Government of the Republic of Trinidad and Tobago
Ministry of Health

Spotlight Initiative
To eliminate violence against women and girls

PAHO
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Americas

National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence:

Trinidad and Tobago

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- Ensuring services provided meet global standards
- Building capacity of service providers
- Improving service provider coordination and coverage (https://spotlightinitiative.org/)

The Guidelines are based on a process of national consultation with staff from health service settings in Trinidad and Tobago and review of policies, protocols and guidelines, led by Nyla Lyons, PhD, Consultant. They draw on World Health Organization (WHO) and Pan American Health Organization (PAHO/ WHO) evidence-based recommendations for the care of women subjected to intimate partner and sexual violence and are aligned with the Essential Services Package of the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence. The Spotlight Initiative gratefully acknowledges the contribution of staff of the Ministry of Health and Regional Health Authorities who participated in the consultations and enabled the Guidelines to be tailored to the local context.

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Abbreviations and Acronyms

Abbreviation or Term	Definition
A&E	Accident and Emergency
AIDS	Acquired Immunodeficiency Syndrome
CADV	Coalition Against Domestic Violence
CAPA	Crime and Problem Analysis
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERF	Central Emergency Response Fund
COVID-19	Coronavirus Disease
EC	Emergency Contraception
ERHA	Eastern Regional Health Authority
ESP	Essential Services Package
GBV	Gender-Based Violence
IPVSV HIS	Intimate Partner Violence and Sexual Violence Health Information System
HIV	Human Immunodeficiency Virus
IAWG	Inter-Agency Working Group
ILO	International Labour Organization
IPV	Intimate Partner Violence
LIVES	Listen, Inquire, Validate, Enhance Safety, Support
MDG	Millennium Development Goal/s
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization

NCRHA	North Central Regional Health Authority
NWRHA	North West Regional Health Authority
OB/GYN	Obstetrics/Gynaecology
PAHO	Pan American Health Organization
PEP	Post-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RHA	Regional Health Authority
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SV	Sexual violence
SWRHA	South West Regional Health Authority
TRHA	Tobago Regional Health Authority
TTO	Trinidad and Tobago
TTPS	Trinidad and Tobago Police Service
UN	United Nations
UNFPA	United Nations Population Fund
VAW	Violence Against Women
WHO	World Health Organization

Foreword

Violence against women continues to be a significant challenge for public health and is a clear violation of the fundamental human rights of women. Violence has had profound short and long-term consequences on women's physical, mental, sexual, and reproductive health, including their personal and social well-being. Eliminating violence against women and girls is therefore a public good that holds several significant benefits to individuals, families, communities and nations.

The United Nations, having recognised the critical role that the elimination of violence plays towards national development, included a specific goal in the 2030 Sustainable Development Agenda to address gender-based violence (GBV). The Sustainable Development Goal (SDG) 5 calls for gender equality and empowerment of all women and girls, with Target 5.2 calling to eliminate all forms of violence against all women and girls

Health services are a unique resource that can identify women and girls who are victims of violence and provide them with appropriate care that connects them to other support services that can potentially prevent future harm. Consequently, strengthening the health system's response to GBV is critical to achieving SDG 5 and Target 5.6, which is to ensure universal access to sexual and reproductive health and reproductive rights.

The National Clinical and Policy Guidelines on Intimate Partner Violence (IPV) and Sexual Violence (SV) were developed on the platform mentioned above. These Guidelines are the first of their kind in Trinidad and Tobago. They provide a critical response to the unacceptable levels of these types of violence in our country. We hope that these guidelines will strengthen the delivery and coordination of health care services for IPV and SV. The guidelines are also intended to improve the capacity of health care providers to holistically respond to the physical, mental and social needs of survivors to ensure appropriate follow-up care.

The Ministry of Health continues to champion issues surrounding GBV by providing leadership and governance while increasing awareness of this issue throughout the health sector. It is hoped that with the development and implementation of these Guidelines, all survivors of GBV in Trinidad and Tobago will soon have access to high-quality health services that protect their health, well-being and safety.

The Honourable Terrence Deyalsingh, Minister of Health,
Ministry of Health, Republic of Trinidad and Tobago.

Message from PAHO/ WHO

This document, Trinidad and Tobago's first National Clinical and Policy Guidelines on Intimate Partner Violence (IPV) and Sexual Violence (SV), is regarded as a critical response to the levels of these types of violence. The National Women's Health Survey (2018) showed that health care workers are the professionals that survivors of IPV and SV most often turn to for care and support, indicating the importance of building the capacity of the health sector to respond.

Health consequences of IPV and SV include injury, disability, unwanted pregnancy, unsafe abortions, sexually transmitted infections including HIV, gynaecological problems, pregnancy complications, mental illness, self-harming behaviour, chronic pain, substance use, risky sexual behaviour, and death. These feed into a very wide range of negative consequences, affecting general well-being and preventing those affected, who are mostly women and girls, from fully participating in society.

Development of these Guidelines was supported by the Spotlight Initiative: a multi-country partnership to eliminate violence against women and children of the European Union and the United Nations (https://spotlightinitiative.org/). The Ministry of Health and Pan American Health Organization/ World Health Organization (PAHO/WHO) collaborated closely in developing the Guidelines though the establishment of a Committee of Ministry of Health Representatives for the Spotlight Initiative. National review and consultation were undertaken with representatives of the Ministry of Health, National AIDS Coordinating Committee, front-line and administrative staff of Regional Health Authorities, civil society organisations and United Nations agencies. These ensured that the Guidelines are based on national law, health sector policies and protocols and build on existing initiatives, good practice and health-care providers' experiences and guided by technical expertise from PAHO/WHO. The recommended procedures and practices are therefore aligned with WHO evidence-based guidance documents and the Essential Services Package (ESP) of the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence.

Features of the Guidelines include:

- Statistics on IPV and SV in global context
- Review of relevant national policies, legislation, procedures and facilities
- Principles for quality of care
- Pathways of care for survivors of IPV and SV

- Documentation and health information systems
- Roles of health institutions in prevention
- Responding to IPV and SV in emergencies, including COVID-19.

PAHO/ WHO is proud to have been part of guiding this ground-breaking initiative and we look forward to collaborating further with national stakeholders to implement the Guidelines.

Dr Erica Wheeler, PAHO/ WHO Representative,
Trinidad and Tobago, Aruba, Curaçao Sint Maarten, Bonaire, Saint Eustatius and Saba

Executive Summary

Spotlight Initiative
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Introduction

The development of National Clinical and Policy Guidelines on Intimate Partner Violence (IPV) and Sexual Violence (SV) is regarded as a critical response to the levels of these types of violence in Trinidad and Tobago. The National Women's Health Survey conducted in 2017 indicated that almost one in three (30.2%) of ever-partnered women in Trinidad and Tobago experienced lifetime physical or sexual abuse at the hands of their intimate partner (1). In addition, around one in five (19.0%) of Trinidad and Tobago survey participants had experienced non-partner sexual abuse in their lifetime (comprising forced intercourse, attempted intercourse or unwanted sexual touching), and 3.2% in the previous year (1). In 2019, women and girls represented 77.3% of the 872 domestic violence incidents reported to the Trinidad and Tobago Police Service (2). Addressing IPV and SV is central to the achievement of Sustainable Development Goal (SDG) 5, Achieve gender equality and empower women and girls, and SDG 16, Promote just, peaceful and inclusive societies (3).

