnerable, and incapable of taking care of oneself, creates a shame that forces many women to deny or tolerate the violence or develop maladaptive coping behaviors.

Clinicians and counselors have a unique opportunity to establish trust and open channels of communication with women in such situations. This opportunity may be the women's first and only chance to talk about their fears and the dangers they face daily.

Practical Guidelines on Handling Abuse Issues in Clinical Settings

It is understandable that physicians, like society in general, are uncomfortable talking about domestic violence. As in many other areas of behavioral inquiry, however, it is necessary, and guidelines have been developed with techniques for raising the subject and eliciting truthful responses.

The first step in approaching this problem is to educate all medical personnel and staff in a clinical practice about the reality of violence against women and girls with disabilities, why patients are reluctant to talk about it and why physicians are reluctant to ask about it.

1) Conduct universal screening.

Considerable research has been done on the most effective means of identifying women who are victims of domestic violence. Studies have shown that women are more likely to disclose such stigmatizing experiences if screening is done by a nurse instead of asking patients to complete a brief written assessment. Computer-based health-risk assessment has also been shown to encourage more disclosure and documentation of abuse when patients receive computer-generated health advice and physicians receive patient risk summaries. Researchers at the Center for Research on Women with Disabilities developed a tool for identifying women with disabilities who are in abusive situations, called the Abuse Assessment Screen - Disability, or AAS-D. It is concise and relatively simple to administer in a clinical setting.

2) Document the victim's injuries, history of abuse, and identity of the perpetrator.

Physicians are accustomed to preparing documentation for legal proceedings, and the credibility of their testimony is generally high. Therein lays the power of physicians to make a critical difference in the survival and well-being of abused women. With medical expertise combined with awareness of the dynamics of domestic violence, health professionals would be well equipped to disentangle the complexities of abuse in the context of disability. Specific information on recognizing the signs and symptoms of abuse in the medical history and medical examination should be recorded on the patient's record. In documenting evidence of suspected abuse, descriptions, photographs (with the woman's consent), and observations should be included. If abuse is suspected, statements to that effect should be written in the patient's record, whether or not discussion of this concern or any follow up take place.

One important detail in eliciting authentic abuse histories is to speak to the victim apart from the person who accompanies her. That person may very well be the perpetrator. Classic perpetrator behaviors in such settings include insistence on being with the patient at all times, speaking for the patient (a common behavior of many people toward women with disabilities, especially those with speech impairments), excessive expressions of concern, gestures of affection, and offers to help. For women with disabilities, these intimidating behaviors can come not only from intimate partners, but also from family members and personal care assistants. For disabled women with speech impairments, as often seen in cerebral palsy, mental illness and other neurological impairments, it is especially important to have someone take the time to communicate with them directly and privately.

Some mentally disordered patients incapable of informed consent to medical interventions; it is mean if a mental disorder prevents a patient from choosing decisively, communicating or accepting the need for a medical intervention; the informed consent should be given by the guardians or the health professional who accompany the patients. The decision and consent should serve the best of interest of the patients.

Speak up with abuse victims and offenders.
It takes a certain amount of courage to address suspected abuse with patients. Examination of one's own feelings and experiences is essential for approaching others on this topic with confidence. By entering into such discussions with patients, healthcare professionals bear witness to the violence, and thereby have moral and legal obligations to take action while at the same time protecting their own physical and emotional well-being.

3) Provide safety planning and referrals.

Assess the degree of danger the patient may be experiencing by asking if she is fearful at the moment, if the batterer is in a violent phase or under the influence of drugs or alcohol now, or if he has a weapon with him there at the clinic. For situations of extreme danger, contact the police and Social Welfare Department for the safety of the victim, your staff and yourself, and the other patients in the clinic.

The basic components of safety planning should be done by the counselor or health care providers to identifying family, friends, or church members the woman could stay with if her safety were threatened; developing a code system with a trusted person to signal for help; and keeping cash, keys, and other important documents at a safe location. We have added to these the disability elements of preparing plans for emergency accessible transportation; alternative means of communication; keeping extra medications, medical supplies, and, if possible, extra assistive devices at a safe location; and arranging for emergency back up personal care assistance. Planning is also appropriate on safety measures in medical settings, such as having trusted persons accompany the patient and always keeping mobility devices within reach. Referral information should be on hand for the local police, Social Welfare Department, Legal Aid, and FDPF such as the local center for independent living or home health care agencies.

4) Acknowledge that healing occurs at varying rates and support the patient's method of coping.

Solutions to abusive situations are much more difficult to identify for women with disabilities, particularly when financial dependence and the need for personal assistance serve to perpetuate the abuse. Alternatives, such as exploration of eligibility for government-funded benefit programs and natural supports in the woman's environment (family, friends, neighbors, church members and local organizations), may take time to cultivate. Communication with local rehabilitation resources, disability rights organizations, or developmental disabilities support systems may open new avenues for changes to a non-violent living arrangement.

Many women with disabilities survive intimidation, coercion, and violence by using denial. Although this is effective in the short term, it can lead to missed opportunities for intervention when intervention could be most effective. Pointing out the facts of a situation, the extent of injuries, the possible long term effects of such injuries, and the impact on a woman's physical and emotional functioning, can help her to understand her present and her future and encourage her to seek assistance. Under no circumstance a HCW should not underestimate a women's strength and sympathize with them as this will undermine the capability and strength of coping with the situation.

5) Understand the liability implications for failure to intervene appropriately, including the duty to warn and reporting requirements.

Fiji have legislated mandatory reporting by healthcare professionals related to abuse of persons with disabilities and older persons who cannot speak for themselves. It is essential that physicians become familiar with these requirements just as they would for legislation related to the handling of controlled substances. Careful consideration must be given, however, to the woman's ability to speak and take action for herself, as well as the possibility of retaliation by the batterer. Women should be informed, involved, and consulted at every step of this process.

6. Understand the correlation between substance abuse and domestic violence.

Research has shown a very strong correlation between substance abuse and domestic violence, mainly on the part of the perpetrator, but also occasionally by the victim. Women may use or abuse drugs/alcohol to cope with violence. Screening for substance abuse risk factors and behaviors should be conducted along with screening for domestic violence in the health evaluation of all patients. Abuse of prescription medicines, alcohol, or illegal substances is no more tolerable among persons with disabilities than it is for anyone else. Disabled women who are victims of violence by substance abusing partners may have other avenues of relief in addiction rehabilitation service programs.

b. Migrant women

Due to their double status as migrants and as women, migrant women are at a high risk of VAW (UN DESA 2004, UN Secretary-General 2006). Limited options for women's legal employment in countries of destination leads to an over representation of women in the informal sector such as domestic work, agricultural work, or sex work, which lacks legal protection and puts women at an increased risk of violence. (UN Women Virtual Knowledge Centre, CEDAW GR 26)

In addition, fear of losing residency status may prevent migrant women who experience violence by an employer or an intimate partner, from accessing justice and leaving an abusive work or intimate relationship

c. Adolescent girls

Adolescents are risk of several forms of violence, child marriage, sexual violence, trafficking or intimate partner violence. (UN Women Virtual Knowledge Centre)

Adolescent survivors of VAW face additional barriers compared to adult survivors. Often, they are less aware of existing services, lack financial resources to access services and are hesitant to seek services due to a perceived lack of confidentiality. Due to their age and stage of development, adolescent girls face particular consequences of VAW, compared to adults. Adolescent pregnancy, which may result from sexual violence, is associated with the risk of low birth-weight for new-borns, higher pre-natal, neonatal and infant mortality and morbidity. (UNFPA 2013)

Furthermore, adolescent girls who become pregnant, due to lack of physical maturity, are at an increased risk of pregnancy-related complications, which is a leading cause of death among girls age 15-19 in developing countries. (WHO 2011a, UNFPA 2014)

d. Older women

Older women may suffer multiple forms of discriminations and are at greater risk of violence compared with women of a younger age. The factors that put elderly women at risk include age-specific factors, physical vulnerability, possible illness, isolation, language, dementia or dependence on the family or other caregivers. . Furthermore, they are also vulnerable to economic abuse especially in case of deferment of their legal capacity to somebody else. (CEDAW GR 27)

Others may also face problems in accessing information about services and resources (CAADA 2011, WHO 2011a), as well as fear that they will not be believed and that their claims may be dismissed as illness or amnesia.

e. Rural women

Rural women are at higher risk of VAW for many reasons; for example social isolation and lower levels of education, and poor literacy. In addition, rural women have greater challenges in accessing services and resources compared to women living in non-rural regions. In some cases, services may not exist, be limited or inaccessible due to geographical challenges or the lack of transportation. (CAADA 2011, CEDAW 2011) Due to poverty and the lack of opportunities in rural regions, women who stay in the village may also be at risk of trafficking, sexual exploitation and forced labour. (CEDAW 2011)

f. Transgender

Many people may have a profound lack of understanding of who is a transgender. A Transgender person is defined here as 'individuals whose gender identity and/or expression of their gender differ from social norms related to their gender of birth. (APTN, UNDP, 2012) Transgender people may suffer from multiple forms of discriminations and be at greater risk of violence. The risk factors include discrimination toward their gender identity, gender expression, or their sexual attraction.

A study in Fiji reveals that approximately 48% of men who are having sex with men, including transgendered people had been verbally abused while 28% had been physically abused. The most commonly experienced type of discrimination reported by the respondents was being denied employment, promotion or further training (MENFiji, 2012).

7. Consequences of gender-based violence

a. The impact of violence against women on women's health

Gender-based violence has been linked to many serious health problems, immediate and long-term; physical, sexual and reproductive, mental and behavioral health.

The FWCC study on Fiji national VAW prevalence (2013) reveals:

- With 30% of ever-partnered women injured due to domestic violence in their lifetime, and a significantly increased risk of emotional distress symptoms including suicidal thoughts and actions, domestic violence is undoubtedly one of the biggest risks to women's physical health and mental well-being in Fiji. Injuries and emotional distress have a severe impact on women's physical health, their ability to care for their families, earn an income, and engage in social and economic development. The findings also show that women living with domestic violence have higher rates of miscarriage and an increased likelihood of unwanted prgnancies, which also brings damaging health impacts and social and economic costs to the community.

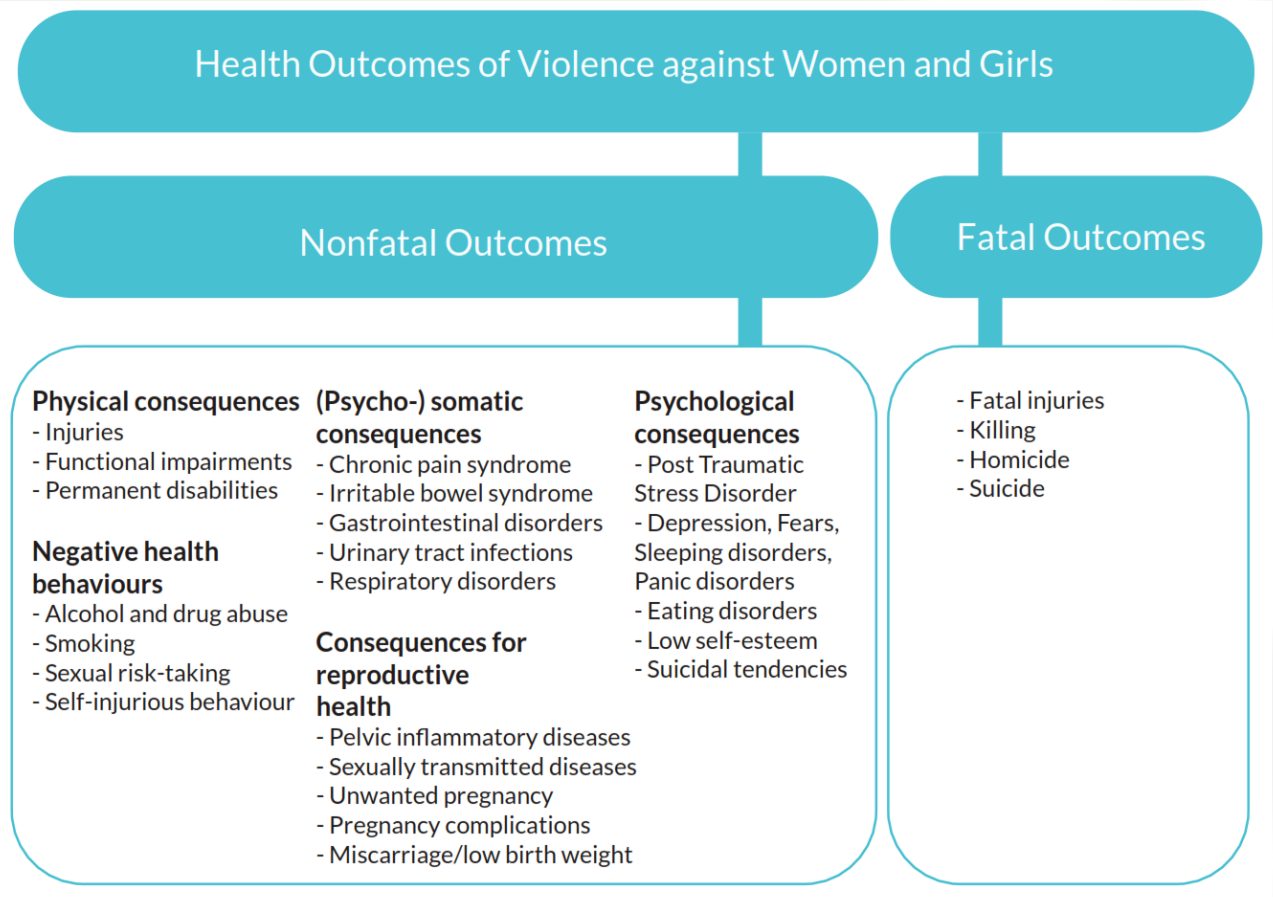
- Men's control over women's access to health care is pernicious and exacerbates health problems for both women and children. It increases the long-term costs of providing treatment, as opposed to early intervention in preventative health care. (FWCC, 2013, page 2-5)

VAW can result in women's deaths. Fatal outcomes may be the immediate result of a woman being killed by the perpetrator, or in the long-term, as a consequence of other adverse health outcomes caused by violence.

The physical and psychological impact on women due to VAW includes:

Physical	Psychological
- injury - disability - chronic health problems (irritable bowel syndrome, gastrointestinal disorders, various chronic pain syndromes, hypertension, etc.) - sexual and reproductive health problems (contracting sexually transmitted diseases, spread of HIV/AIDS, high-risk pregnancies, etc.) - death	Effects can be both direct/ indirect - Direct: anxiety, fear, mistrust of others, inability to concentrate, loneliness, post-traumatic stress disorder, depression, suicide, etc. - Indirect: psychosomatic illnesses, withdrawal, alcohol or drug use.