The National Women's Health Survey also showed that health-care workers are the professionals that survivors of violence most often talk to about incidents of violence against them. Among women who experienced physical or sexual IPV, 13.4% had told a health-care professional, while 4.9% had told the police and 4.2% had told a religious leader (1). These figures indicate the importance of developing capacity in the health sector to address IPV and SV.

The National Clinical and Policy Guidelines presented in this document are aligned with the Health Module of the Essential Services Package (ESP) of the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (4), which is guided by World Health Organization (WHO) evidence-based recommendations for the care of women subjected to IPV and SV (5, 6).

Defining intimate partner violence (IPV) and sexual violence (SV)

IPV and SV are types of gender-based violence (GBV). GBV is an umbrella term, which includes all violence directed at a person because of their gender. GBV affects women disproportionately (1, 2, 7-9). Violence against women (VAW) means "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 in private life" (10).

The focus of the current guidelines is on addressing IPV and SV by strangers or others who are not partners, also known as non-partner SV (8).

IPV refers to behaviour within an intimate relationship that causes physical, sexual or

psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, controlling behaviours, and/ or forms of deprivation and neglect. This definition covers violence by both current and former spouses and partners (11). IPV is the most common form of VAW (6, 9, 12-14).

SV is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (15).

SV includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. SV can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. Sexual assault is the use of physical or other force to obtain or attempt sexual penetration (15).

Health consequences of IPV and SV can include injury, unwanted pregnancy, induced termination of pregnancy, sexually transmitted infections including HIV, gynaecological problems, pregnancy complications, mental illness, self-harming behaviour, chronic pain, substance use, risky sexual behaviour, and death (16).

Persons impacted by IPV and SV

IPV and SV occur in every sector of society, among all age groups and among all races. However, men are most often the perpetrators of IPV and SV and are responsible for the most severe forms of violence and control, while women and girls are most often subjected to IPV and SV (12, 13). Men may also be subjected to IPV and SV perpetrated by men or women. Other populations who are especially vulnerable to IPV and SV include: people living with HIV; persons engaged in sex work; persons with disabilities; children, and migrants and refugees.

Scope of Guidelines

The Clinical and Policy Guidelines primarily address IPV and sexual VAW. They do not cover violence against children and may have limited applicability to other vulnerable populations. Many of the recommendations, however, may be relevant to SV against men and VAW by other family members, such as a mother-in-law or a father (aspects of family violence).

Goals

The Guidelines provide actions and recommendations for the clinical care of women subjected to IPV and SV. The specific goals include:

1. To strengthen the capacity of health-care providers to deliver a minimum package of clinical services for women subjected to violence.
2. To develop standards of care and assist health-care providers to better identify and respond to the needs of women subjected to violence.
3. To strengthen the health systems response and the delivery of high-quality care for women subjected to violence.

Intended users

The National Clinical and Policy Guidelines aim to steer the work of health-care providers (doctors, nurses, social workers and support staff) and health and programme managers working in various service settings, including health centres, district health facilities, hospitals, maternal and child health clinics, family planning, HIV/ sexually transmitted infection (STI) and mental health settings. They also provide guidance to policy makers in developing an enabling environment for high quality health care.

Guidelines' development methods

The development of the Guidelines draws upon primary information sources including interviews and group discussions, and review of secondary sources to develop evidence-based recommendations for the clinical care of women subjected to violence. This process comprised of the following activities:

1. A review of WHO guidelines, handbooks and tools relating to the development of good practice in care, treatment, and support in the health sector of survivors of IPV and SV (5, 6, 14, 17-24).
2. A review of existing Trinidad and Tobago guidelines, operating procedures, policies and other documentation relating to the care of women subjected to violence (25-28).
3. A review of relevant international human rights agreements and national legislation (10, 29-38).
4. Consultations with staff in each of the five Regional Health Authorities (RHAs) of Trinidad and Tobago. The purpose of the consultations was to share the scope of work of the National Clinical and Policy Guidelines, and to elicit staff feedback on

the performance of the health system and delivery of care for women subjected to violence. Group and individual meetings were held.

5. One on one consultations with Ministry of Health including (but not restricted to) the Directorate of Women's Health, the Directorate of Health Policy, Research and Planning and other stakeholders, such as the National AIDS Coordinating Committee and the Coalition Against Domestic Violence.

Structure of Guidelines

The Guidelines are organised in five major sections.

I. Background

National and global statistics on VAW are presented, and definitions of VAW, GBV, IPV and SV provided. Relevant national policies and legislation are reviewed, notably the National Sexual and Reproductive Health Policy, 2020 (25). The structure of the national health system and the facilities providing care for survivors are described.

II. Guiding principles for quality of care

In line with international guidance documents (4-6) and consultation with national stakeholders, the following principles for quality of care for survivors are presented and detailed: women-centred care, a rights-based approach and gender equality. Issues such as confidentiality, safety, a non-judgemental approach and patient autonomy are highlighted.

III. Delivering care and support to survivors of IPV and SV

Section III details recommended pathways of care for survivors of IPV and SV with a focus on women survivors. Recommendations from international guidance documents (4-6) have been adapted based on national consultations and protocols (25, 28). Critical steps along the pathway are detailed: identification of violence, first-line support, immediate treatment and care, additional care after sexual assault, ensuring safety and providing referrals to further services. A methodology for first-line support, known as the LIVES approach (Listen, Inquire, Validate, Enhance safety, Support) is presented (6).

Section III also presents opportunities for the involvement of health institutions in primary, secondary and tertiary prevention of IPV and SV (5, 24).

IV. Delivering services in emergencies

The Guidelines were developed during the COVID-19 pandemic, highlighting the importance

of developing strategies to deliver services during emergencies. During COVID-19, movement restrictions and socioeconomic stress have increased the risk of IPV while restricting access to services. Section IV outlines international recommendations for preventing and responding to GBV in emergencies (17, 39-41). Some critical recommendations include: consider IPV and SV services as essential and include them in emergency preparedness and response plans; coordinate services across sectors; increase remote access by community outreach, e-health communication options; update referral information and disseminate information about available services to health-care workers and the general public; and coordinate with other sectors to address risk factors such as harmful use of alcohol.

V. Recommendations to strengthen health systems' capacity and services

Based on the foregoing analyses, recommendations are made in Section V to strengthen health systems' capacity and services. National level recommendations focus on leadership and governance, intersectoral and within-health-service coordination and collaboration, implementation of accountability measures, development of the evidence-base by strengthening of information systems, integration of GBV into associated health policies and plans, and the development of standard operating procedures and protocols. At RHA level there is a similar need for coordination and streamlining mechanisms, health information systems and building linkages and referral mechanisms within the health sector and with non-health agencies.

Recommendations are also made to strengthen primary, secondary and tertiary prevention. The adoption and implementation of the current Guidelines can assist in reducing incidence and harm arising from IPV and SV. Health-care providers have critical roles in prevention through first-line support and providing high quality health care and referral. Multi-sectoral coordination and collaboration, involving local communities and civil society organisations are important to address social environmental risk factors and provide additional support. RHAs and local health facilities can develop communication tools (e.g. web pages, audio-visual materials, posters and leaflets) targeting different audiences, including the general public, survivors and health-care workers themselves.