Health consequences of violence against women and girls



Source: Hellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009

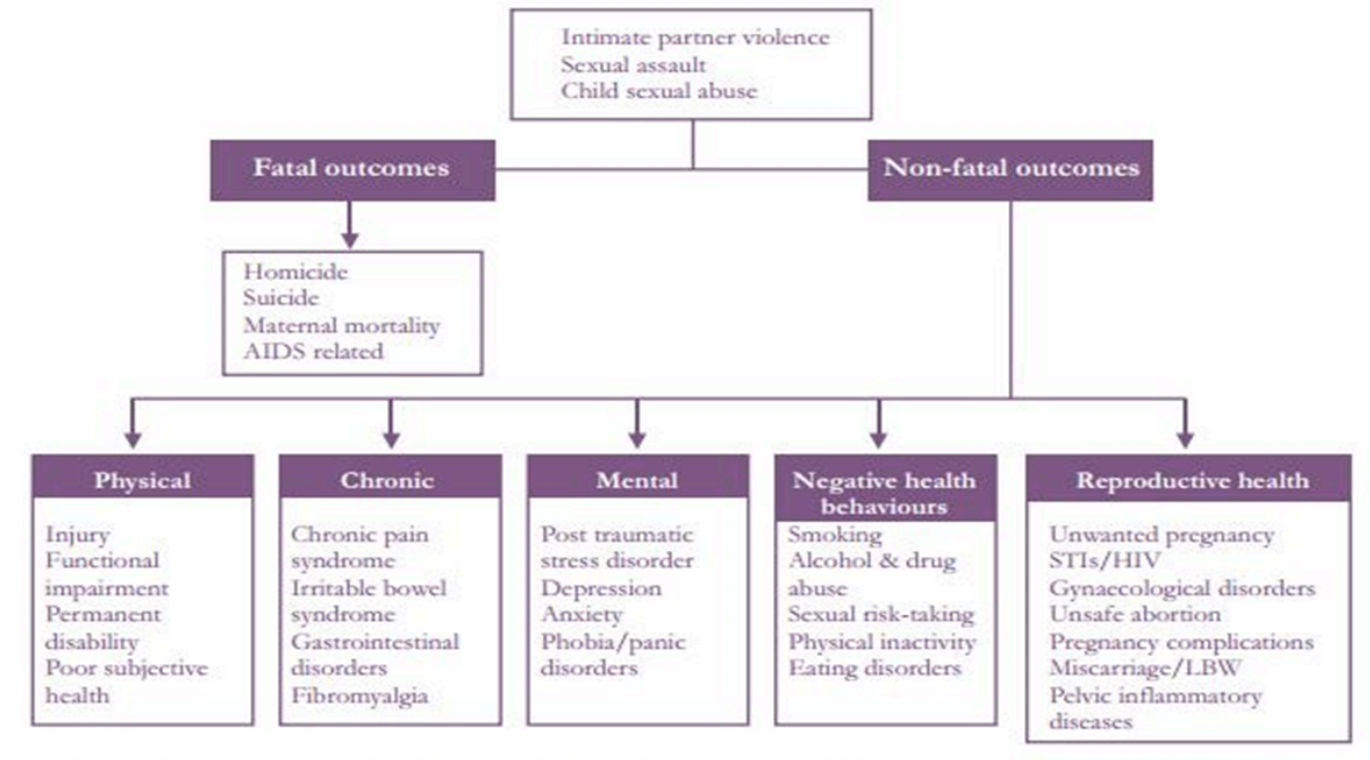
b. The impact of violence on children's health

Violence against children can happen in many settings; at home, within the family, in schools and educational settings, in institutions such as orphanages, in places where children work, and in the community.

In the family, violence against children frequently takes place in the context of discipline, in the form of physical, cruel or humiliating punishment. It is often accompanied by psychological violence, such as insults, belittling, name calling or rejection. (UN Secretary-General 2006b, Durrant 2005, UN Secretary-General 2006a) This can also include witnessing violence between parents.

Most violence against children remains hidden. Many children are afraid to talk about the violence they experience. This fear is closely related to their age and cultural barriers attached to reporting violence, especially in cases of rape or other forms of sexual violence. Intimate partner violence exposure affects children's physical health, social and emotional behavior, cognitive functioning, and neurobiological and relational development. (Sandra A. et al, 2011)

Different forms of violence have different impact on children's health. Even when the child is not physically targeted, the social and health consequences for children may be significant; these include anxiety, depression, poor school performance and negative health outcomes. (WHO 2002, WHO/PAHO 2012b)



Source: Heise I, Ellsberg M, Gottemoeller M, Ending violence against women, population reports, Volume XXVI, No.4, December 1999

CHAPTER

2

The role of health systems in the response to gender-based violence

Violence against Women is a public health issue, with a significant impact on women and girls physical, psychological and sexual health. It affects women throughout the entire life-cycle and is a major cause of injury, disability and death amongst women. The health consequences caused by gender-based violence may range from physical injury, chronic pain, anxiety and depression to deadly outcomes such as suicide and homicide. The risk factors caused by Gender-based violence include physical, mental, sexual and reproductive health problems. (S. Bott et al, 2004) Health care professionals as well as the health system play an essential role in a multi-sectorial response to VAW.

This chapter provides an overview of key recommendations to guide health care professionals, a standard of care for patients who have been subjected to violence as well as addressing the barriers to an effective health care response.

The health system has a crucial role in responding to VAW and sexual assault. The health professional needs to be aware and well equipped with skills and knowledge in order to provide good quality care for VAW clients.
It is vital that health care professionals are able to respond in a safe and effective manner to patients who seek medical care as a result of violence. Without such knowledge and skills, there is the potential to cause further harm to women.

Gender differences and inequalities are a major cause of inequity in health and health care. There is increasing recognition amongst health care providers and researchers of the importance of considering gender issues in health policy, planning, practice and research both to reduce health inequities, and to increase the efficiency and effectiveness of health care services. (BMZ, 2009)

1. HEALTH WORKFORCE

Health professionals have an important role in dealing with VAW because they can reframe violence as a health problem rather than just a social custom.

Examples of where health professional practices may be harmful to women and/or place them at increased risk of danger or re-victimization could include:

- Expressing negative attitudes toward the victim
- Breaching client's confidentiality, or
- Discussing a woman's injuries in a consultation room that can be overheard by a potentially violent spouse standing outside

The key elements for health professional in responding to VAW are (from both- women and disability clients):

- Recognize signs and symptoms of VAW including disability
- Provide the patient with information on VAW and its consequences on women's health
- Ask questions about VAW in case of clinical symptoms that indicate possible experience of VAW
- Create a conducive environment to ensure confidentiality
- Establish rapport
- Collect the patient's medical history and undertake a medical examination
- Provide appropriate medical and psychological care, counseling and safety planning to clients
- Document the immediate and long term health consequences of VAW and provision of care
- Provide the patient with information and referral to other service providers, as needed (such as specialized
  medical care, women's shelter, crisis centre…etc)
- Assist the patient in safety planning
- Ensure follow-up care
- HCWs should collect and provide information in away responsive to the need of people with Disability
- Health Care Workers should have basic conselling skills during first level of care

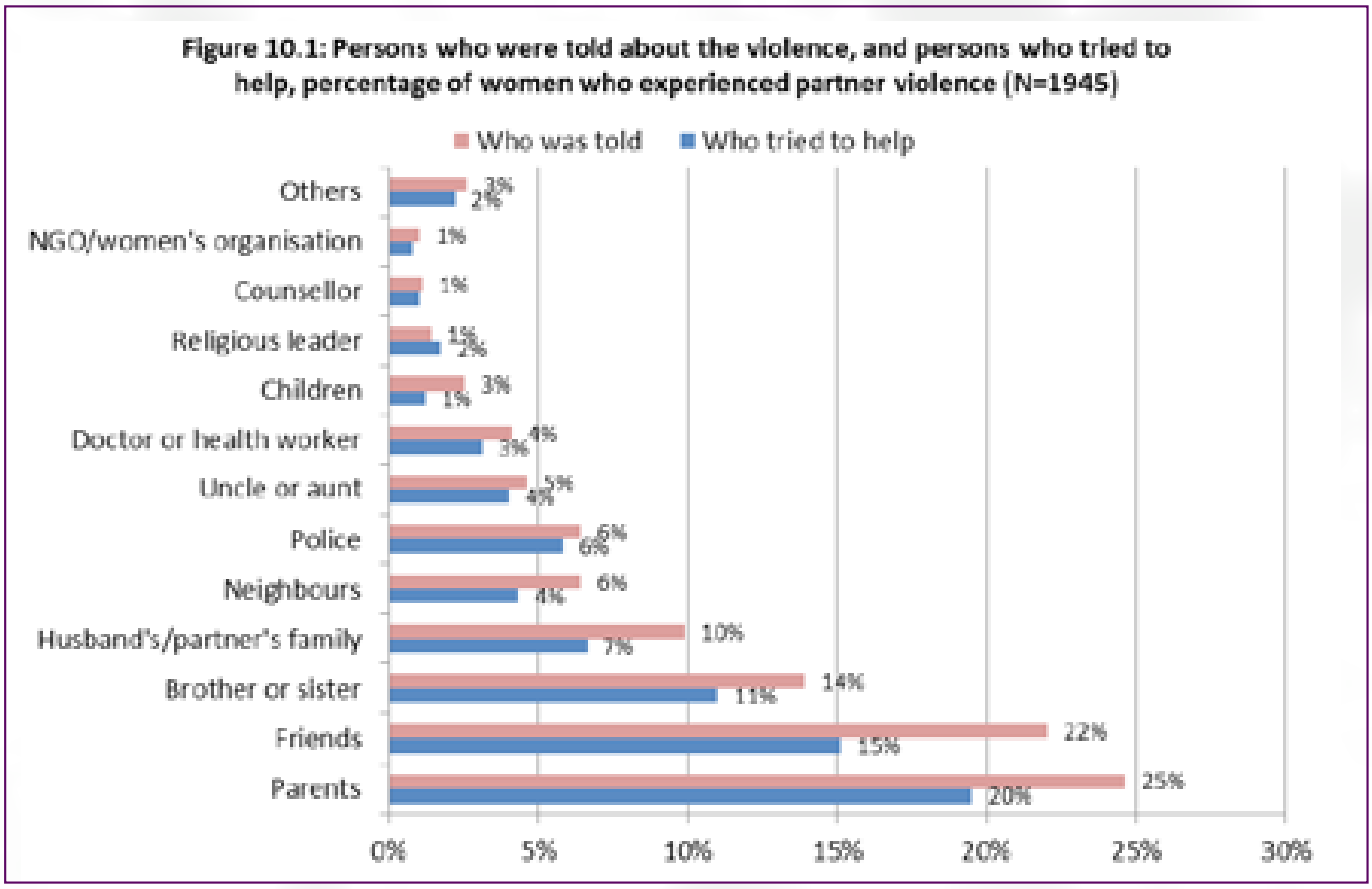
Health care providers must ensure the same level of quality of care for all persons regardless of their gender, age, race/ethnicity, disability, sexual orientation, HIV status or any other characteristic. Services must be fully accessible to all survivors of gender-based violence and must take into account their special needs

Training requirements both knowledge and skills on management of IPV and sexual assault for the health care workers. This training should be included in the National Tertiary Course at Fiji National University.

2. INFORMATION

Primary Point of contact

For women survivors of intimate partner violence who experience isolation and control by a violent partner, health professionals might even be the only point of contact, particularly in a situation where these women do not want to report the violence to the criminal justice authorities. The evidence shows that women who have experienced violence use health care services more often than those who have not. (WHO 2013) A wide range of health professionals are likely to come into contact with women who have experienced VAW and therefore provide an important entry point for women's access to health care. These professionals include: general practitioners, doctors, obstetricians and gynecologists, family planning specialists, nurses, midwives, dentists, ear, nose and throat doctors, eye specialists, community health workers and mental health specialist. However, according to the FWCC prevalence research, "Almost half of the women who experienced violence (47%) had never told anyone before the survey, with only 4% reporting to doctors or other health workers. (see Figure 10.1, FWCC, 2013, page 114.).



Forensic medicine:

Forensic medicine plays an important role in collecting evidence to support the criminal prosecution of a perpetrator. Thus, good recording of the history of assault, undertaking a medical and psychological examination, performing different laboratory tests and documenting injuries are important.

3. SERVICE DELIVERY

Be alert of a woman's situation

Knowing about a woman's situation of violence may help in diagnosing or treating many conditions, such as chronic pain or reoccurring sexually transmitted diseases. In order to enhance access to services clear understanding of what are the barriers in accessing the services.

Barriers to an effective health care response to gender-based violence

Numerous factors prevent women survivors of VAW from receiving appropriate health care. Such barriers exist at the levels of both the patient who experienced VAW and the health care provider. Barriers at a patient level include both internal and external barriers.

Internal barriers may include:

- Feeling shame, guilt
- Fear of reprisals from the perpetrator
- Fear of stigma and social exclusion by their families and communities
- Social isolation and the feeling of having to deal with the experience of violence all by themselves
- Long-term experiences of mistreatment that can damage women's self-confidence and self-esteem
- Lack of safe options for their children and fear of losing child custody
- Fear of losing status following separation from a violent spouse.
- Lack of realistic options, e.g. for financial resources, housing, employment , safety and disability support
- self-stigma

External barriers may include: include:

- lack of physical access to health care services
- fear of negative responses from service providers
- not knowing which steps health care professionals will take
- language and cultural barriers (most immigrant women-need clarification if this include disability)
- inappropriate physical conditions of the facility or insensitive behaviour of health professional
- personal bias

The key principle for service provision

Gender-sensitive approach

The support need for individual women varies, for example women with physical or mental disabilities; women living in rural or remote areas; pregnant women and women with young children; migrant women; lesbian and bi-sexual women; transgender persons; sex workers; HIV positive women; substance abusing women; older women; girls and adolescent women.

Health service providers need to respect the diversity of service users and should apply a non-discriminatory approach to all patients.

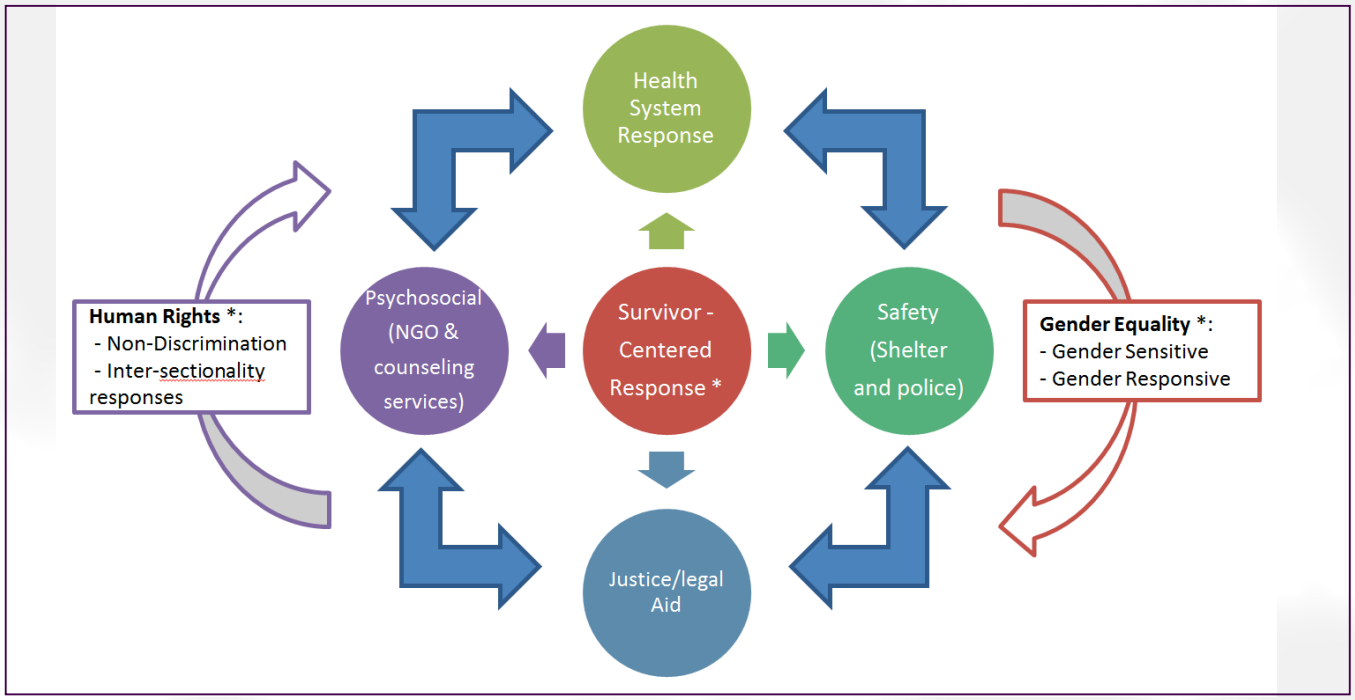
Integration Response

> " Any intervention must be guided by the principal to **"do no harm"**, ensuring the balance between benefits and harms"(WHO 2013)

It is important to acknowledge that women survivors of violence have different needs, depending on their individual situation, the severity of the violence experienced and the consequences and impact of the violence on their health and well-being.

Providing a comprehensive and coordinated response for VAW's survivors is essential. A response should aim to ensure survivor safety and perpetrator accountability by linkages to core services such as immediate and long term health care, access to police and legal services, counselling and psychological support.

The key sectors response



* Guiding Principles of GBV Prevention and Response: Human Rights-based Programming, Survivor-centered approach and promoting Gender Equality.

In order to provide comprehensive care to the survivor, health care providers shall:

- create a supportive environment,
- treating the survivor with respect and dignity,
- encourage the survivor's recovery, and
- promote the survivor's ability to identify and express her needs and wishes, and also reinforce her capacity to make decisions about possible interventions. (UNICEF, 2010)

Health-care providers should always offer first-line support to women who disclose violence. First-line support includes: (WHO, 2013)

- being non-judgmental, be supportive and validating in response to what the woman is saying
- providing practical care and responding to her concerns
- asking about her history of violence, listening carefully, but not pressuring her to talk
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed; and providing or mobilizing social support.

The health providers should always ensure that the consultation is conducted in private and respect is given to client confidentiality. It is also very important to inform women of the limitations of confidentiality (e.g. when the life or wellbeing of an individual is in immediate danger, or when there is mandatory reporting).

> If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

Ensuring the patient's safety

In any interventions, the safety of women survivors and their children should always be paramount. (WHO 2013, WAVE 2006)

This means that health care providers need to refrain from any action, even well-intentioned, that might put women survivors at risk of experiencing further violence.
The providers need to assist female patients who have experienced VAW to increase safety for herself and their children, where needed. (WHO 2013)

In practice, not all health facilities are specialized or adequately equipped to provide comprehensive protection and support to women survivors of violence and their children. In some instances the immediate protection of the woman and her children may be more important than health assessment and treatment. Therefore, referral pathways linking health care providers to specialized services such as police protection units and women's shelter is very important. Moreover, health service providers need to be familiar with how to refer women to the necessary services in order to seek these protection orders (e.g. legal services, counselling centres that can provide legal advice etc)

Respect for the patient's dignity, and privacy

> All patients who present to health facilities who have suffered either physical or sexual assault are to be treated in a private area that is separated from other patients and allows for confidential conversation to occur.

Health care professionals should be always supportive and non-judgmental about what the patient is saying. When asking about the patient's history of violence, they should listen carefully, without pressuring the survivor to talk. Extra caution should be taken when discussing sensitive topics and when interpreters are involved. (WHO 2013) They should always remain neutral about what has happened, convey the message that there is no excuse for violence, and they should respect a patient's decision. (WAVE 2006, WAVE 2011)

All health care facilities should empower to ensure the availability of female examiners where requested and respect the patients modesty in examinations. There should be availability of appropriate private waiting areas, and appropriate consultation and examination rooms, where no one in the waiting room or in adjoining areas can overhear any conversations. Health service providers should not share any information regarding a survivor without her informed consent. Patient's file should be kept in well secure place and no un-authorize person should have access to the document.
However, there are some exceptional circumstances where there is an immediate risk to the safety of the patient, her children, or health staff, the health provider should contact the police and share the information that is necessary in order to secure the safety of those involved.

Ensure patient's empowerment, autonomy and participation

> Empowerment of VAW survivor is the process of " helping women to feel more in control of their lives and able to take decisions about their future". (Dutton 1992,WHO 2013)

Frequently, relatives, friends and health professionals try to tell the survivor what to do. However, such advice can create even more pressure on her and is rarely helpful. (WAVE 2006)
Providing women with information on their rights and on legal and other services is a key strategy for empowerment, as it enables them to make informed decisions and to provide them with a sense of control over their lives.
Health-care providers should support survivors in their decision-making by presenting and discussing options and providing practical care to the patient's concerns. The woman should always be the one to make the decisions about her life. (WHO 2013)
The health professionals should respect patient's decisions about treatment, as well as her interaction with police, the legal system or other service providers. .

Informed consent and confidentiality

> Medical reports can be released only under the following circumstances:
> 1. Official request by Fiji Police Service and Social Welfare
> 2. Request by court system
> 3. Request by the client

Health care professional should always seek the patient's informed consent throughout the process. Privacy and confidentiality of clients should be maintained at all times. Health professionals should refrain from passing on the survivor's information to family members, other service providers, governmental bodies or researchers, unless she gives her informed consent. In some exceptional circumstances where the life and health of women or children are in danger, health providers should inform survivors of their obligation to report. (WHO, 2013)

To help in improving the services, health care providers should promote the participation of women survivors in the evaluation of the services provided. Survivors have the right to provide suggestions or file complaints if they are not satisfied with the quality of the service they have received. (WAVE 2011)

4. MEDICAL PRODUCTS

To ensure all service deliveries have adequate Medical Supplies and Commodities for quality Management of Clients.

5. LEADERSHIP AND GOVERNANCE

Development of relevant policies and SOPs for Management of GBV clients at all level of care.

6. FINANCING

Provision of finance and management

- Resource mobilization
- Collaboration with other organization to strengthen service delivery

CHAPTER

3

Clinical Management

Immediate Health care response to Gender-based Violence

The key principles and standards for service provision should be based on human-rights, gender-specific, and a women-centred approach.

Management for survivors of VAW at a service delivery level includes:

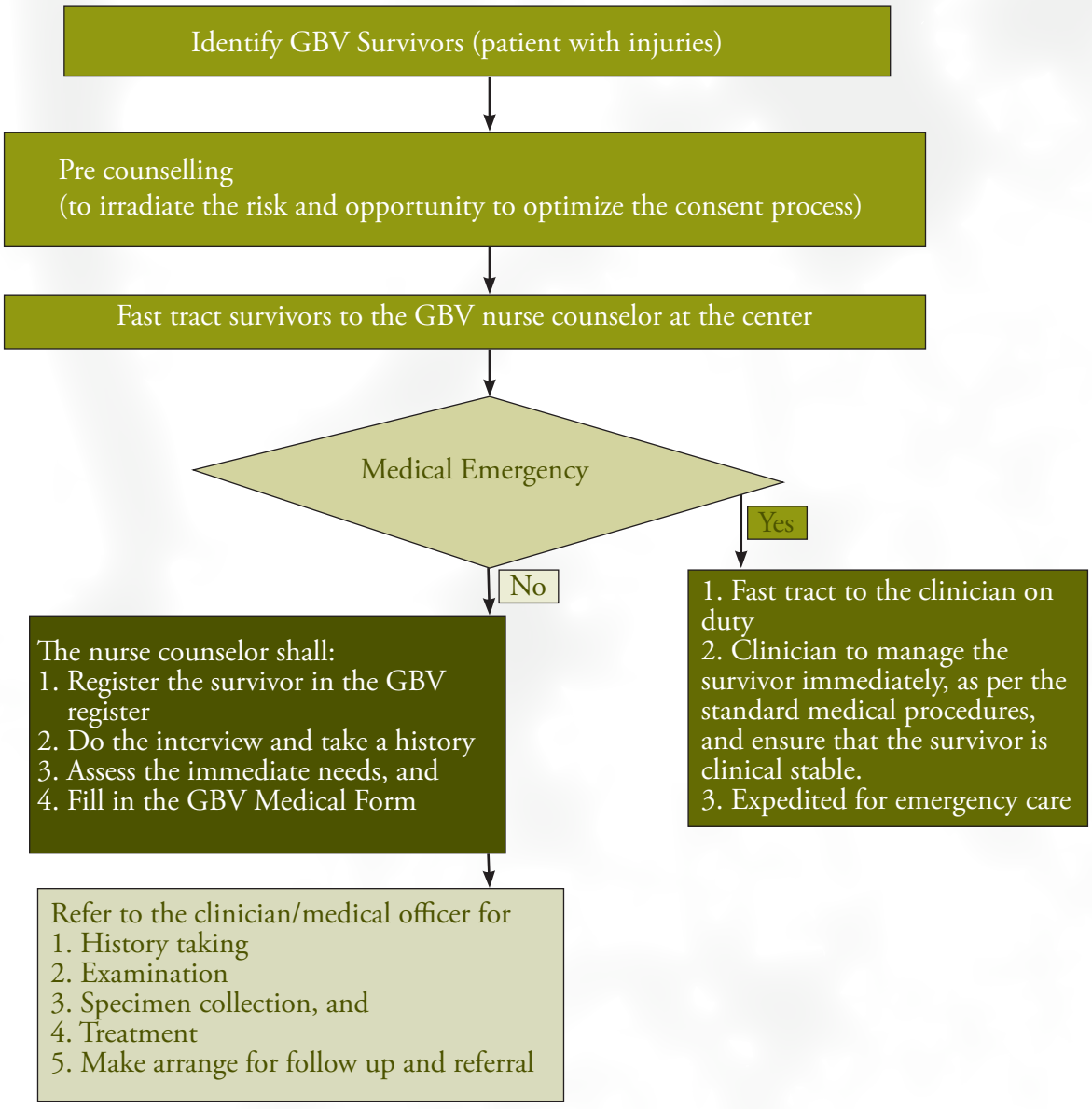
- First line support
- Care of injuries and urgent medical issues
- Sexual assault exam and treatment (EC, STI and HIV PEP)
- Mental health assessment
- Stress management

1. Identifying gender-based violence

The survivors of VAW are always part of the general population in Fiji who seek medical care and treatment, however they are not likely to spontaneously disclose. To increase the chances of disclosure, health care professionals should always be alert, and sensitively enquire if a women presents with symptoms that may indicate VAW. (Feder et al, 2011)

By approaching a patient in a professional and supportive manner, can help to break the individual's feelings of isolation, guilt and shame that survivors of violence may experience.

Flow Chart of Receiving Survivor



2. Understanding the signs of Violence Against Women

Health care professionals should be alerted and consider asking about VAW if clients present with the following **symptoms**: (Black, 2011 and WHO, 2013)

- Symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders
- Suicidal or self-harm
- Alcohol and other substance use
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

In addition, health care professionals should also be aware that certain types of behaviours observed with female patients can be indicators of exposure to intimate partner violence. These **behaviours** includes: (Department for health, UK, 2005)

- Frequent appointments for vague symptoms
- Injuries inconsistent with explanation of cause
- Woman tries to hide injuries or minimize their extent
- Partner always attends unnecessarily
- Woman is reluctant to speak in front of partner
- Non-compliance with treatment
- Frequently missed appointments
- Multiple injuries at different stages of healing
- Patient appears frightened, overly anxious or depressed
- Woman is submissive or afraid to speak in front of her partner
- Partner is aggressive or dominant, talks for the woman or refuses to leave the room
- Poor or non-attendance at antenatal clinics
- Early self-discharge from hospital

3. Minimum Standard requirement for asking questions

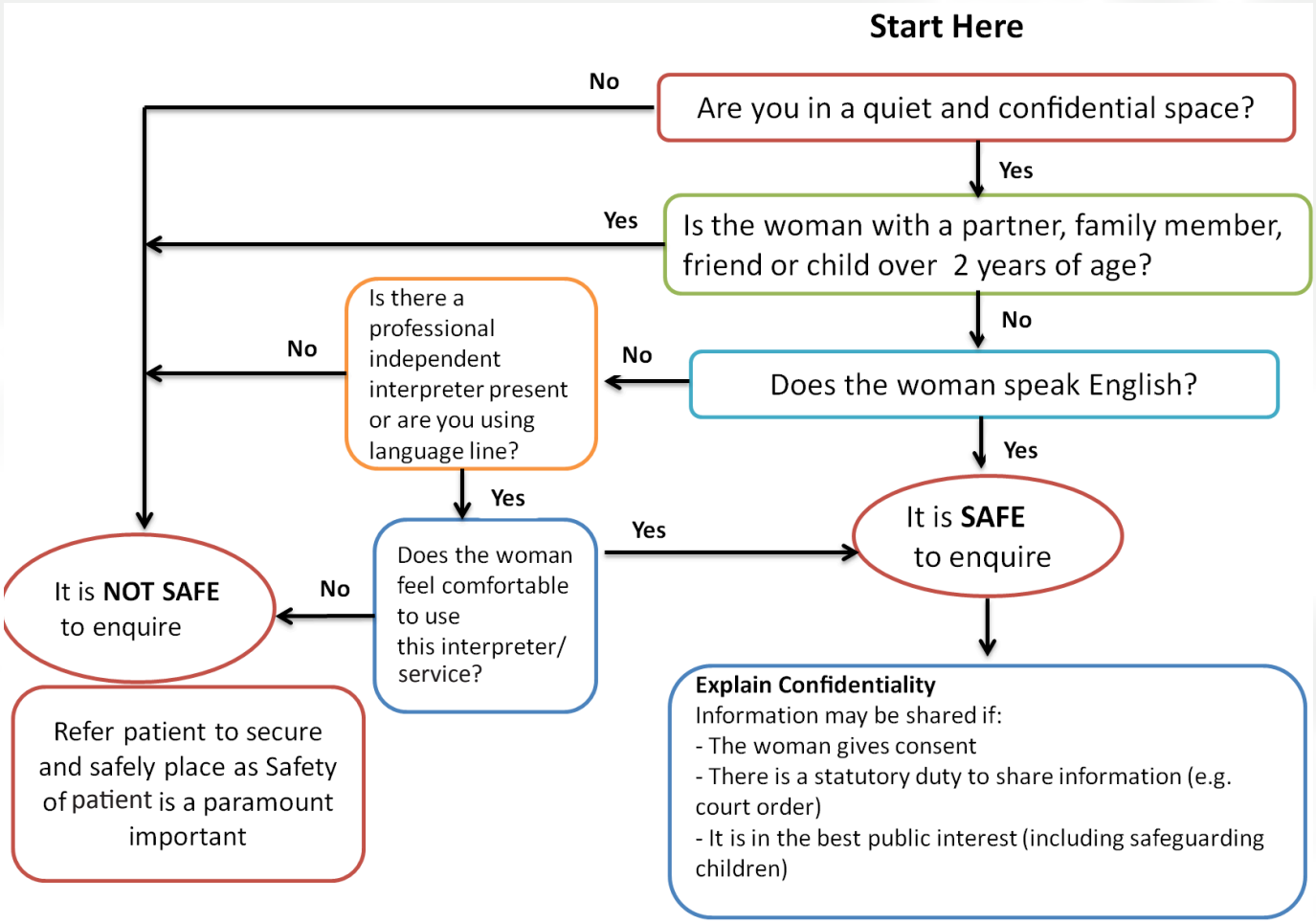
All health care facilities and providers need to ensure that a number of minimum requirements are in place to support and provide services to VAW. The minimum requirements includes: (WHO, 2013)

- A protocol or Standard Operating Procedure (SOP) to guide the intervention.
- Health care providers are trained on the correct way to ask about violence and how to respond to women who disclose
- Availability of a private and safe place to conduct consultation
- A system for referral is in place
- Health care providers are made aware and are knowledgeable about services and resources to refer women for follow-up care.