In summary, to prevent and respond adequately to IPV and SV, it is critical for the health sector to strengthen the delivery and coordination of services, and the capacity of health-care providers to address the physical, mental health, safety, and social needs of survivors and link them to appropriate follow-up care. Based on the consultations and reviews conducted, recommendations to strengthen the health sector response and increase capacity of health-care providers are made in these Guidelines.

Section I: Background

Violence Against Women: the global and national context

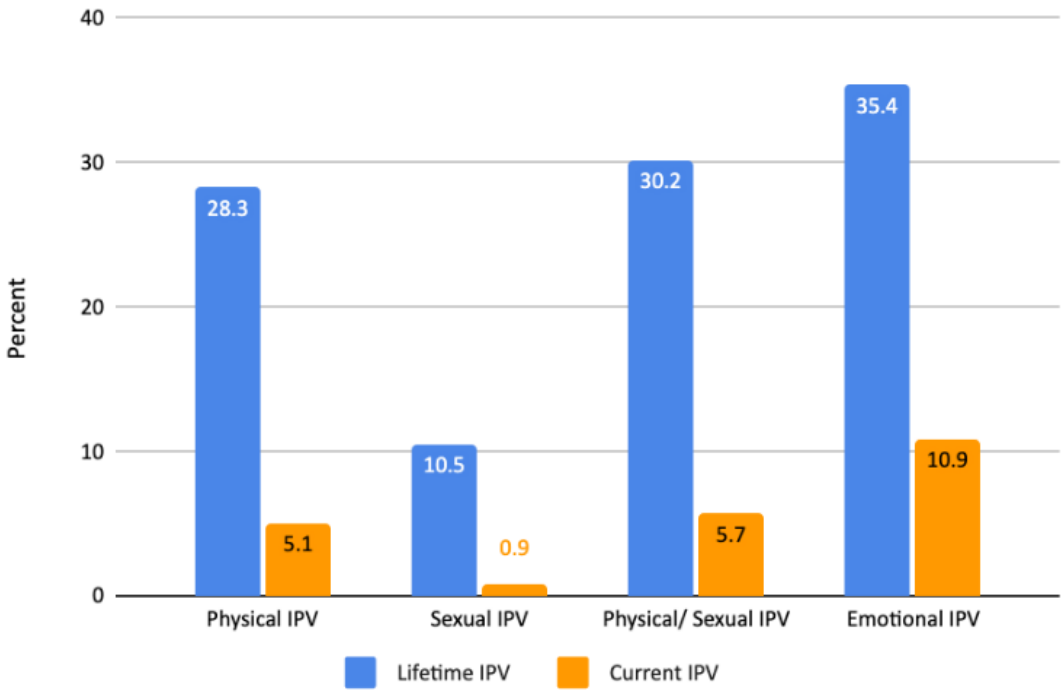
Violence Against Women (VAW) is a systemic and widespread human rights violation occurring at global proportions. In many instances, it is unrecognised, unreported and, in many countries, still seen as accepted behaviour. The manifestations and forms of VAW vary in different settings, but most takes place within families or between intimate partners and the perpetrators are mostly men (8, 12). Addressing intimate partner violence (IPV) and sexual violence (SV) is central to the achievement of Sustainable Development Goal (SDG) 5, Achieve gender equality and empower women and girls, and SDG 16, Promote just, peaceful and inclusive societies (3).

According to estimates for 2018, 30% of women worldwide have experienced physical and/or sexual IPV or non-partner SV (9). The reported figures do not include other forms of VAW such as physical violence by relatives, employers or other individuals; femicides in the name of "honour"; and trafficking, among others. In some countries the lifetime prevalence of VAW is as high as 70% and, it has been found that rates of depression, and contracting HIV are higher in women who have experienced this type of violence when compared to women who have not (8, 9, 13, 42).

The development of National Clinical and Policy Guidelines on Intimate Partner Violence and Sexual Violence is regarded as a critical response to the levels of these types of violence in Trinidad and Tobago. The National Women's Health Survey conducted in 2017 indicated that almost one in three (30.2%) of ever-partnered women in Trinidad and Tobago experienced lifetime physical or sexual abuse at the hands of their intimate partner (1). 2018 estimates for lifetime prevalence of physical or sexual IPV are 27% for Trinidad and Tobago and 26% for the world as a whole (9). Of ever-partnered women in Trinidad and Tobago, 5.7% reported that they had experienced these types of violence in the 12 months prior to data collection. In addition, around one in five (19.0%) of Trinidad and Tobago survey participants had experienced non-partner sexual abuse in their lifetime (comprising forced intercourse, attempted intercourse or unwanted sexual touching), and 3.2% in the previous year (1).

Data from the Crime and Problem Analysis (CAPA) Branch of the Trinidad & Tobago Police Service (TTPS) revealed that there were approximately 7,594 reports relating to domestic violence incidents between 2014 and 2019. Approximately 75% of these reports were of VAW and girls. During the same period there were 197 domestic violence related deaths of which 54% were female. In 2019, women and girls represented 77.3% of the 872 domestic violence incidents reported to the Trinidad and Tobago Police Service (2). These findings suggest that women are disproportionately affected when compared to their male counterparts. VAW is a prevailing issue that requires cross cutting approaches to eradicate the negative impact created at an individual, familial, community, national and global level.

Figure 1: Lifetime and current prevalence of physical, sexual, physical and/ or sexual and emotional IPV among ever-partnered women: Trinidad and Tobago, 2017



Source: National Women's Health Survey, Trinidad and Tobago (1).

The National Women's Health Survey also showed that health-care workers are the professionals that survivors of violence most often tell about incidents of violence against them. Among women who experienced physical or sexual partner violence, 13.4% had told a health-care professional, while 4.9% had told the police and 4.2% had told a religious leader (1). These figures indicate the importance of developing capacity in the health sector to address IPV and SV.

In times of emergency, such as during the 2020-'22 COVID-19 pandemic, risks of violence to women and girls increase. Staying home reduces the risk of acquiring COVID-19; however, for thousands of women and girls, staying home may not mean greater safety, but rather greater risk of violence, including SV, when they are isolated with their abusers or potential abusers (20). Recommendations for providing care in emergency situations such as the COVID-19 pandemic are provided in Section IV of the current guidelines.

Defining violence against women, gender-based violence, intimate partner violence and sexual violence

This document shares the World Health Organization's definition of violence as,

> *The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (8).*

The term gender-based violence (GBV) and violence against women (VAW) are oftentimes used interchangeably, but they are not the same. Both terms have evolved from the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (30). In 1992, the CEDAW Committee commented that discrimination against women includes GBV, defined as follows:

> *The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. (7)*

The Declaration on the Elimination of Violence Against Women (1993), went on to define VAW as a sub-category of GBV:

> *The term "violence against women" means 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 in private life. (10)* [1]

The definition's reference to "gender-based" violence underlines that VAW is rooted in gender inequality and that responses to such violence must take into account the power dynamics and social norms that perpetuate VAW.

The Government of the Republic of Trinidad and Tobago defined GBV as follows in the National Sexual and Reproductive Health Policy (2020):

> *An umbrella term for any harmful act that is perpetuated against a person's will and that results from power inequalities that are based on gender roles. It includes*

1. The Inter-American Convention on the Prevention, Punishment and Eradication of Violence, 1994, also known as the "Convention of Belem Do Para" defines VAW similarly: "For the purposes of this Convention, violence against women shall be understood as any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere." (29)

> *sexual abuse of children, rape, domestic violence, sexual assault and harassment, human trafficking of all persons and several harmful traditional practices which damage the sexual and reproductive health of women, men, girls, and boys. Gender-based violence (GBV) also results in death in Trinidad and Tobago. (25)*

Evidence from Trinidad and Tobago and elsewhere shows that GBV is most frequently directed at women and girls (2, 8, 9, 43).

The focus of the current guidelines is on addressing IPV and non-partner SV against women. They are based on evidence-based guidelines on care of women subjected to these types of violence (5, 6, 14, 17-24), adapted to the Trinidad and Tobago context. They do not cover violence against children and may have limited applicability to other vulnerable populations.[2] Many of the recommendations, however, may be relevant to SV against men and VAW by other family members, such as a mother-in-law or a father (aspects of family violence).

IPV refers to behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, controlling behaviours, and/ or forms of deprivation and neglect. This definition covers violence by both current and former spouses and partners (11). IPV is the most common form of VAW (6, 9, 12-14).

SV is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (15).

SV includes rape, defined as physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. SV can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. Sexual assault is the use of physical or other force to obtain or attempt sexual penetration (15).

Health consequences of IPV and SV include injury, unwanted pregnancy, induced termination of pregnancy, sexually transmitted infections including HIV, gynaecological problems, pregnancy complications, mental illness, self-harming behaviour, chronic pain, substance use, risky sexual behaviour, and death (16).

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2. The development of further guidelines for the care of children and other vulnerable populations subjected to family violence, IPV and SV is recommended.

The legal and policy context

Summary of related legislation

The Government of the Republic of Trinidad and Tobago has demonstrated its ongoing commitment toward eliminating IPV and SV against women and children and improving the delivery of health and other related services to women. This commitment is reflected in the development of laws (including their subsequent amendments), national policies, and commitment to international agreements. Legislation affecting the rights of women, gender sensitivity and equality in access to health services, and the needs of women have been incorporated in the following local legislation and policies passed (and some amended) over the last 15- 20 years:

- Sexual Offences Act (33, 34)
- Domestic Violence Act (35, 36)
- Offences Against the Person Act (37)
- Equal Opportunity Act (38)

Relevant international human rights agreements ratified by the Republic of Trinidad and Tobago include:

- Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women: "Convention of Belem Do Para", ratified 1996 (29)
- Convention on the Elimination of All Forms of Discrimination Against Women, ratified 1990 (30, 44)
- International Covenant on Civil and Political Rights, ratified 1978 (45, 46)
- International Covenant on Economic, Social and Cultural Rights, ratified 1978 (46, 47)
- Convention on the Rights of the Child, ratified 1991 (46, 48)
- Convention on the Rights of Persons with Disabilities, ratified 2015 (46, 49)

Summary of related national policies

Over the past four years, attention was given to the development of national policies and plans seeking to eliminate gender biases and promote equality and access to health services for women survivors of violence. These include a green paper on the National Policy on Gender

and Development, 2018 (26) which supports the principles of a rights-based approach and gender sensitivity. The green paper on National HIV and AIDS Policy, 2019 (27) incorporates access to HIV and related health services for people living with HIV. The National Sexual and Reproductive Health Policy was signed off in 2020 and addresses the needs of women including survivors of IPV and SV through the integration of SRH and GBV programmes (25).

Relevant international policy frameworks include:

- The WHO Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, 2016 (22)
- The PAHO/ WHO Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women, 2015 (23)

Findings arising from policy and legislative analysis

While these advances are significant, a review of the legislation and policies highlights a number of gaps which continue to impact equal and equitable access to health services by women survivors of violence. Gaps include:

- The need to increase emphasis on the personal safety and accessible resources for survivors
- The need to address issues of confidentiality in the health system and ensure the delivery of judgement-free and sensitive care
- The need to increase sensitization and public awareness of rights of women as they impact access to, and the uptake of, health and related services

Access to and the availability of health services

The health sector of Trinidad and Tobago includes public and private care systems and survivors of IPV and SV may access care through either of the two systems. The Ministry of Health is responsible for policy and planning at the national level, helping to ensure that action plans are standardized. The RHAs are responsible for service delivery and each is responsible for specific geographic areas. There are several vertical services, such as the Queens Park Counselling Centre and Clinic (for STI services), which are still managed under the Ministry of Health. Most documented standards, protocols and guidelines for the provision of basic health care at the level of the medical institutions and at other levels are the responsibility of the Ministry of Health. A referral system ensures integration and coordination of the different levels of care.

The following sections describe the various levels of service delivery for women accessing care in the public sector. Overall, survivors of IPV and SV access care at the primary and secondary health care level and may be referred for follow-up care through a combination of non-government, private and other entities providing a range of services

Primary care services

Health centres

The basic level of care is accessed through a variety of services offered at the primary health care level at health centres, located in communities throughout Trinidad and Tobago. These services include family planning, child welfare, chronic disease, general practice, home visits, cancer screening, pre-natal clinic, postnatal clinic, psychiatric clinic, immunisation and social work services. The services are staffed by health-care providers including physicians, nurses/district health visitors, social workers and auxiliary staff. Health-care providers may identify women subjected to IPV in a variety of settings including during home visits, and among those accessing antenatal, postnatal, family planning, and child welfare services. Survivors of violence may be referred to secondary care facilities by primary health care medical personnel whenever required. Services at most health centres are available between 8 am and 4 pm.

District health facilities and outreach centres

District Health Facilities are expanded versions of community health centres which were introduced to provide expanded services and functions on a 24-hour basis. There are also outreach centres, which offer fewer services and have shorter hours. Persons subjected to violence can access services for physical injuries at the District Health Facilities and may be further referred to a general or specialist hospital for additional care. District Medical Officers

also operate at district health facilities.

Secondary care services

Public hospitals and affiliated inpatient and outpatient services

Survivors may access care at any general hospital or specialist hospital. Specialist hospitals offer a range of services, including psychiatric, maternity care, and women's health, that may serve as entry points. General hospitals are often the first point of entry for survivors of IPV and SV, offering immediate care for physical injuries, some psychological support, linkages to the police service and referral to medical and psychiatric in-patient and out-patient services. Survivors of sexual assault may be offered HIV/STI testing and post exposure prophylaxis (PEP) at the accident and emergency department or referred to the HIV clinic to access PEP.

Referral services

Survivors of IPV and SV may be referred to inpatient and outpatient services, including psychiatric and further medical services. Social workers may assist in access to financial and other support through other government agencies. Survivors may also be referred to community support networks and services for follow-up care.

The Ministry of Social Development and Family Services, through its National Family Services Division, was established to promote the health and wellbeing of families through the provision of prevention, developmental and remedial programmes and services. Case management and the coordination of referral mechanisms to prevent further violence and secure stability for survivors are among the core functions of the National Family Services Division.