In some situations, there is a need to use the interpreter to help in clients during consultation. The health care providers need to be cautious in involving the third person in consultation process. In this situation, health care provider should: (STDV, 2008)

- Avoid using family members as interpreters
- Ensure that patient is comfortable with using the interpreter
- Ensure that the interpreter is trained to interpret around issues of VAW

Assessment for safety to enquire for intimate partner violence



(Source: Standing Together Against Domestic Violence, UK)

How to ask about gender-based violence

VAW is a very sensitive topic in many parts of the world including Fiji. In the majority of situations, encouraging women who have experienced violence to disclose or tell their story, takes specialized communication skills on the part of the health care provider. Training health care professionals is essential in order to increase their knowledge and confidence on asking and managing patients who have experienced violence.

The Table below is the list of tips for communicating with survivors of VAW – do's and don'ts.

Do's	Don'ts
- Take the initiative to ask about - Explain that the information will remain - Explain that the information will remain confidential and inform her about any limitations to confidentiality - Listen attentively - Use eye contact and focus all attention on her. - Be aware of your body language - Show a non-judgmental and supportive attitude and validate what she is saying - Use a sympathetic voice to reassure the survivor - Carefully listen to her experience and assure her that her feelings are justified - Show her that you believe her story - Be patient with women and girls survivors of VAW - Emphasize that violence is not her fault and that the perpetrator is responsible for his behavior - Use supportive statements, such as "I am sorry that this happened to you" - Underline that there are options and resources available. Try to find adequate services together with her	- Ask about violence in the presence of a partner, family member or friend. - Use judgmental language - Don't blame the woman. Avoid questions such as "Why do you stay with him?" - Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the survivor - Do not judge a survivor's behaviour based on culture or religion - Don't pressure her to disclose.

Sources: Adapted from Perttu et al 2006, Warshaw 1996, WHO 2003, WHO 2013

Note: All questions should be kept very simple, easy to understand, and avoid using legal or technical terms such as 'gender-based violence' "domestic violence," 'perpetrator of violence' as the meaning might not be clear to some women.

4. Medical examination and providing medical care

With or without disclosure of sexual or physical assault by women, health care providers should ensure comprehensive examination and care are provided as required by the clinical symptoms observed.
Bear in mind that many survivors of sexual violence are often in a distressed state and very emotional after an assault, due to fear and trauma experienced.

Intervention during the first 5 days after the assault:
a. Provide first line support

Providing appropriate first line support can save women and children's lives.

Health care providers should always offer immediate support to all women who disclose. If they are unable to do so, they should ensure that someone else is immediately available to provide first-line support to women. See Care pathway for intimate partner violence in chapter 4.

It is important to ask the survivor if she is afraid for her safety, and to assist her to be safe if she says yes (through referrals).
The first line support includes:

- being non-judgmental, supportive and validating what the woman is saying. For example, under 'being non-judgmental, supportive and validating what the woman is saying', possible things to say include: "It's not your fault." "I believe you." "Take your time." "I know this is hard." "You are not alone- many women unfortunately experience what has happened." "I am here to help you." "I will do my best to help you and answer your questions. If I don't know the answer, I will help you find someone who can." Etc
- providing practical care and support that responds to her concerns
- asking about her history of violence, listening carefully, but not pressuring her to talk
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing/mobilizing social support

Providers should ensure:

- that the consultation is conducted in private
- respect client's confidentiality. Women should be also well informed about any limits of confidentiality.

b. History taking and physical examination
Health care providers should explain all aspects of the consultation to the patient, so that she understands all her options and is able to make informed decisions about her medical care. The explanation should also include any limitations of confidentiality, such as any legal obligations to report VAW to the police or other authorities.

> It's important to obtain informed consent from the patient on all aspects of the consultation. A signed or marked the consent form is required to support the documentation for legal proceedings.

History taking

History taking is very important part of management process. It's a key to support a patient's diagnosis, helping providers to formulate to focus on physical examination. In addition, its helps the providers to get to know patients, winning their confidence, and understanding the social context of their lives.

The gathering of information should include:
a. A **detailed description of the physical assault, its duration,** whether any weapons were used such as belts, household objects, knives..etc as well as date and time of the assault (BMFWJ, 2010).
b. A **detailed history of the sexual assault**: -- including the nature of the penetration, if any, whether ejaculation occurred, recent menstrual and contraceptive history, and the mental state of the survivor (details in table below)

When interviewing the patient about an assault, health care professionals should:

- ask her to tell in her own words what happened
- avoid unnecessary interruptions and ask questions for clarification only after she has completed her ac count
- bearing in mind that some patients may intentionally avoid sharing particularly embarrassing details of the assault, such as details of oral sexual contact or anal penetration
- use open-ended questions and avoid questions starting with "why", which tends to imply blame
- address patients questions and concerns in a non-judgmental, empathic manner.

The key information in history taking includes:

General medical history	Sexual History
1) Take a detailed medical history 2) The woman's mental health status (WHO, 2013)	1) Ask whether the victim is sexually active or not active 2) Date and time of last consensual inter course and number of partners in last 7 days especially important when collecting semen for forensic evidence 3) The risk of HIV and other sexually transmitted infections (STIs)
Gynecological history:	**Details of incident**
1) Reproductive history (Gravidity, Parity, Abortion) 2) Last menstrual period (LMP) - if the woman is pregnant; does the dates coincide with abuse 3) Previous STI and treatment 4) Use of family planning 5) The risk of pregnancy	1) Date, time and frequency of abuse, and date of last incident in cases of repeated abuse 2) Location 3) Number of assailants 4) Details of perpetrator (name, age, address-contact, employment, relationship to survivor, mental status of perpetrator during violent incident, and other personnel information), is he/she still posing a threat? 5) Details of physical/ sexual assault, was a weapon or object used 6) Occurrence of ejaculation 7) Use of condoms 8) Drugs or alcohol taken or given 9) The detailed history of the attack should be documented, including the nature of attack, penetration, if any, whether ejaculation occurred.

Physical examination

After taking the history, health care professionals should conduct a complete physical examination (head-to-toe; for sexual violence also including the patient's genitalia).

The results of the physical examination, the condition of clothing, any foreign material adhering to the body, any evidence of trauma, however minor, scratches, bite marks, tender spots, etc., and results of a pelvic examination should be documented.

> The survivor should not shower or bathe, urinate or defecate, or change clothes before the medical examination, as evidence may be destroyed.
>
> Also important to understand that for most women who experience sexual assault, their greatest impulse is to get in the bath or shower and try to scrub themselves clean, to rub off what happened to them or any remnants of the assault. So important to note for health workers that if she has bathed already, to not make her feel badly about it.

Patient examination should be done in a professional manner. The key principles of examination includes: (Perttu/Kaselitz 2006, Warshaw/Ganley 1996, WHO 2003)

- Explain the medical examination, what it includes, why it is done and how, to avoid the exam itself becoming another traumatic experience. Also, give the patient a chance to ask questions.
- Do not leave the patient alone (e.g. when she is waiting for the examination).
- Carefully examine areas covered by clothes and hair.
- If she has experienced sexual violence, examine her whole body – not just the genitals or the abdominal area.
- Examine both serious and minor injuries.
- Note emotional and psychological symptoms as well
- Throughout the physical examination inform the patient what you plan do next and ask permission. Always let her know when and where touching will occur. Show and explain instruments and collection materials.
- Patients may refuse all or part of the physical examination. Try to re-enforce patient the important of examination. How ever, the patient's decision should be always respected.
- Both medical and forensic specimens should be collected during the course of the examination. This should be done by a health care professional trained in forensic medicine in the same place and by the same person which reduces the number of examinations that the patient has to undergo and can ensure the needs of the patient are addressed more comprehensively.
- Do not leave the patient alone while waiting to be seen by a doctor or nurses (e.g. when she is waiting for the examination).

Head-to-toe examination of a child or adolescent survivor:

1. Preparation - Ensure examination room has adequate light - Have swabs ready - Show client and explain what you might have to do - Never have an adult or child completely undressed. First undress upper half, than bottom half	**5. Asses Mental State** - Assess ability to consent, i.e. drunk, mentally retarded etc - When you feel patient is 'slow', 'can't quite hold a normal conversation,' it is advisable to seek expert opinion from a psychiatrist/clinical psychologist
2. Position - Lay on her back, knee up (for female examination) - when examining a child: If child is unable to cooperate, delay examination or arrange for an examination under anesthesia	**6. Genital findings** - Breasts: Any injury, bruising, bite marks etc - Describe any change noticed on: Labia Majora, Labia Minora, urethra, fossa navicularis, Posterior fourchette, Perineum, Hymen
3. General Appearance - check height/weight for children and adult always - General (nutritional) status - Signs of neglect or physical abuse - Obvious functional impairments	**7. Hymeneal examination** Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outward and downward. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa.

4. External-genital Injuries

- Describe type of injuries, their position, age and note whether 'lesion is consistent with injury caused by blunt/sharp object/burns.
- Use a diagram to illustrate injuries
- Clothing: Mainly relevant in acute cases, i.e. describe whether torn, type of dirt, blood etc
- Note down the details of the injuries on the examination form, and also mark it all down on the body map (annex1)

8. Note for Vaginal Examination

- Discharge: Physiological, infection, color, odor, consistency
- Hemorrhage: Traumatic/menstrual
- Uterine size by palpation and/or with bimanual

9. Anal examination:

- Left lateral position with flexed knees
- Gentle parting/ separation of buttocks
- Description:
  - Acute changes /TEARS
  - Fresh tears at 'x' o'clock
  - Anal margin - look for irregularities, deficits, distortion, etc
  - Fissures - at 'x' o'clock
  - Acute fissures can occur in young children who have not been abused, they tend to occur in the mid line, either posterior or anterior

Performing the head-to-toe examination of children

The following are the important points should be considered when examining children:

- Record the height and weight of the child.
- In the mouth/pharynx, note the palate or posterior pharynx, and look for any tears in the frenulum.
- Describe whether child is anxious, fearful, tearful, happy, withdrawn etc. These observations may complement the history and/or physical findings
- Record the child's sexual development and check the breasts for signs of injury.
- Girls should have an anal examination as well as a genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it. Look for bruises, tears, or discharge and help the child lie on her back or on her side
- Use of a digital camera to take photographs as part of evidence is crucial. Use of film cameras provides strong evidence in court and is preferred to digital cameras, which can be easily edited.

Note: HCWs should be trained on the correct use of camera and how to take appropriate photograph.

Genital and Anal Examination for Girls

- Explain each step of the examination.
-Examine the external genitalia.
- Examine the labia and other related structures.
- Take all the swabs in the following order: external vaginal swab, internal vaginal swab, high vaginal swab, and rectal swab. Take oral swabs for seminal fluid in cases where oral sex is implicated. Skin swabs are collected where a seminal stain is suspected on the skin.
- Speculum examination on girls who have not reached puberty causes pain and may cause injury. If it is necessary, the child need to be referred to a higher level health facility for this procedure. It should be done only if the child has internal bleeding from a penetrating vaginal injury. In this case, speculum examination is done under general anesthesia at a Divisional hospital. A nasal speculum may be used for this purpose in very young girls. For small girls, a pediatric speculum is recommended
- Obtain pubic hair and any other pieces of physical evidence that may be seen in the genitalia.
- Document wounds, giving the location, size, and type (bruise, stab wound, incised wound, or laceration).
- Control bleeding, if any.
- Examine the anus; look for bruises, tears, or discharge.
- Help the child lie on her back or on her side.

Genital and Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis.
- Check for discharge at the urethral meatus (tip of penis).
- In an older child, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child.
- Examine the anus, looking for bruises, tears, or discharge, and help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated.
- Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.
- Check for injuries to the frenulum of the prepuce and for anal or urethral discharge; take swabs if indicated.
- Do not carry out a digital examination to assess anal sphincter tone. Record the position of any anal fissures or tears. Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation. It is not diagnostic of sexual assault.

5. Specimen collection Laboratory Investigations and Forensic examinations

General Consideration

- The evidence should be collected as soon as possible after the incident.
- Transportation and preservation regulations of specimens should be observed to ensure reliable results

Specimen's collection

Health workers should collect all materials that might serve as evidence to support clients diagnostic and management as well as support evidence in the legal purposes.

a. Materials such as hair, fingernail scrapings, sperm, saliva, or blood that is visible on the client's body.
b. Swab: from the injuries, oral cavity, genitalia, .etc
c. Urine sample
d. Blood sample

To maintain validity, sperm's specimen should be collected as soon as possible (within 72 hours) after the incidence to establishing DNA testing laboratory.

Laboratory Tests

Laboratory investigations are done to help to collect evidence that may help the treatment of the survivor and also to prove or disprove a contact between the offender and survivor. The forensic evidence may be used for medical and legal purposes to support the survivor's account, confirm recent sexual contact, show the force or coercion used, and help identify the perpetrator.

The laboratory tests include HIV testing, pregnancy tests, urinalysis, and screening for STIs. Additional tests can be done, e.g- full blood count and biochemistry if needed.

The health care provider should also make arrangements for laboratory investigation screening for STIs including:

- Hepatitis-B: Hepatitis B surface antigen
- Syphilis: RPR, and TPHA for syphilis
- Gonorrhea: Grams stain and culture for intra cellular diplococci
- Chlamydia: Nucleic Acid Amplification Tests (NAATs)
- Trichomonas: Wet mount for Trichomonas Vaginalis

Confirm or exclude pregnancy:

A pregnancy test should be done to confirm or exclude pregnancy at the time of visit and during the follow up unless she has a permanent contraception such as tubal ligation or post-menopausal. If menses is overdue in a woman who has had a regular cycle, or a period has been missed - do urine for HCG to confirm pregnancy and if need be do ultra-sonography to confirm pregnancy and also ascertain gestational age.
Note: investigations such as X-rays should be done if needed.

Collection of Forensic Specimens

Informed consent specifically for specimen collection should be obtained, and documented.
Health care providers should explain that the specimens may be used for the criminal justice process should a legal action go ahead. If a report of the assault has not been made (i.e. to the police) there may still be some benefit in collecting the specimens (and securely holding them for a time).
Some results of the tests may not be available to the patient (unlike diagnostic tests done by medical practitioners).

Consult with your local laboratory regarding appropriate types and handling of specimens. For example, do not collect DNA evidentiary material if your laboratory does not perform this test.

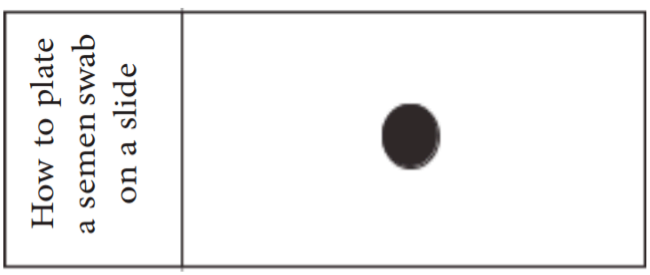
Once collected, the specimens should not be out of the doctor's sight until handed to the police. This process is called "continuity of evidence" and is designed to avoid allegations of specimen tampering. Record the name of the police officer to whom the specimens are handed, and the date and time of transfer should be recorded.

Instructions to the patient

If the patient alleges oral penetration with possible ejaculation in the mouth, drinking and tooth brushing should be postponed until oral forensic specimens are collected.

General precautions

- Always wear gloves for examination and specimen collection
- Recap swabs and other specimens and seal with a patient label.
- In order to find spermatozoa, the laboratory will need a slide and a swab. The slide is used to look for sperm (the adjacent diagram shows how to plate the specimen). The sperm are then extracted from the swab for DNA typing.
- Every specimen should be labelled with identifying data and sealed into a bio-hazard bag.



SAMPLE LABEL

Name of patient	**Ada Wells**
Date & time of collection	**01.10.02 0400 hrs**
Specific type of specimen	**Endocervical swab**
Name of doctor	**Dr A Welborn**

Other Collection

Clothing	Trace evidence from the patient's clothes will not be lost if the patient is instructed to undress over a large sheet of paper (drop sheet). One way of doing this is to ask the patient to stand on a sheet of paper, behind a screen and hand out the items of clothing one by one, to be placed in individual paper bags. Note which items of clothing have been collected. Check with the police which items of clothing are required.
Drop sheet	The drop sheet could have evidence from the offender such as pubic hairs, head hairs and clothing fibres. The drop sheet could have evidence from the scene such as sand, fibres or vegetation. The drop sheet is folded in such a way so as to retain any evidence, placed in a paper bag and sealed with a patient label.
Sanitary pad/tampon	These items should be dried and sealed in a double paper bag.
Fingernail scrapings	An allegation of the victim scratching the assailant may leave foreign DNA or fibres under the patient's fingernails. The fingernail(s) can be cut and the clippings placed in the container.
Head hair for comparison purposes	Twenty representative hairs should be cut from over the head, placed on a piece of paper, folded as the drop sheet, sealed and bagged
Oral swab	Spermatozoa in the mouth collect in the same places as saliva. The best reservoirs are therefore the gingival margins of the lower teeth and under the tongue. This swab should be done if there is allegation of oral penetration within the last 12–24 hours. Alternatively, have the patient rinse his/her mouth with 20–30 ml of sterile water and collect the rinsing in a sterile container.
Saliva on skin	Assailant DNA can be recovered. The double swab technique involves (a) swabbing the affected area with a swab moistened with tap water, followed by (b) swabbing with a dry swab. Both swabs should be air dried and submitted.
Semen on skin	The double swab technique can be also be used for skin where dried semen may be present. Both the first moist swab and the second dry swab should have slides made from them. Use this technique wherever ejaculation may have occurred, including the vulva and anus.
Pubic hair combing	Performed infrequently and only if foreign hair is noted on examination. Submit comb and products. Collect foreign materials with a swab stick and submit in a sterile container.
Vaginal swab	A swab taken with or without the use of a speculum, depending on patient/doctor preference.
Endocervical warm swab	Can be collected with the use of a speculum for direct visualization of the cervix. Use water to lubricate the speculum
Anal and rectal swab	An endoscope may be used, or the anus can be swabbed under direct vision.

Victim / Assailant DNA for comparison	If there is no allegation of oral penetration, a buccal swab may be taken. Otherwise, blood will provide DNA
Blood for DNA	Should be collected into an appropriate tube
Blood for drugs	Use a plain tube.
Urine for drugs	Instruct the patient to provide a full sterile container of urine.

c. Diagnosis and management

Based on the above, the healthcare provider shall make the following diagnoses:

- Medical diagnosis
- Surgical diagnosis
- Gynecological diagnosis
- Psychological diagnosis

Treatment of injuries

Patients with severe, life-threatening conditions should be referred for emergency treatment immediately. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated in situ by the examining health care worker or other nursing staff. Any wounds should be cleaned and treated as necessary. The following medications may be indicated:

- antibiotics to prevent wounds from becoming infected
- a tetanus booster or vaccination (according to local protocols)
- medications for the relief of pain, anxiety or insomnia. (WHO 2003)

a. Emergency contraception

Sexual assault may place women and girl of reproductive age at risk of unwanted pregnancy. Therefore, emergency contraception should be offered to survivors of sexual assault as soon as possible to maximize effectiveness. Emergency contraception should be initiated as soon as possible after the rape, as it is more effective if given within 3 days, although it can be given up to 5 days (120 hours).

Note: pregnancy test should be done immediately following assault. This will provide valuable information about the pregnancy status of the patient.

Recommendation:

- if levonorgestrel is available: a single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12 hours apart
- If levonorgestrel is not available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available.
  With high dose of oestrogen (50μg), oral 2 tables, two doses, 12 hours apart
- If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUD) may be offered to women seeking on-going pregnancy prevention. IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (WHO, 2010).
- A pregnancy test is not required, but if one was done and the result was positive, emergency contraception would not be necessary or effective
- If a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman and girl is pregnant as a result of rape, she should be offered safe abortion.

Managing side effects:
Nausea: routine use of anti-nausea medications is not recommended.
Vomiting: Should repeat another dose (plus Anti-Nausea medication) if vomit happens within 2 hours after taking ECPs,

d. Post-Exposure Prophylaxis (PEP) for HIV

Sexual assault may be associated with the transmission of HIV. The level of risk of exposure contracting HIV is depending on the nature of the assault, injuries/tears, and multiple perpetrators. Those exposures included:

- receptive vaginal or anal intercourse with or without a condom, or
- contact between the perpetrator's blood or ejaculation and mucous membrane or non-intact skin during the assault, or
- recipient of oral sex with ejaculation; or
- the person who was sexually assaulted was drugged or otherwise unconscious at a time of the alleged assault and is uncertain about the nature of the potential exposure, or
- the person was gang-raped.

Post exposure prophylaxis for HIV should be given immediately to the survivor after level of risk is calculated (should be given within 72 hours after exposure).

Health care provider should discuss HIV risk to determine use of PEP with the survivor on the following:

- limitations of PEP
- the HIV status and characteristics of the perpetrator if known
- assault characteristics, including the number of perpetrators
- side-effects of the antiretroviral drugs used in the PEP regimen

Recommendation:

- HIV testing and counselling is recommended prior to giving PEP but should not preclude PEP being offered. However, people with HIV infection, should not be given PEP and should be linked to care and provided with antiretroviral therapy. The provision of counselling should also include the important of adherence, and of regular follow up.
- PEP should be initiated as soon as possible after the assault, ideally within a few hours and no later than 72 hours after the exposure.
- Recommendation ART: fixed-dose combination is recommended.

ART Syrup-Based Regimen for Children

	Medicine	Application
First Line	AZT + 3TC: Zinovudine: 2 mg/kg Lamuvidine 4 mg/kg	Twice a day for 28 days
Second Line	D4T* + 3TC: Stavudine: 1 mg/kg (only if a fridge is available) Lamuvidine: 4 mg/kg	Twice a day for 28 days

Note: Syrups require refrigeration so they are not appropriate unless the healthcare providers have a fridge.

Post-exposure prophylaxis for Sexually Transmitted Infections (STIs)

Presumptive treatment is preferable to testing for STIs, in order to avoid unnecessary delays. Women and girl survivors of sexual assault should be offered prophylaxis/presumptive treatment for the following STIs: chlamydia, gonorrhoea, trichomonas, and syphilis.

The recommendation of presumptive regiment includes:

Ciprofloxacin (500mg)*	Single dose
Plus Azythromycine (1g)	
Plus Flagyl (2g)	
PLUS	
Benzathin Penicilline (2.4MU)	IM single dose, OR
Doxycycline (100mg)**	Twice daily for 2 weeks

Note:
*. Replace Ciprofloxacin to Ceftriaxone (500mg, IM, single dose) if the woman is pregnant or breast feeding
** Doxycycline should not be used during pregnancy and breast feeding

e. Psychological/mental health interventions

The health care provider should refer survivors of intimate partner violence to specialist health care providers for psychological/mental healthcare interventions.

Note: it is very important to have counselor who has undergo special training on Psychological/mental care available to manage the cases.

For survivors of sexual violence, health professionals need to observe three main stages after the assault when setting appropriate interventions:

1) During the first days of the assault, health care providers should
- continue to provide first-line support
- provide survivors with information on coping strategies for dealing with severe stress
- Discuss safety plan

2) Up to three months post-trauma, health care providers should
- continue to provide first-line support
- apply "watchful waiting" for 1-3 months after the event: explaining the woman that she is likely to improve over time and offering her the option to come back for further support by making regular follow-up appointments. "Watchful waiting" should not be applied if the woman is depressed, has alcohol or drug use problems, is suicidal or self-harming or has difficulties functioning in day-to-day tasks.

3) Interventions from 3 months post-trauma- Health care providers should:
- assess for mental health problems (symptoms of acute stress/Post Traumatic Stress Disorder (PTSD), depression, alcohol and drug use problems, suicidal or self-harm)
- treat depression, alcohol use disorder and other mental health disorders
- if the survivor is suffering from PTSD - arrange for PTSD treatment

Note: Behaviour change intervention should be included as part of the counselling process.

6. Guidelines of people with disabilities (CALCASA, 2010)

People with disabilities are at risk of similar forms of sexual assault and abuse as people without disabilities (e.g., rape, incest, forced, unwanted or disguised touching, exposure to or making pornography, sexual harassment, sexual trafficking, unwanted sexual jokes and any other unwanted sexual contact or activity).

People with disabilities may wait longer than people without disabilities to make a complaint and they may have experienced sexual abuse by multiple perpetrators and across many years.
When they are not getting any support, they may experience problems with substance abuse, eating disorders, depression and other trauma symptoms. In addition, they may also encounter additional problems with self-protection, alienation, dissociation and overly compliant and acquiescent behavior.

Disability protocol and sensitivity:
- Make no assumptions based on appearance or communication
- Talk directly to the abuse survivors and not to the care provider, family members, case manager, social worker or interpreter.
- Involve third party if a survivor gives full consent
- Take special notice of any person who answers for and does not ever leave the survivor
- People with cognitive disabilities and/or mental illness may take longer to process feelings and information. You may need to take additional time to manage this case.
- Be aware that the victim may have extremely limited knowledge about sexual activity, or their own bodies
- Support the survivor in making decisions and choices as you would with any other survivor

Survivors who are deaf
- Be aware that many hearing impaired people will want to " read" your lips. The providers may consider writing questions and getting written answers from patients who are hearing impaired.
- Sit directly in front of the patient and speak clearly but not loudly.
- Be aware that some people who are deaf will not have the vocabulary for rape —they may use terminology such as "sex with me." This can lead to misinterpretation.
- Ensure an interpreter is present when there is a substantial conversation and when it's important to relay accurate information from a client and ensure she is provided with accurate information.
- Be aware of your behavior that may be misinterpreted by the survivor.

Survivors who are blind
- Speak directly to and facing the person rather than through another person without a disability. Offer any assistance directly. Do not assume help is needed.
- If person asks for assistance, contact verbally first and then use the back of your hand to contact the back of the persons hand.
- If person uses a cane for orientation you can simply give directions to parts of the room or for example a chair.
- Always describe clearly what you are doing when interviewing and examining patients who are blind or partially sighted.

7. Documenting VAW

The aims of documentation are:
- **For the health professional's legal purposes:** Health care providers have a professional obligation to record the details of any consultation with a patient. The notes should reflect what was said (by the patient) and what was seen and done by the health care provider.
- **For the health patient's legal purposes:** Medical records can be used in court as evidence. It can help the court with its decision-making as well as provide information about past and present violence.
- **For good clinical care:** Documentation can alert other health care providers who later attend the patient to her experiences of VAW and thereby assist them in providing appropriate follow-up care (Warshaw et al 1996, WHO 2003).

Note: Lack of coordination between health care providers and police/prosecutors can result in evidence getting lost

Recording and classifying injuries
Health care professionals should describe any injuries carefully. The description should include the type and number of injuries, as well as their location, using a body map. In case a survivor does not disclose, health care professionals should note whether the injuries are compatible with her explanations. This may help clarifying the situation at a future visit and provide documentation in case she decides to pursue legal action. (Warshaw et al, 1996)

Interpretation of injuries

Interpretation of injuries for medico-legal purposes is a complex and challenging matter. This requires proven expertise on the part of the practitioners performing it, based on continuing education, exposure to peer review, and quality assurance.

The documentation should:

- document injuries using standard terminology such as abrasions, bruises, lacerations, incisions, stab wounds or gunshot wounds
- refer the task of injury interpretation to a forensic specialist

How and what should be documented

Mechanisms for documenting consultations include hand-written notes, diagrams, body charts and photography. Documentation should include the following:

- demographic information (i.e. name, age, sex);
- consents obtained;
- history (i.e. general medical and gynaecological history);
- an account of the assault;
- results of the physical examination;
- tests and their results;
- treatment plan;
- medications given or prescribed; and
- patient education;
- referrals given.

Photography is also an important tool that should be used by all health care providers.

Checklist for using photography to document findings:

Should always obtain informed consent from patient	**4. Chain of custody:** All evidence including forrensic evidence should be locked
1. **Identification:** Each photograph must identify the subject, the date and the and the time that the photograph was taken.	5. **Security:** Photographs form part of a patient record and as such should be accorded the same degree of confidentiality. Legitimate requests for photographs include those from investigators and the court.
2. **Scales:** A photograph should be in sequence. Getting proper measurements are vital to demonstrate the size of the injury. Placing a ruler beside the wound will provide this information.	6. **Sensitivity:** The taking of photographs (of region of the body) is considered to be inappropriate behaviour in some cultures and specific consent for photography (and the release of photographs) may be required.
3. **Orientation:** The first photograph should be a facial shot for identification purposes; this may not be required if the photographs have been adequately identified. One full body photograph is required to identify that the photographs of the injuries belong to that person.	

Source: WHO, 2003

Forensic examinations. (WHO 2003)

The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places.

In any other criminal investigation, the following principles for specimen collection should be strictly adhered to:
- collect carefully, avoiding contamination;
- collect specimens as early as possible; 72 hours after the assault the value of evidentiary material decreases dramatically;
- label all specimens accurately;
- dry all wet specimens;
- ensure specimens are secure and tamper proof;
- maintain continuity; and
- document details of all collection and handling procedures.