Comparing levels of service delivery

Table 1: Features of levels of health service delivery in provision of care and support to survivors of IPV and SV

Service Delivery	Features
Primary care settings and services	• Located in the community and provide some core services • Easily accessible
District Health Facilities	• Equipped to provide some services on a 24-hour basis to the general public • May have some specialized services
Secondary care/ hospital-based services	• Provide a greater range of services to survivors, with staff with linkages to social workers, counsellors and community services
Specialty services (e.g. shelters for domestic violence survivors, long term psychological/ mental health services)	• Dedicated and specialized trained staff • Highly responsive to individual need

Source: Consultations with staff of RHAs and the Ministry of Health

Integrating GBV and sexual and reproductive health care

Women who experience violence may sometimes present with poor sexual and reproductive health outcomes. It is important to be able to recognise these. Table 2 highlights SRH and behavioural effects adult survivors of IPV and SV may experience.

Table 2: Sexual, reproductive and other health effects of IPV and SV

Type of Violence	Sexual, reproductive and other health effects
Sexual abuse and assault	Unwanted pregnancy, pelvic inflammatory disease, infertility, sexually transmitted infections (STIs) including HIV/AIDS, gynaecological problems, early sexual experiences, early pregnancy, unprotected sex, termination of pregnancy, re-victimisation, high-risk behaviours, substance abuse, suicide, death.
IPV	Poor nutrition, exacerbation of chronic illness, substance abuse, brain trauma, organ damage, partial or permanent disability, chronic pain, unprotected sex, pelvic inflammatory disease, gynaecological problems, low-birth weight, adverse pregnancy outcomes including miscarriage, maternal death, suicide, death.

Source: (50)

Integrating care for survivors of IPV and SV into existing health services, rather than being a stand-alone service, is a critical step in strengthening the health sector response to GBV. The National SRH Policy demonstrates the government's ongoing commitment to expanding access to SRH services, improving the standards of care for women and integrating health services for GBV (25). The SRH Policy seeks to accomplish the following:

- To ensure every person in Trinidad and Tobago in need of SRH is offered and has access to comprehensive SRH services through the public health system
- To educate the population on SRH
- To reduce adolescent pregnancy through the provision of comprehensive SRH information and services
- To reduce maternal and new-born mortality and morbidity, and
- To increase quality and uptake of services through strengthening health systems.

The comprehensive package of SRH services to be delivered includes (25):

- Family Planning Services
- Maternal Health Care
- STI/HIV and AIDS Services
- Miscarriage-related services (as per the National SRH Policy, relevant National legislation, and the guidance of the Medical Board of Trinidad and Tobago)
- Adolescent Sexual and Reproductive Health
- Fertility Services
- Elimination/Reduction of Cancers of the Reproductive and related Organs
- SRH/CNCD Management
- Sexual and Gender Based Violence
- Men's Health
- Other Women's Health issues
- Women not in reproductive age.

The SRH policy introduces the key principles for integration of SRH and GBV programming, as part of a comprehensive package of services to address the needs of women survivors of sexual and partner violence. The main body of the policy acknowledges the need to integrate services for GBV and provides the framework and coordinating mechanisms needed to do this.

Section II: Guiding principles for quality of care

Guiding principles

WHO recommends a minimum set of principles and standards to guide the health-care provider response in addressing the needs of women subjected to violence (5, 6). These intersecting principles include:

1. Women-centred care, i.e. care organized around women's health needs and perspectives.
2. A rights-based approach, i.e. care that incorporates women's human rights.
3. Gender equality, i.e. the awareness of differences in power between women and men which determine their access to resources and how they are treated (5, 6, 14).

Principle 1: Women-centred care

To provide women-centred care to survivors of IPV and SV, health-care providers must plan and manage services that protect the privacy and confidentiality of women, help maintain their safety, be non-judgemental and be responsive to women's concerns and needs..

Do no harm

Women-centred care is care that does no harm, or at least avoids causing any further harm, while also maximizing the benefits of how services are designed and delivered. This also means that health workers should weigh the potential risks of actions taken, for example, when documenting cases, storing information, and assessing and strengthening safety of the survivor.

Safety

Maintaining the safety of the women disclosing abuse, and her children, is a priority in providing woman-centred care. It is important to believe what the woman is saying, empathize, and not belittle her experiences and concerns. Health-care providers must listen carefully to the details, to be able to assess the risks and support the woman's safety planning.

Responding to women's concerns and needs

Care must take into account women's perspectives and respond to her concerns and needs in a humane and holistic way. Health workers should aim to empower women to participate in their own care. The woman's decision should prevail, and the health worker must respect women's autonomy in making decisions related to their care. The woman should be supported to make decisions and take action when and how she wants to. The woman has the right to treatment regardless of whether a criminal case is pursued.

Non-judgemental

Health workers must respond with empathy and without judgement. It is important to listen to the survivor's story, believe her, and take what she says seriously. Violence is never the fault of the woman survivor. Every health-care provider must document cases accurately and without judgement. Health-care providers must not interpret what the woman says but should provide an accurate account of what she says and what is observed (e.g. injuries). The medical record should be kept somewhere confidential and should not be accessible to non-medical staff.

Principle 2: A rights-based approach

Women's human rights are set forth in international human rights agreements and should be incorporated into the care provided to all women subjected to violence. These include rights to the following:

- Life – a life free from fear and violence
- The highest attainable standard of health – health services of good quality, available, accessible and acceptable to women
- Non-discrimination – health-care services offered without discrimination.
- Privacy and confidentiality – care, treatment, and counselling provided that is private and confidential; information disclosed only with the consent of the woman
- Information – the right to know what information has been collected about their health and have access to this information, including their medical records (6).

Informed consent must be provided prior to examination, treatment and before sharing the patient's information with others, as applicable. A survivor may consent to examination and care but withhold consent to share information with other providers. Information should only be shared with other providers without the consent of the patient if there is a real risk to her life, a child or person with a disability is being abused, or a person discloses that they intend to harm or kill someone else. In such circumstances, while it is always preferable to do this with the consent of the survivor, in some cases it may be necessary to do this without her consent. If the law requires health-care providers to share any information with other service providers or report violence to the police, the health-care provider must tell the survivor this.

Confidentiality is a critical component of the care for survivors of violence. Confidentiality of health records must be maintained, for example by keeping such documents and any relevant notes in a safe place and not anywhere that anyone can see or access them.

It is important that the survivor be informed of any limits to confidentiality at the very start of her interaction with the health-care provider. It is not appropriate for the survivor to be asked to disclose and share her experience in a safe space, but then later be informed that confidentiality cannot be maintained. Survivors should always be informed of what information is being shared, with whom and why (6).