Note: Health care workers should be aware of the capabilities and requirements of their forensic laboratory; there is no point collecting specimens that cannot be tested

Providing evidence in court

Health care professionals may be called upon to give evidence, either in the form of a written report or as an expert witness in a court of law. Therefore, they would be expected to:
- be prepared
- be familiar with the basic principles and practice of the legal system and obligations of those within the system,
- make sound clinical observations, which will form the basis of reasonable assessment and measured expert opinion; and
- reliably collect samples from victims of crime

Health care providers **should not:** (WHO 2003).
- provide opinions which are at the edge of, or beyond, the expertise of the witness;
- provide opinions that are based on false assumptions or incomplete facts;
- provide opinions based on incomplete or inadequate scientific or medical analysis; and
- provide opinions which are biased, consciously or unconsciously, in favour of one side or the other in proceedings.

On some occasion, health care providers have been asked to provide writer reports or give evidence in court. It is paramount that health care professionals should aim to always convey the truth of what they saw and concluded in an impartial way. Health Care workers should prepare for this presentation, as there will be questions by court officials. They should understand that it is extremely important for them to prepare well as the victims are relying on them to provide support the evidence the collected upon examination.

The key principle of provide writing report and provide evidence includes: (WHO, 2013)

Writing reports	Giving evidence
1. Explain what you were told and observed	1. Be prepared
2. Use precise terminology	2. Listen carefully
3. Maintain objectivity	3. Speak clearly
4. Stay within your field of expertise	4. Use simple and precise language
5. Distinguish findings and opinions	5. Stay within your field of expertise
6. Detail all specimens collected	6. Separate facts and opinion
7. Only say or write what you would be prepared to repeat under oath in court.	7. Remain impartial
8. Remember, court officials are not medical officers and do not understand medical terms. All medical terms and classifications must be explained clearly, using non-medical explanations for lay persons.	

Storage and access to patient records and information

All health care providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Patient records and information are strictly confidential; it should not be disclosed to anyone except those directly involved in the case.

All patient records (and any specimens) should be stored and locked in a safe place. Biological evidence needs to be refrigerated or frozen; check with your laboratory regarding the specific storage requirements for biological specimens.

8. Risk assessment and safety planning

The safety of patients who experienced VAW is always a main priority. Always keep in mind that in times of separation and divorce, the risk of violence increases: the majority of murders, attempted murders and acts of serious violence are committed when survivors attempt to leave violent partners. (WAVE 2006)

Health care professionals have an important role to play in supporting a survivor through jointly assessing potential risks of further violence, supporting her in her safety planning, as well as offering referrals to social welfare.

Note: Social welfare and Ministry of Health should have an up-to-date official agreement (MOU) to support referral and shelter of victims.

The risk factors for repeating or escalating violence

The following risk factors have been identified in international studies as risk factors for a high degree of dangerousness in instances of intimate partner violence (Gondolf 2001, Robinson 2004, Humphreys at al 2005, WAVE 2006):

- Previous acts of violence against the woman, the children or other family members, as well as former partners
- Previous acts of violence outside the family
- Separation and divorce are times of high risk
- Acts of violence committed by other family members
- Possession and/or use of weapons
- Threats should always be taken serious
- Extreme jealousy and possessiveness
- Extremely patriarchal concepts and attitudes
- Persecution and psychological terror
- Non-compliance with restraining orders by courts or police

Note: It is important to ask the survivor about her own assessment of the situation. Any risk assessment tools should not be a substitute for listening to her view of the situation.

Supporting the patient in developing a safety plan

Safety planning is part of the overall process of risk management, which aims at preventing violence by tracing in to account risk factors and protective factors. Developing a safety plan may help the woman prepare to leave the relationship safely if the violence escalates.

Develop a safely plan

- Identify one or more neighbours you can tell about the violence, and ask them to help if they hear a disturbance in your house.
- If an argument seems unavoidable, try to have it in a room or an area that you can leave easily.
- Stay away from any room where weapons may be available. E.g. Kitchen
- Practice how to get out of your home safely. Identify which doors, windows, elevator or stairways would be best.
- Have a packed bag ready, containing spare keys, money, important documents and clothes.
- Keep it at the home of a relative or friend, in case you need to leave your home in a hurry.
- Devise a code word to use with your children, family, friends and neighbours when you need emergency help or want them to call the police.
- Decide where you will go if you have to leave home and have a plan to go there (even if you do not think you will need to leave).
- Use your instincts and judgment. If the situation is dangerous, consider giving the abuser what he wants to calm him down. You have the right to protect yourself and your children.
- Remember, you do not deserve to be hit or threatened.

Source: adapted from Heise et al, 1998.

9. Sexual harassment

Sexual Harassment:
Any unwelcome sexual advance, request for sexual favour, verbal or physical conduct or gesture of a sexual nature, or any other behaviour of a sexual nature that might reasonably be expected or be perceived to cause offence or humiliation to another.

10. Medical Supplies

All health facilities must have necessary medical commodities as well as the administrative supplies to provide the minimum standard of care for VAW survivors. Those medical and administrative supplies include:

Medical commodities

1) A post sexual assault kit that includes post-exposure prophylaxis (PEP; emergency contraception (EC) items for collecting forensic evidence (syringe, speculum, empty sterile bottle, blood tube, and high vaginal swabs); sterile gloves; sterile swabs; and medication for symptomatic conditions. In the absence of a pre-prepared rape kit, a health facility should collect these items on a tray or in a closed plastic box with contents clearly listed.
2) Supplies and equipment for preventing and controling infection
3) Resuscitation equipment.
4) Sterile stitches and dressing trays.
5) Extra clothes for survivors whose clothes may be collected for evidence.
6) Sanitary supplies.
7) Pregnancy test kits.

Medication

The basic medications for survivors of sexual violence should be available at all times at the service delivery. The following medications include:
1) Treatment for STIs including hepatitis- B
2) Post Exposure Prophylaxis for HIV (PEP)
3) Emergency Contraceptive Pills- such as combined oral contraceptives, or Progesterone Only Pills
4) Tetanus Toxoid (TT)
5) Analgesics such as propranolol or NSADs
6) Sedatives (e.g., phenergan)
7) Local anesthesia for suturing (lignocaine)
8) Antibiotics

11. Self-care for health care providers

Considering the high prevalence of VAW in Fiji, it is likely that health professionals will be responsible for assessing, treating and managing a high number of cases in the course of their work. Thus, this exposure to survivors' injuries, distress, despair and general helplessness may have an impact on health care providers emotional and psychological well-being. This is often referred to as 'vicarious trauma' which means that through being of secondary witnesses to trauma as patients tell about their experiences of physical and sexual violence, the health providers start taking on some of the pain and despair of the patient.

The causes of vicarious trauma include:
- Exposure to stories of trauma
- Desire to help/change survivor's situation
- Feeling powerless or frustrated when a service provider does not see positive changes in the survivor's situation.
- Overly identifying with survivors (especially if the health workers has suffered similar trauma)
- Thinking we have the power to change the survivor's situation

Self-care management stress: (RHRC, web)

SOURCES OF STRESS:	STRATEGIES
Lack of Confidence	- Utilize supervision, peers - Realize your own strengths - Seek mentors and practice skills - Seek training, observe others, read
Personal reservation	- Know your "buttons" - Desensitize yourself (write the most troubling things a survivor could say/do and rehearse your response) - Find a colleague for practice and support
Built-up Stress	- Be aware of your own limits, Know the signs of burn-out - Attend to your needs for leisure, socialization, rest, and pleasure - Know when to ask for help - Deal with any personal past or present history of abuse
Physical Responses	- Practice relaxation - Take slow, deep breaths - Progressive muscle release - Maintain a neutral expression - Keep your voice calm
Organizational/Administrative Confusion	- Clarify agency policies - Know and practice safety procedures - Supervisors should advocate for staff safety - Initiate a "buddy" system - Establish liaisons with police

It is important and necessity of having strong supervision, and that it is the role of supervisors to help staff debrief after upsetting cases or situations, and to allow staff to have a confidential place to discuss these things internally since they cannot share them with anyone else.

CHAPTER

4

Referral Pathway

Health care professionals are often the first point of contact for survivors of VAW. They are not only providing survivors with medical care, but also play an important role in referring the survivor to other necessary services such as safe shelters, organizations providing psychosocial or legal counseling, police and legal justice department, and others.

Women who have experienced VAW have multiple and complex needs. This includes medical care, safe accommodation, psychosocial counseling, police protection and/or legal advice. Therefore, an effective response to VAW requires a comprehensive set of services. Referral is an important aspect in case management as part of a holistic response to survivors of violence. Referral systems benefit both the patient who experienced VAW and the health care provider.

Effective referrals:

Effective referrals require that health care professionals to be:
- able to recognize and facilitate the disclosure of VAW and provide first-line support
- able to assess the individual situation and needs of the patient in particular the risk of further or escalating violence
- knowledgeable about the existing referral system and services and support the patient in identifying the best options.
- knowledgeable about national laws on VAW, including definitions of relevant criminal offence, about available protection measures and any reporting obligations on their part.
- able to obtain the consent of the survivor before sharing information about her case with other agencies or service providers and follow the procedure that protects the woman's confidentiality

Note: Particular emphasis should be put on collecting feedback from survivors who use the services provided and on ensuring safety and confidentiality of personal data of the survivor. The feedback information should be kelp confidential and can be used to improve the services.

Inform consent and referral

- In situations where there is an immediate danger to the safety of the patient or health staff, or if the survivor is unable to consent, due to her medical condition, a referral may need to be made to ensure the safety and best interests of all those involved.
- There may be situations where there is an immediate risk to the safety of the patient, her children or health staff, where police are required and the consent of the patient is not sought to activate this action.

Check List Before Referral

History Taken and Documented	Yes ☐	No ☐
Physical Examination with Necessary Investigation	Yes ☐	No ☐
Mental Status Examination (if needed)	Yes ☐	No ☐
Medical Report Form Filled	Yes ☐	No ☐
ECP given	Yes ☐	No ☐
PEP for HIV (if needed)	Yes ☐	No ☐

Disclosure:

The women have their rights to maintain their confidentiality and decide not to disclose their status. However, when the life of the women is in danger, health care providers have the obligation to report to the authority to ensure the safety and security of the women. The process of disclosure on her behalf needs to be done with the extra cautioun.

In Fiji, there is no drop policy if the matters are reported to the police. The process of arresting of perpetrators and issuing restraining order is initiated once the police receive a report.

As noted throughout this guideline, informed consent of the survivor is very important.

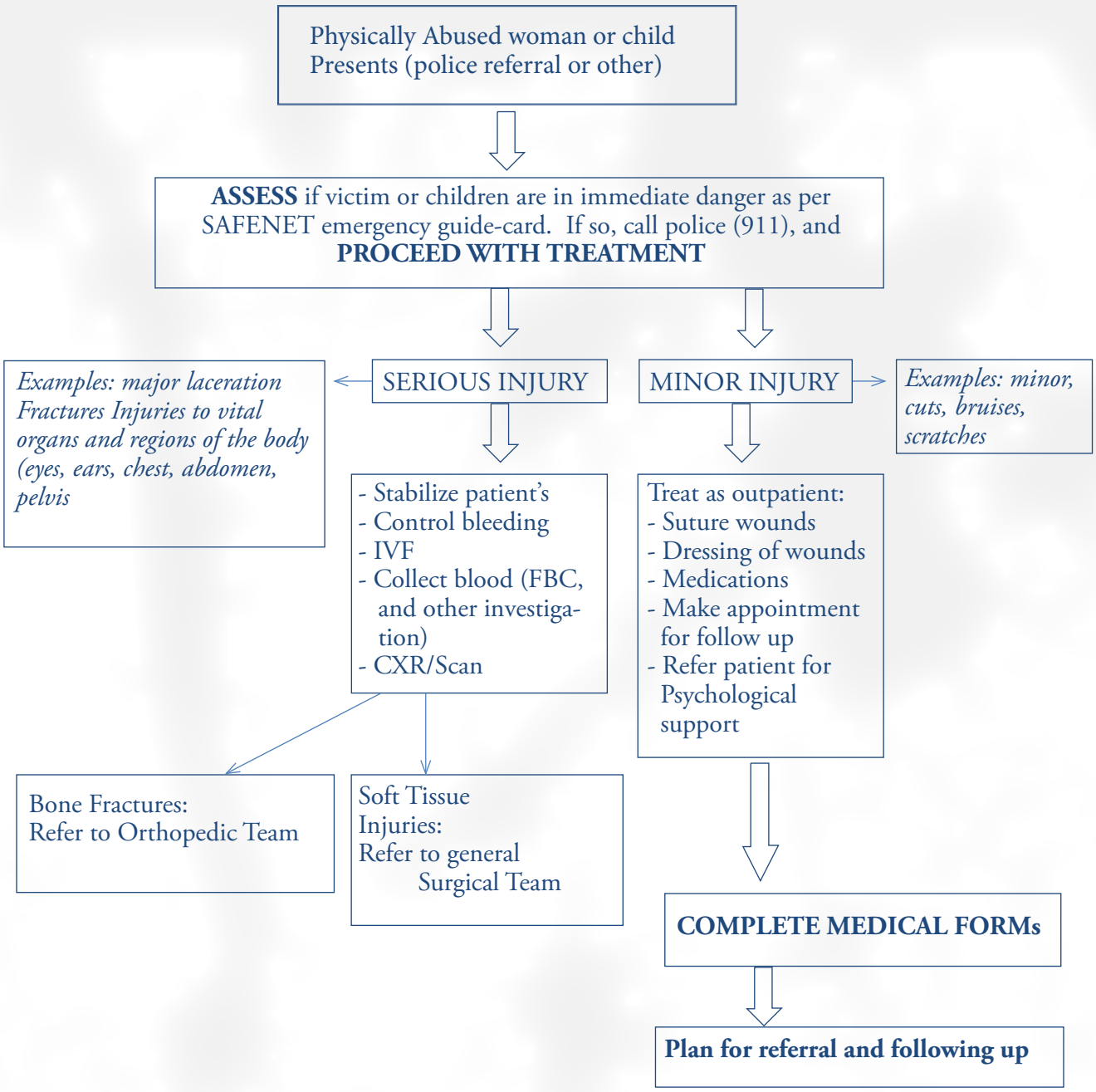
1. Key actors and support groups in Fiji

The key contact organizations for client's support in Fiji that provide Protection, treatment, counselling, legal, child welfare, safety and shelter.