Health-care providers should learn about the specifics of the law and conditions in which they are required to report. According to the current Trinidad and Tobago legislation, reporting to the police is mandatory for suspected cases of sexual offences against children. Suspected cases of domestic violence against children and persons who are dependents because of age, infirmity or disability must also be reported to the police (see Box 1). Therefore, if a survivor of SV is a child or the case involves SV against a child or children, the survivor must be told that a report must be made to the police. Likewise, if a survivor of domestic violence is a child or an adult dependent, the survivor must be told that a report must be made to the police. It should be noted that reporting to the police is not mandatory for sexual offences against adults and for domestic violence against adults who are not dependents. In the case of adult survivors of IPV and SV, the health worker should support the woman in considering her options, including if she wishes to report to the police and what it would entail. In practice, this may require the health worker to inform her about medico-legal evidence collection. The health-care provider should assure the survivor that, outside of required reporting, they will not tell anyone else or share any information with third parties without her permission.

In instances where risks of breaks in confidentiality are greater, as may be the case in smaller communities, special measures to protect confidentiality should be considered. If a survivor wishes to report to the police but is concerned about confidentiality in her own community, a possible strategy may be to submit a report to the police in another district. Personal details of the woman that can help to identify her should not be shared for any form of surveillance or monitoring as these may also cause a woman suffering from violence to feel stigmatized. It may also pose a threat to her safety, resulting in further violence against her.

Box 1: Mandatory reporting to the police under current Trinidad and Tobago Sexual Offences and Domestic Violence legislation

The wording of the main paragraphs of legislation on mandatory reporting is shown below.

Sexual Offences Act 2012, section 31, subsections 1-3

(1) Any person who —

(a) is the parent or guardian of a minor;

(b) has the actual custody, charge or control of a minor;

(c) has the temporary custody, care, charge or control of a minor for a special purpose, as his attendant, employer or teacher, or in any other capacity; or

(d) is a medical practitioner, or a registered nurse or midwife, and has performed a medical examination in respect of a minor,

and who has reasonable grounds for believing that a sexual offence has been committed in respect of that minor, under this Act or section 9, 10, 18 or 19 of the Children Act, shall report the grounds for his belief to a police officer as soon as reasonably practicable.

(2) Any person who without reasonable excuse fails to comply with the requirements of subsection (1), is guilty of an offence and is liable on summary conviction to a fine of fifteen thousand dollars or to imprisonment for a term of seven years or to both such fine and imprisonment.

(3) No report made to a police officer under the provisions of subsection (1) shall, if such report was made in good faith for the purpose of complying with those provisions, subject the person who made the report to any action, liability, claim or demand whatsoever.

Domestic Violence (Amendment) Act 2020, section 26A, subsections 1-3

(1) Subsection (2) applies to a person –

(a) who –

(i) has actual custody, charge or control of;

(ii) has, for a special purpose, as his attendant, employer, teacher or caregiver, or in

any other capacity, temporary custody, care, charge or control of;

(iii)resides with; or

(iv) is a medical practitioner, registered nurse or midwife, and has performed a medical examination in respect of,

an adult who by reason of physical or mental disability, age or infirmity is dependent on another person or a child; or

(b) who is a social worker.

(2) A person to whom this subsection applies, who has reasonable grounds to believe that a person has engaged, is engaging or is likely to engage, in conduct that constitutes domestic violence against an adult who by reason of physical or mental disability, age or infirmity is dependent on another person or a child, shall report the grounds for his belief to a police officer as soon as reasonably practicable.

(3) Any person who, without reasonable excuse, fails to comply with the requirements of subsection (2), commits an offence and is liable on summary conviction to a fine of fifteen thousand dollars and to imprisonment for seven years.

Source: (33, 36)

Principle 3: Gender equality

It is also important that health-care providers ensure gender equality in the delivery of health care. This means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy. As a health-care provider, it is important to understand that VAW is rooted in unequal power between women and men and therefore it is important to:

- Be aware of the power dynamics and norms that perpetuate VAW
- Reinforce the woman's value as a person
- Respect women's dignity
- Listen to the woman's story, believing her, and taking what she says seriously
- Not blame or judge women
- Provide information and counselling that helps women to make their own decisions

Section III: Delivering care and support to survivors of IPV and SV

IPV and SV have undesirable impacts on physical and mental health. Health-care settings provide a unique opportunity to identify persons subjected to violence safely, provide emotional support, care for physical and mental health conditions and prevent future harm. The health sector is often the first point of contact for those who seek care and support services.

The Ministry of Health and the five RHAs play a critical role in the identification, response and prevention of IPV and SV in Trinidad and Tobago. Survivors of violence often seek care to address their immediate and ongoing physical, mental and related health needs. They may access care in a variety of settings:

- Primary health care
- Acute care facilities such as Accident and Emergency Departments
- Specialist health care facilities, departments and professionals in fields such as (but not restricted to) Obstetrics/ Gynaecology (Ob/ Gyn), Family Planning and Mental Health
- Inpatient and outpatient care facilities

These health-care settings also provide important opportunities for prevention to help address the factors contributing to violence. Health-care providers must be knowledgeable, skilled, and compassionate in order to help the survivor, and to establish effective preventive counselling and support.

Pathway of care for IPV and SV

The pathway of care presented here comprises the necessary actions for the delivery of high-quality care for survivors of IPV and sexual assault. The pathway translates the evidence compiled globally by WHO into practical steps, assisting in standardizing and enhancing the provision of clinical services for health-care providers in their respective service delivery settings (6).

The specific steps in the delivery of clinical care are illustrated in Figure 2 and Table 3 and comprise: (1) Identification of violence (2) Immediate care (3) Additional care and (4) Referrals. Each step will be expanded upon and described in the following subsections of Section III. They are aligned with existing national protocols where appropriate.

Figure 2: Steps in the delivery of care for survivors of IPV and SV

Source: Developed from (6) and consultations with RHA and Ministry of Health stakeholders

Table 3: Mapping of service delivery settings against steps in the Pathway of Care

Awareness and identification of violence:	**First Line Support (LIVES)**	**Additional care:**	**Referrals:**
• Primary care • Acute care facilities • Ob/Gyn, Family Planning • Mental health • Inpatient and outpatient services • Specialty Services for long term care	• All service delivery settings **Care for immediate health conditions:** • Secondary/ Urgent care • Ob/Gyn, Family Planning • Mental health • Inpatient services • Referral and follow-up services	• Secondary/ Urgent care • Ob/Gyn and Family Planning • Mental health • Inpatient • Referral and follow-up services	Health-care providers establish formal referral systems and networks with • Police/law enforcement • Justice/legal services • Social services • Community based services

Source: Developed from (6) and consultations with RHA and Ministry of Health stakeholders

Step 1: Identification of violence

Health-care providers must be available to provide immediate and ongoing assistance to survivors to minimise the harmful consequences of IPV and SV. Violence may manifest through physical and mental health conditions which can alert health-care providers to inquire further. Box 2 can facilitate the necessary process of clinical inquiry as it provides a list of clinical conditions/ health consequences that are shown to be associated with IPV. Health-care providers can look out for these warning signs of violence before asking about violence itself.

Box 2: Clinical conditions that may indicate IPV

- Symptoms of fear, depression, anxiety, Post-Traumatic Stress Disorder, sleep disorders
- Suicidality or self-harm
- Traumatic injury (such as bruising and swollen eye area), particularly if repeated and with vague or implausible explanations
- Alcohol and other substance use
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain and sexual dysfunction.
- Adverse reproductive outcomes, including multiple unintended pregnancies, 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)
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Source: (5, 6, 51)

Asking about violence

Health-care providers should actively identify the possible signs of violence when assessing a patient's current condition, experiences and their past history. They should ask about exposure to violence if they suspect violence and certain minimum conditions are met. Box 3 shows the conditions necessary to assure the safety of the survivor and that she is provided with adequate services.