Service provider	Type of service	Emergency phone contact
Police Department	Protection Legalities	3318525 Central 6660222 Lautoka 3477222 Eastern
Ministry of Health	Treatment and Medical Support	3313444 CWMH 6660399 Lautoka Hospital 8811444 Labasa Hospital
Social welfare division	Support Services	3315754 Suva 8811534 Labasa 6668392 Lautoka
Medical Services Pacific (working with Fiji Police Force, the MOHMS and MSWWPA).	Clinic for Post Rape Care (providing medical examination, medical forensics, post rape care, medical home visits counseling and support services) Medical Referrals for safe abortion & post miscarriage treatment. Neutral Counseling for Survivors Legal Aid for Survivors. Telephone Counseling Adults and children. National Child Help Line	Office and Clinic (679) 3630108 (679) 3548062 24 Hour Counseling Mobile: 9910894 Tele Counseling 5640 Helpline (TBD)
Fiji Women's Crisis Centre	- Counselling/ Advocacy – provide moral and emotional support to women, girls, children, inclusive of disabilities and LGBTQ communities - Support through police, medical, legal and court processes - Community awareness - Training of other service providers on Gender and VAW&G	- Suva office - 3313300 / 9209470 (24 hour counselling) - Labasa Office - 9377784 (24 hour counselling) - Ba Office - 9239 775 (24 hour counselling) - Nadi Office - 9182884 (24 hour counselling) - Rakiraki Office – 9129790 (24 hour counselling)
Empower Pacific	Counseling Services Social Work support Psychosocial support Community Awareness Referrals and Follow Up	- 3100191 Suva Branch - 6254226 Lautoka Hospital Branch - 6650483 Lautoka Head Office. - 6233934 Nadi Branch - 8813111 Labasa Branch

ANNEXES

ANNEX 1: STANDARD OPERATING PROCEDURE FOR PHYSICAL ABUSE



Adapted from MHMS Kiribati SOP- Healthcare Treatment of survivor of gender Based Violence, 20014

ANNEX 2: STANDARD OPERATING PROCEDURE FOR SEXUAL ABUSE

Sexually Abused woman or child presents (police referral or other)

↓

ASSESS if victim or children are in immediate danger. If so, call police, and proceed with **TREATMENT**

↓

CLINICAL ASSESSEMENT and full history on standard form with Female nurse in attendance

PHYSICAL EXAMINATION HEAD TO TOE:
- Injuries: bruises, scratches
- Collect bloods as indicated
- Vaginal Examination to look for:
- Injuries and palpitation of female reproductive organs
- Collecting of vaginal and other swabs

Serious Injuries to reproductive organs:
- Refer to OB/GYN
- Refer to general Surgical Team
- Sexual assault Victim: Give PEP for HIV if needed and pregnancy prophylaxis

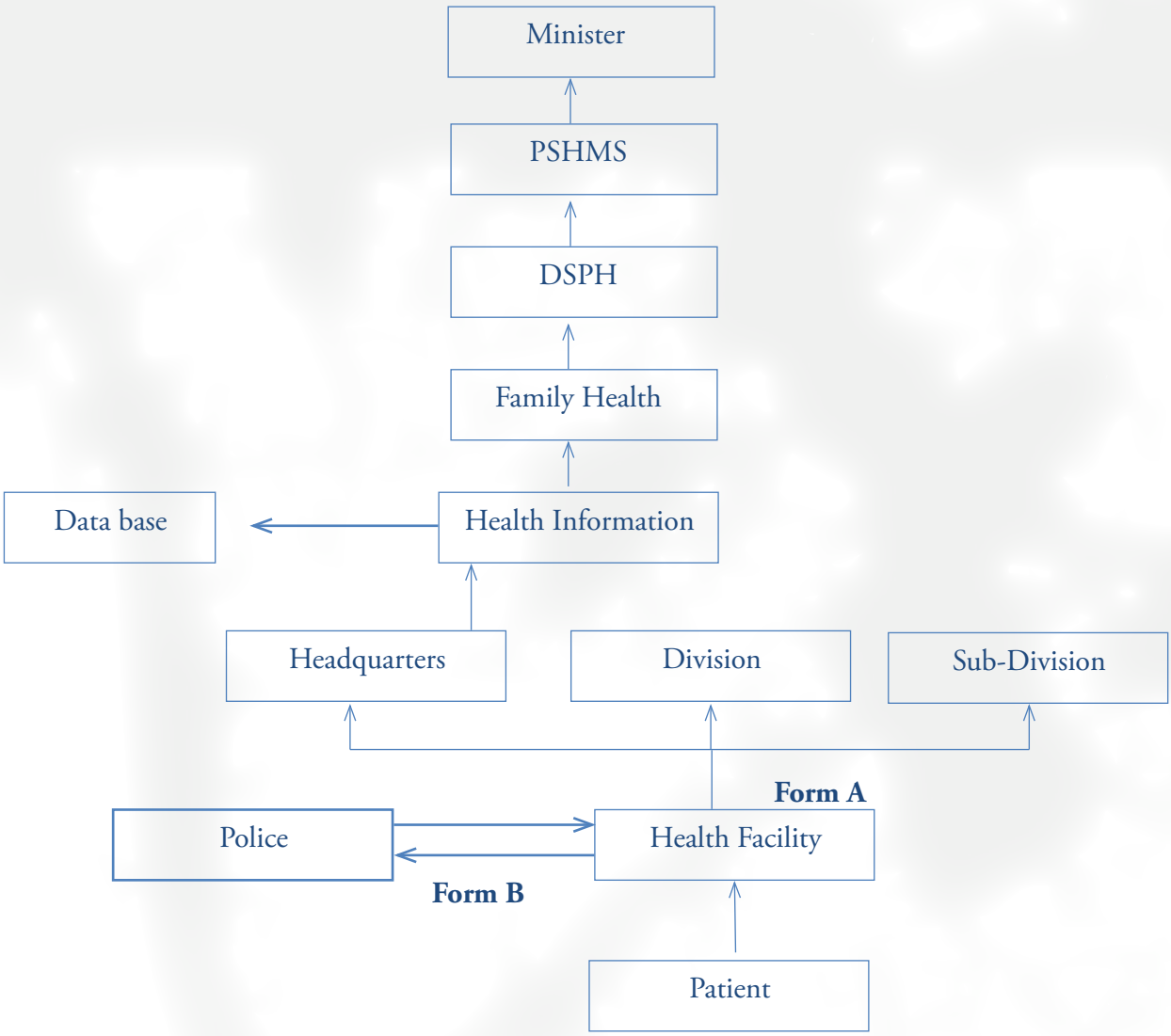
Treat minor injuries and/or no injuries, STI and pregnancy prophylaxis

COMPLETE MEDICAL FORM (3 copies) Health Care Facility, Court, and Client

↓

Continue to follow SAFENET FLOW CHART

Annex 3: GENDER BASE VIOLENCE REPORTING SYSTEM IN FIJI

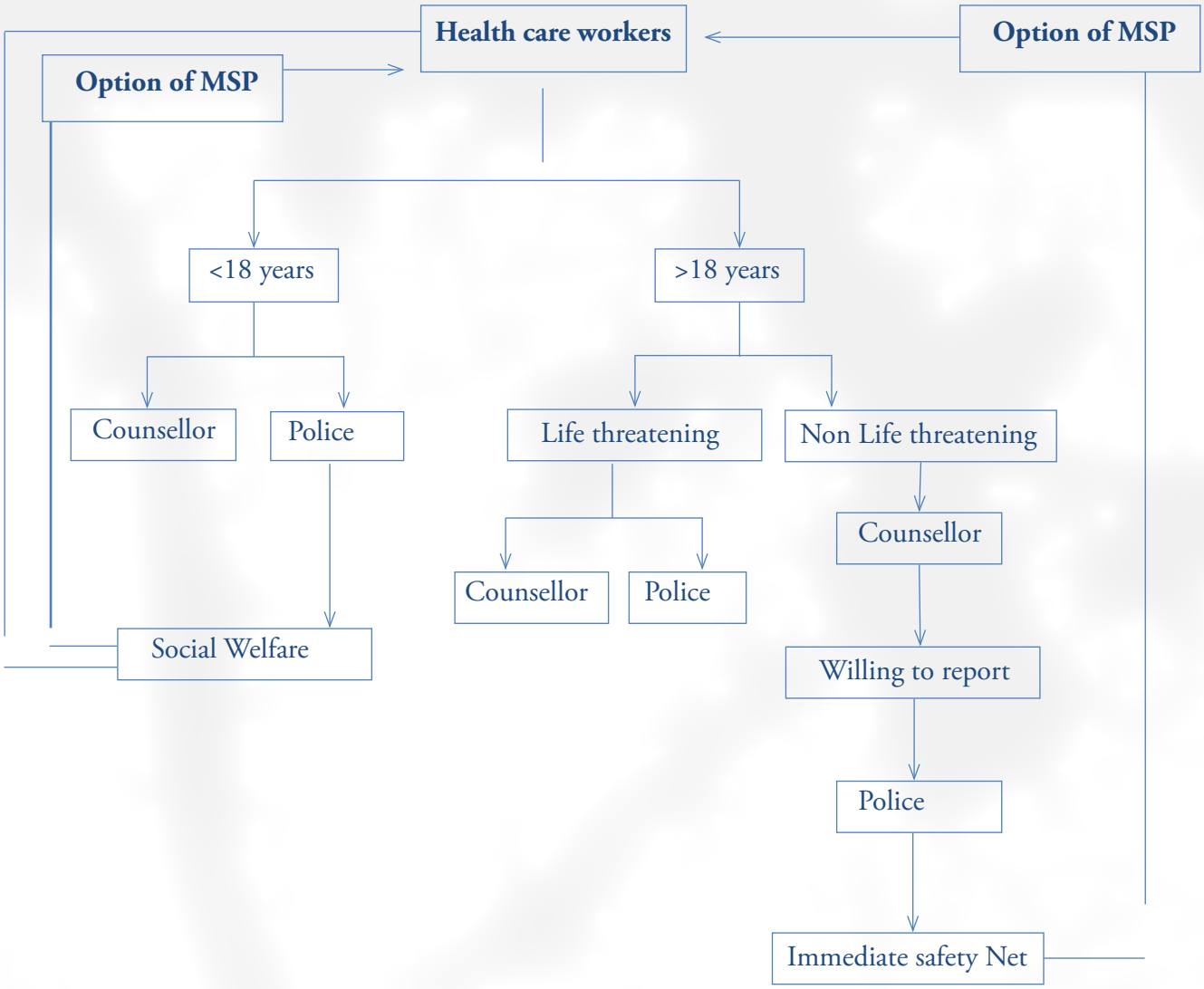


Three documents

1. Patient's register: can be register book or form that records basic medical information for the patients
2. Form-A: form that capture basic information about the patients, and will be used to report within the health system. All health facilities need to report on form-A in monthly basis
3. Form-B: is a confidential form contains all details information of the patients, and will be used to report to the police for legal action. All health facilities need to report on from-B immediately to police

Note: all formed should be duplicated and keep a copy at the health facility

Annex 4: Holistic Referral Pathway



Note: All Person with disability should be also refer to Disability People Association (DPA)

Annex 5: STANDARD MEDICAL REPORT FORM PHYSICAL/SEXUAL ABUSE CASES

Form A: Standard medical report form: Physical/Sexual abuse cases

This form is use to record and report within the health services only

1. Date and place details	
Clinician name:	DOB:
Health facility location:	
Date/time of incident:	Date/time of presenting at the health services:

Referral source

☐ Police ☐ Other support agencies ☐ other(s)

☐ Self ☐ Other health facilities

2. Client details	
Client name/or code #:	Gender: ☐ Male ☐ Female
Date of birth:	

Age:

☐ Patient equal and over 18 ☐ Patient under 18

Patient pregnant: ☐ Yes ☐ No

Due date:……

Have any children: ☐ Yes ☐ No

How many:

Address:

Ethnic background (statistic purpose only)

☐ Indigenous Fijian ☐ Fiji –Indian descendant ☐ Other

3. Type of assault

☐ Physical ☐ Sexual ☐ Other

4. Referral

☐ Yes ☐ No

Specify where:

Form B: Standard medical report form: Physical/Sexual abuse cases

This form is use to record and report to police for legal action

1. Date and place details	
Clinician name:	DOB:
Health facility location:	
Date/time of incident:	Date/time of presenting at the health services:
Referral source ☐ Police ☐ Other support agencies ☐ other(s) ☐ Self ☐ Other health facilities	

2. Client details	
Client name/or code #:	Gender: ☐ Male ☐ Female
Date of birth:	Marital Status:
Occupation:	
Age: ☐ Patient equal and over 18 ☐ Patient under 18	
Patient pregnant: ☐ Yes ☐ No Due date:……	
Have any children: ☐ Yes ☐ No How many:	
Address:	
Ethnic background (statistic purpose only) ☐ Indigenous Fijian ☐ Fiji –Indian descendant ☐ Other	

3. Type of assault		
☐ Physical	☐ Sexual	☐ Other
Past history of assault:	☐ Yes	☐ No

4. Perpetrator and history details	
Perpetrator name:	Gender: ☐ Male ☐ Female
Relationship with victim:	Current location of perpetrator (details home, village of perpetrator):
Place of assault:	
Name person giving history of current assault: Role of history giver- (e.g. Patient/police/family member/ translator): History:	

5. Assessment patient safety	
☐ Yes ☐ No	Is abuser here now?
☐ Yes ☐ No	Is patient afraid of their husband/partner?
☐ Yes ☐ No	Is patient afraid to go home?
☐ Yes ☐ No	Is patient feel her fertility to have family restricted due to partner behavior/or abuse
☐ Yes ☐ No	Has physical violence increased in severity or frequency?
☐ Yes ☐ No	Has husband or partner physically abuse children?
☐ Yes ☐ No	Have children witnessed violence in the home?
☐ Yes ☐ No	Is there a weapon in the home?
☐ Yes ☐ No	Treats of homicide By whom? ☐ Partner ☐ Victim
☐ Yes ☐ No	Treats of suicide By whom? ☐ Partner ☐ Victim
☐ Yes ☐ No	Alcohol or substance abuse ? By whom? ☐ Partner ☐ Victim

6. Specimen collection

Date and time of specimens collection:

Type of specimens;

☐ Blood ☐ Saliva ☐ Urine ☐ Semen

☐ Vaginal swab ☐ Cervical swab ☐ Urethral swab ☐ Anal swab

Location where the specimen taken:

Has the client cleaned up or bath before specimen collection: ☐ Yes ☐ No

7. Treatment

Date and time of triage: | Triage delay: Min/hours

Provider present:

☐ Doctor (state name):…….... ☐ Nurse (state name):…….....

☐ Counsellor(state name):…….. ☐ Other (state name):…….....

Incident visit type:

☐ Sexual assault ☐ Physical assault ☐ Child (under 18 years of age)

Past Medical History:

Past History of assault:

Current medication:

Allergic reaction:

Treatment details:

Injuries:

8. Follow up and Referral

☐ Medical specialist ☐ Social welfare

☐ Counsellor ☐ Other (please specify)

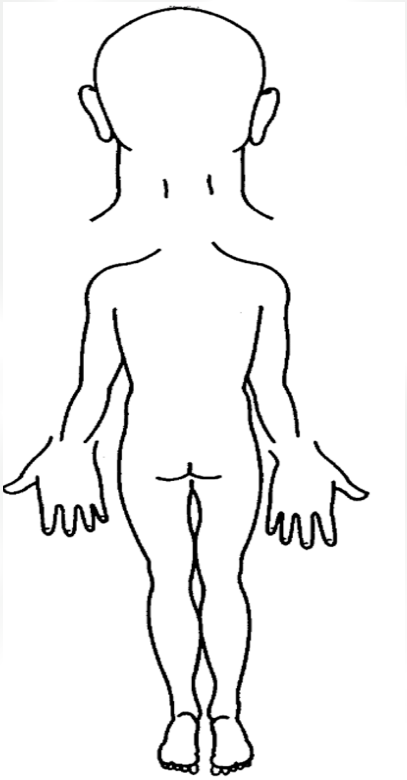
Follow up arrangement:

Comments/summary:

9. Body Map- (Adapted from DSAC Executive Permission, Nov, 2012)

(please marks all the injuries and provide specification on this form)

A. Front of Body – (for adult and children)

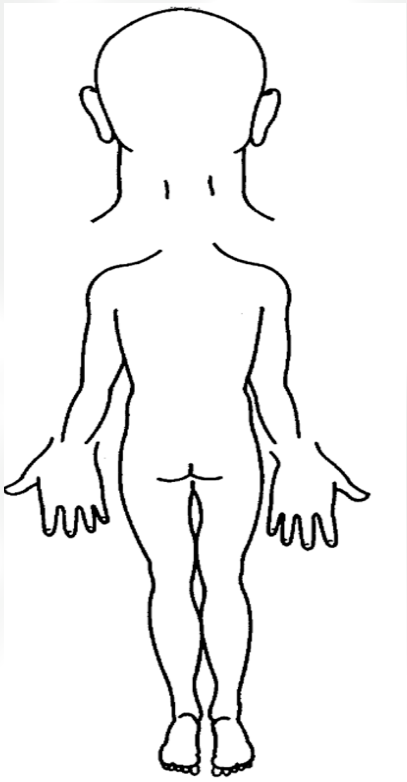
Normal	Specify abnormal	Body map
☐ Face		
☐ Eyes		
☐ Nose		
☐ Mouth		
☐ Ears		
☐ Neck		
☐ Shoulders		
☐ Breast		
☐ Thorax		
☐ Upper arm		
☐ Lower arm		
☐ Hands		
☐ Abdomen		
☐ Upper leg		
☐ Lower leg		
☐ Feet		

Note:

- **Measure, describe and show the areas of: Abrasions, laceration, areas of pain and tenderness, fractures..etc**
- **Trace evidence e.g. vegetation, soil, ..etc include marks, scars, and Tattoos**
- **It is important to report (tick) on normal– provide legal evidence that all areas of body have been examined, not only record on the " injured" area**

Body Map-
(please marks all the injuries and provide specification on this form)

B. Back of Body - (for adult and children)

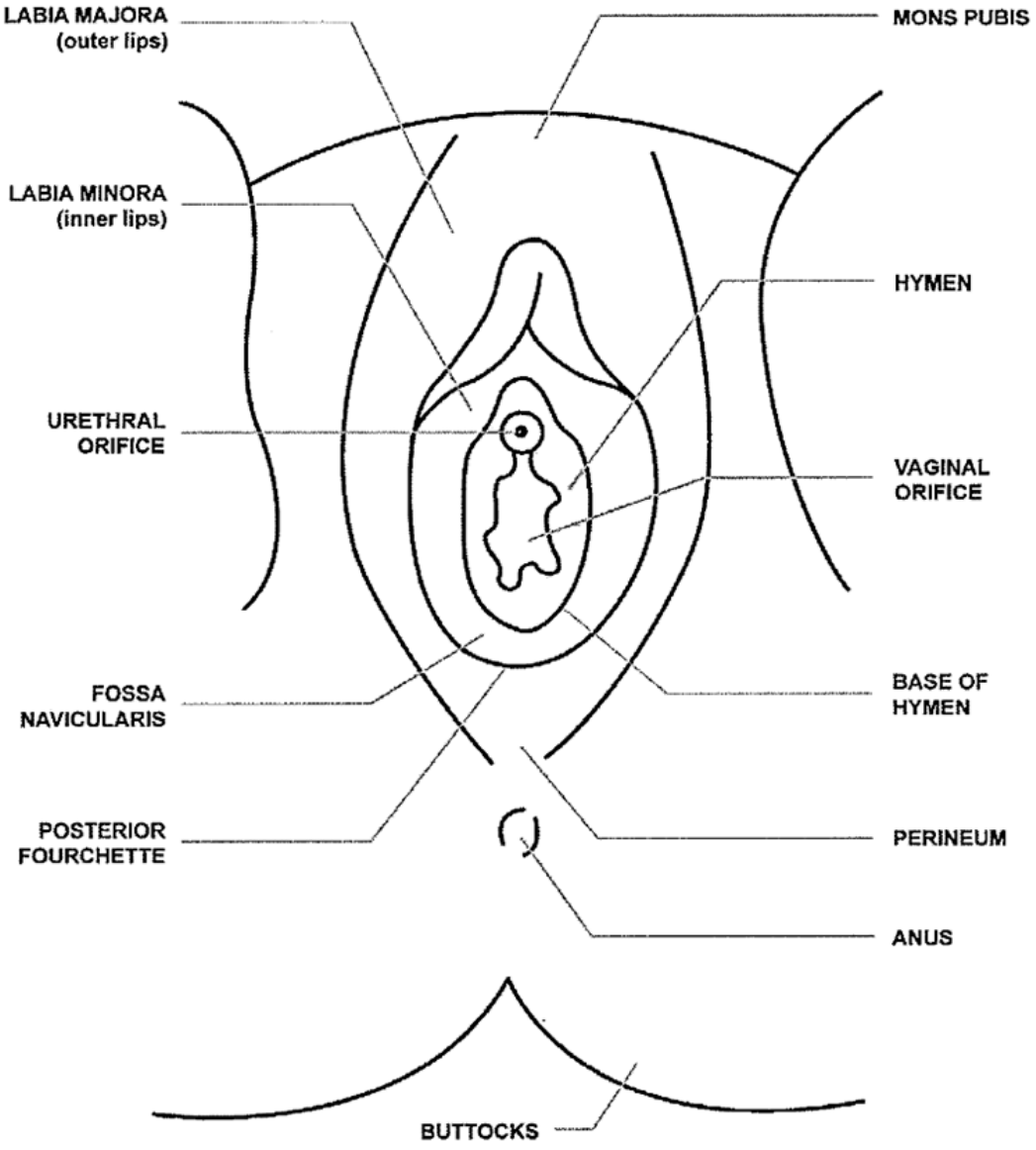
Normal	Specify abnormal	Body map
☐ Scalp		
☐ Ears		
☐ Neck		
☐ Shoulders		
☐ Back		
☐ Upper arm		
☐ Lower arm		
☐ Hands		
☐ Buttocks		
☐ Upper Leg		
☐ Lower Leg		
☐ Feet		

Note:

- **Measure, describe and show the areas of: Abrasions, laceration, areas of pain and tenderness, fractures..etc**
- **Trace evidence e.g. vegetation, soil, ..etc include marks, scars, and Tattoos**
- **It is important to report (tick) on normal– provide legal evidence that all areas of body have been examined, not only record on the " injured" area**

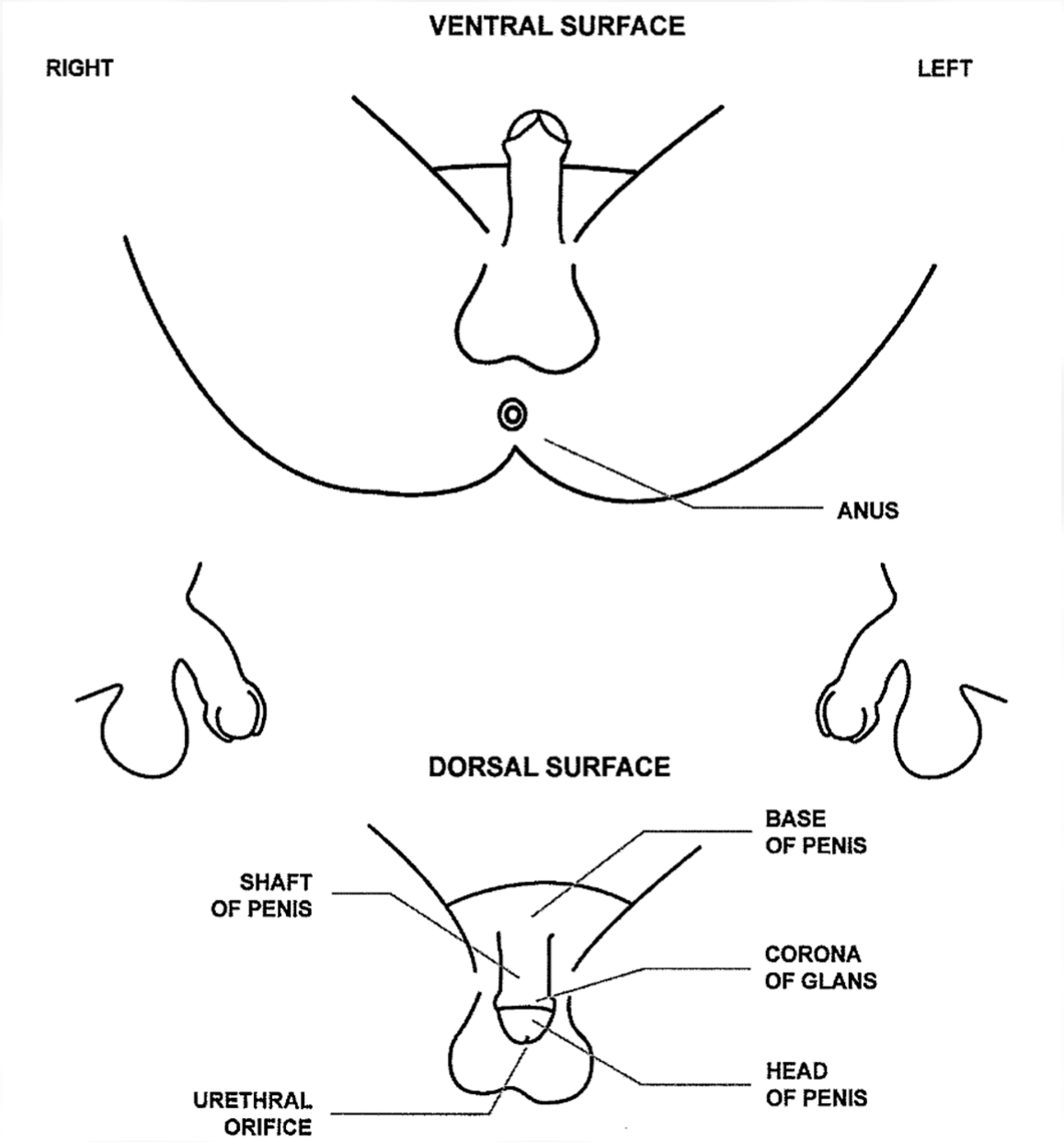
Body Map-
(please marks all the injuries and provide specification on this form)

C. Female Genitalia -



Body Map-
(please marks all the injuries and provide specification on this form)

A. Male Genitalia - (for adult and children)



Annex 6: FORENSIC KIT ITEMS FOR ASSAULT VICTIMS

Pacific countries

Background

When a victim of assault presents to a hospital or clinic, the health care professional should have all the equipment they require on hand.

The equipment can be roughly divided into those items that the hospital or clinic will already have and those items that could be in a 'kit' so that they are readily available. As each case of assault is different, it is envisaged that some or all of the items in the kit could be used or may be used and then the kit would need to be restocked for the next time.

Specimens collected from victims can be broadly divided into two categories, those used for diagnostic health purposes and those used for criminal investigation. In most settings, the type of specimens collected for the purpose of forensic investigation will be dictated by the quality and sophistication of available services at medico-legal or forensic laboratories. For instance, if a laboratory is not able to perform DNA testing (or access such testing from another laboratory), there is little point in collecting specimens for DNA analysis. By the same token, there is little use for expensive rape kits if immediate access to high-quality analytical services is not available. Health workers are advised to consult laboratory staff as to which specimens they are able to process, how samples should be collected and handled, and how long the samples will take to process.

Of course health professionals who would be using the forensic kit would need appropriate training.

This equipment list is guided by the table in:
Guidelines for medico-legal care for victims of sexual violence. World Health Organization 2003
This guideline should be read in conjunction with this table as it contains important further information.

EQUIPMENT

ITEM	HOSPITAL / CLINIC ITEM	FORENSIC ITEM	THERAPUETIC ITEM
Examination couch	X		
Desk, chairs and filing cabinet For victim, accompanying persons and health worker.	X		
Light source. Ideally mobile.		X	
Washing facilities and toilet	X		
Refrigerator and cupboard For the storage of specimens, preferably lockable.	X		
Telephone	X		
Fax machine	X		

GENERAL MEDICAL ITEMS

ITEM	HOSPITAL / CLINIC ITEM	FORENSIC ITEM	THERAPUETIC ITEM
Tourniquet			X
Syringes, needles and sterile swabs			X
Blood tubes (various sizes)			X
Speculums (various sizes)			X
Sterilizing equipment For sterilizing instruments (e.g. specula).	X		
Proctoscope/anoscope			X
Examination gloves			X
Pregnancy testing kits			X
STI collection kits			X
Lubricant, sterile water normal saline			X
Sharps container		X	
Scales and height measure For examining children.		X	

FORENSIC ITEMS

ITEM	DESCRIPTION	HOSPITAL/ CLINIC ITEM	FORENSIC ITEM	THERAPEUTIC ITEM
Swabs	For collection of foreign material on victim (e.g. semen, blood, saliva). and containers for transporting. Do not use medium when collecting forensic specimens. swabs*		X	
Microscope slides			X	
Blood tubes	Blood is used for DNA or toxicological analysis.		X	
Urine specimen containers	For pregnancy and toxicological testing.		X	
Sheets of paper	For patient to stand on whilst undressing for collection of loose, fine materials.		X	

Paper bags	For collection of clothing and any wet items.		X	
Tamper proof seal/sticker	Forensic items must be sealed appropriately		X	
Plastic specimen bags	For collection or transport of other (dry) forensic items.		X	
Tweezers, scissors, comb	For collecting foreign debris on skin. Use scissors or comb to remove and collect material in hair.		X	
Tissues or toilet paper	For patient to wipe away lubricant		X	

TREATMENT ITEMS

Analgesics	Such as paracetamol and diclofenac			X
Emergency contraception				X
Suture materials		X		
Tetanus and hepatitis prophylaxis/ vaccination				X
STI prophylaxis Counselling advice pamphlet				X

LINEN

Sheets and blankets		X		
Pillows	To sit patients slightly while examining so that they feel more in control	X		
Face cover	For patient to cover their face during examination if embarrased			X
Towels		X		
Clothing	To replace any damaged or retained items of the victim's clothing		X	

Patient gowns	Or sarong	X		
Sanitary items e.g. pads, tampons				X

STATIONERY

Examination record or profoma			X	
Labels	For attaching to various specimens		X	X
Consent form			X	
Pathology/ radiology referral	For referring patient for further investigation or tests	X		
Information brochure	Ideally the patient should be provided with information about the service they have accessed, methods of contacting the treating practitioner if required and details of follow-up services. These brochures should supplement any verbal information that the victim has been provided with			X
Local flowchart of services	Contact names and numbers of local agencies			X
Transport to a safe place				

SUNDRY ITEMS

Camera and film	For photographing injuries		X	
Colpscope or magnifying lens	Useful for obtaining a magnified view of a wound	X		
Microscope	May be used by the practitioner to check for the presence of spermatozoa	X		
Measuring device	e.g ruler, For measuring the size of wounds. tape measure, calipers		X	
Pen, pencils		X		
Sterilization equipment for medical instruments		X		

Children's drawing material/ toys. Useful to keep children occupied.		X		
Tissues		X		
DO NOT ENTER sign for the door				X

Annex 7: List participants and key stakeholders

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