Box 3: Minimum conditions for asking about partner violence

- Private setting
- Confidentiality ensured
- Training on how to ask and how to respond
- System for referral in place
- A protocol/standard operating procedure should be established to guide 1-4 above

Source: (5)

When to ask

Privacy and confidentiality are critical prerequisites for asking about violence. The issue of violence should not be raised unless the woman is alone. The partner must not be present when asking about violence. Another woman should not be present either, as that woman could be a close relative or friend of the abuser (6). Children should also not be present, as they may repeat what the survivor has said. In practice, the role of the health worker may be to find an excuse and a space for a private interaction with the woman if violence is suspected but she brings someone with her.

All inquiries about violence should take place in an environment that enables privacy, where the conversation between the health-care provider and the patient cannot be overheard. This interaction should ideally take place in a private room. Care should be taken that the room/place chosen does not indicate to others why you are there and what you may be talking about. For example, there should be no signage indicating that consultations relating to violence take place in that room.

As detailed in Section II, privacy and confidentiality are essential components of the rights-

based approach. If there are limitations to confidentiality (such as in situations of mandatory reporting as outlined above in Section II under Principle 2), this information should be shared as early as possible, preferably before a survivor has disclosed.

How to ask

Staff must be trained on the correct way to ask and on how to respond to women who disclose violence. Identification by itself, while a very important step, is not sufficient.

It is recommended that health-care providers raise the subject of violence indirectly before asking direct questions. Health-care providers may raise the subject of violence through the statements such as the following.

- "Many women experience problems with their husband or partner, or someone else they live with."
- "I have seen women with problems like yours who have been experiencing trouble at home."

Depending on the patient's response, health-care providers may continue to ask questions, listen to the woman's responses and continue to explore her needs and concerns. The health worker may ask:

- "Are you afraid of your husband (or partner)?"
- "Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?"
- "Does your husband (or partner) or someone at home bully you or insult you?
- "Does your husband (or partner) try to control you, for example not letting you have money or go out of the house?"
- "Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?"
- "Has your husband (or partner) threatened to kill you?" (6)

Box 4: WHO recommendations for identifying women subjected to violence

- Clinical inquiry is recommended. Health-care providers should ask about exposure to IPV when assessing conditions that may be complicated by IPV. See Box 2 for examples of clinical conditions associated with IPV which may be helpful to improve identification and subsequent care.
- "Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) is not recommended. There are however two exceptions – antenatal care and HIV testing and counselling:
  - Antenatal care is an opportunity to enquire routinely about IPV, because of the dual vulnerability of pregnancy.
  - IPV may affect disclosure of HIV status or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies. Asking women about IPV could therefore be considered in the context of HIV testing and counselling.
- If violence is disclosed, the survivors should immediately be provided with first-line support. It is not sufficient to ask.
- If violence is suspected but not disclosed, the health-care worker still has an important role to play in providing information about consequences of violence and access to health services.

Source: (6)

If the patient answers "yes" to any of the questions listed above, she should be offered first-line support and immediate care as indicated (see Step 2 below for more information). Note that a woman should be provided with support regardless of whether she discloses past or current exposure to abuse.

When violence is suspected but not disclosed, health-care providers may still be able to assist suspected survivors and encourage them to seek help. It is recommended that health-care providers:

- Do not pressure the patient; give her time to decide what she wants to tell you.
- Offer information on the effects of violence on women's health and wellbeing, as well as their children's health. Stress that violence is never justified and help is available.
- Tell her about available support services if she chooses to use them and/or if her

situation changes. If a directory of health and other relevant services is available, this can be provided, together with an appropriate warning about taking them home if an abusive situation exists.

- Offer her a follow-up visit.

Step 2: First-line support

Once a woman discloses and/or acknowledges that she was exposed to violence, the quality of the immediate response by the health system can have an enormous effect on her health and wellbeing.

A woman who discloses having experienced IPV or SV should immediately be provided with first-line support. First-line support may be the most important care that the health worker can provide, and it may be all that the survivor needs.

Some women may need emergency care for life-threatening injuries or other urgent health concerns. In such cases, health workers should follow standard emergency procedures to triage and provide urgent care, followed by first-line support at the earliest opportunity. For urgent health care needs after sexual assault, please see Step 3b below.

First-line support provides practical care and responds to the survivor's emotional, physical, safety and support needs, without intruding on her privacy. Table 4 shows how responding to emotional and practical needs is prioritised in first-line support.

Table 4: Goals and tips for providing first-line support

Goals	You do not need to
Identify her needs and concerns	Try to solve all her problems
Listen and validate her concerns and experiences	Convince her to leave a violent relationship
Help her to feel connected to others, calm and hopeful	Convince her to go to any other service, such as police or the courts
Empower her to feel able to help herself and to ask for help exploring what her options are	Ask detailed questions that force her to relive painful events
Respect her wishes	Pressure her to tell you her feelings or reactions to an event
Help her find social, physical and emotional support	Ask her to analyse what happened, and why
Enhance safety	

Goals	You do not need to
Remember: When you help her deal with her practical needs, it helps with her emotional needs. When you help with her emotional needs, you strengthen her ability to deal with practical needs.	**These actions could do more harm than good.**

Source: (6)

First-line support involves 5 simple tasks. The letters in the word "LIVES" can provide a reminder of these 5 tasks that protect women's lives.

Table 5: The LIVES approach to first-line support

Listen	Listen to the woman closely, with empathy, and without judging.
Inquire about needs and concerns	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)
Validate	Show her that you understand and believe her. Assure her that she is not to blame.
Enhance safety	Discuss a plan to protect herself from further harm if violence occurs again.
Support	Support her by helping her connect to information, services and social support.

Box 5: WHO recommendations for the provision of first-line support

- Health-care providers should, as a minimum, offer first-line support when women disclose IPV or SV. First-line support includes:
  - Being non-judgemental and supportive and validating what the woman is saying; providing practical care and support that responds to her concerns, but does not intrude 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 thinks helpful to increase safety for herself and her children, where needed providing or mobilizing social support.
  - Providers should ensure that the consultation is conducted in privacy, that information about the survivor is kept confidential, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)
  - All health-care providers should be trained in first-line support. In exceptional circumstances, if a health-care provider is 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.

Source: (6)

Safety assessment and planning is an important part of first-line support. Health-care providers should assess whether it is safe for a woman to return to her home and whether there is immediate risk of serious injury.

Signs of immediate risk include that the violence is getting worse, and/or that the perpetrator:

- Threatened her with a weapon
- Tried to strangle her
- Beat her when she was pregnant
- Is constantly jealous

In addition, if the survivor responds “Yes” to the question, “Do you believe he could kill you?”, she is at immediate risk (6).

Assessing and planning for safety is an ongoing process – it is not just a one-time conversation. Health-care providers may assist survivors by discussing their particular needs and situation and exploring options and resources at every visit and/or as the situation changes. It is essential that health workers take the safety concerns of the survivor seriously.

Based on the patient's level of risk and need, health-care providers should be prepared to assist women to develop a safety plan. Even women who are not facing immediate serious risk could benefit from having a safety plan. If they have a plan, they will be better able to deal with the situation if violence suddenly occurs. The following are elements of a safety plan and questions that can be asked to help survivors make a plan.

Table 6: Elements of a safety plan

Elements of a safety plan	Suggested questions for survivors
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? (Suggested documents/ information: passport, ID card, deed, bank account number)
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency? Are accounts joint or can you withdraw for emergency purposes?
Support by someone close by	Is there a neighbour you can tell about the violence who can call the police?

Source: (6)

Step 3: Immediate treatment and care

This section describes immediate responses relevant to all women survivors of IPV and SV (see section a), as well as specific aspects of care relevant for survivors of sexual assault (see section b).

a) Immediate treatment, care and referral for all survivors of violence

History-taking, assessment and documentation

Documenting the survivor's experience with IPV and SV is important to enable ongoing sensitive care and for the purposes of alerting other health-care providers at later visits.

Health-care providers should take a history from the patient to determine what interventions are appropriate. This should include, at a minimum:

- information about the patient's medical history
- information about the type of assault and potential health risks, such as sexually transmitted infections in case of sexual assault (also see section b below)
- an assessment of physical and mental health status.

It is important that any questions about the assault are posed with the objective to provide the best possible health care to the patient. Health workers must review any papers that the woman has and avoid asking questions she has already answered

Do not force a woman to talk about the assault if she does not want to. In all cases limit questions to just what is required for medical care. However, if a woman clearly wants to talk about what happened, it is very important to listen empathetically and allow her to talk (6).

Health-care providers must obtain informed consent in preparation of the examination and any treatment. A woman should be given the choice to refuse any aspect of the exam (or all). The health worker should describe to her what is included in the exam, invite her questions, answer them fully and obtain her consent for each step of the exam, treatment and any sharing of information with other sectors, such as the police.

Health workers must be aware of any reporting requirements (see Section II, Principle 2 above for the Trinidad and Tobago requirements) and take needed steps. For adult women, where mandatory reporting does not apply, the health worker should talk to the woman about her options. If she wants to go to the police, tell her that she will need to have forensic evidence collected and what it would entail. It may be necessary to refer her to a specifically trained provider. If she has not decided whether or not to go to the police, the evidence

can be collected and held. Even if the forensic evidence is not collected, the full physical examination should be done and well documented so that it can help her to pursue a legal case later.

Once informed consent has been obtained, the health worker should do a physical examination to help determine what medical care is needed. Physical and mental examination and care should go hand in hand. It is important to give the woman space to ask questions, pause or stop the exam, and to respond to all of her concerns. The health-care provider should record all findings and document all results, injuries and observations carefully. It is important to work systematically, give sufficient time for the examination and be careful not to increase the survivor's distress.

Box 6: WHO recommendations for documenting IPV and SV

- Proceed slowly and carefully. Ask her for permission at each step of the examination and assure her she is in control.
- Be careful not to increase her distress. Do not force her to talk about something if she does not want to. Avoid asking her the same questions twice.
- Follow the patient's wishes. If there is anything she does not want to have written down, do not record it.
- Enter in the medical record any health complaints, symptoms, and signs, including a description of injuries. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including the source of the injury.
- Be aware of situations where confidentiality may be broken. Be cautious about what is written and where the records are left and stored.
- For greater confidentiality, some facilities use a code or special mark to indicate cases of abuse or suspected abuse.

Source: (6)

Appendix 1 provides a clinical record form for use by health-care providers to document patient history, presenting signs and health conditions associated with violence and care and referrals provided – the Trinidad and Tobago Intimate Partner Violence and Sexual Violence Health Care Form. This form has been developed under the Spotlight Initiative as part of an initiative to develop an IPV and SV Health Information System (IPVSV HIS), following consultations with health-care providers in Regional Health Authorities and the Ministry of Health. The sequence of items to be completed in the form follows the pathway of care recommended in the current Guidelines and is based on the sample history and examinations form of the WHO Clinical Handbook (6), adapted through local consultation. It starts with registration of information about the survivor following identification of a case of IPV or SV, then proceeds through taking general medical history, describing the incident, clinical examination, assessment of mental state, laboratory tests, collection of legal evidence, description of immediate care, safety assessment and referral to other services. The form is recommended as a way of recording information so as to optimise quality of care.

The form has been designed to be used in paper or electronic format.

- Paper version: Paper copies may be used and included as part of a patient's notes if there is no electronic device available for entering the data. As the form conforms to good practice guidelines, it will assist in optimising the care of the patient and in identifying any gaps in care.
- Electronic version: The current electronic clinical record system on care of pregnant women in Trinidad and Tobago, the Perinatal Information System (SIP) is being adapted so that information on IPV and SV can be collected electronically using this form. SIP is a digital data collection system developed by PAHO/ WHO that has been rolled out in several countries across the Americas. Digitisation of the information on IPV and SV will facilitate management of care by different providers and avoid distress that may occur when the survivor has to repeat information about an incident of violence. A manual and tools to assist with administration of the form are currently being developed, and a programme of training and technical assistance in upgrading skills and facilities is being planned by PAHO/ WHO for 2022. The current Guidelines will be revised as the manual, tools, training and technical assistance initiatives become available. Aggregated data from the IPVSV HIS can provide information to care managers and policy makers on the characteristics of cases reported at health care facilities and care and support provided. It can help pinpoint areas of concern in the quality of care provided and enable targeted strategies for improvement.

Treatment of physical health conditions

Basic clinical interventions should be provided appropriate to the injuries that the patient presents with, e.g. antibiotics to prevent wound infection, tetanus shot, pain medication. Some of the immediate/ presenting health conditions arising from violence can be treated on site, while those requiring more specialized care (as in cases of extensive injury, neurological deficits, respiratory distress or swelling of joints on one side of the body) may be referred for hospitalization and or emergency services as appropriate. Health-care providers should immediately refer patients with life-threatening or severe conditions for emergency treatment. Some complications that require urgent hospitalization include:

- Extensive injury (to genital region, head, chest or abdomen)
- Neurological deficits (for example, cannot speak, problems walking)
- Respiratory distress
- Swelling of joints on one side of the body (septic arthritis) (6).

Survivors of sexual assault may require additional forms of treatment, for which timeliness is critical. Further detail is provided in section b below.

Health workers should explain any examination findings and related treatment decisions to the woman. It is important to listen to her concerns, answer her questions and ensure her informed consent. Health workers should teach the woman how to care for any injuries or health conditions, including highlighting any potential warning signs of wound infection which may require her to return to the health service, stressing the importance of completing the course of any medications given, particularly antibiotics, and explaining any likely side effects of medication or treatment and what to do about them.

Mental health and psychosocial support (MHPSS)

Trinidad and Tobago's National Mental Health Policy 2019-2029 (52) recognises links between domestic violence or other forms of abuse and mental ill-health and suicide respectively. The health sector is among the sectors identified as having critical roles to play in the treatment and prevention of mental ill-health and suicide. The National Mental Health Policy notes that there are no specific mental health services for survivors of gender- based violence in the public health care system[3], highlighting the importance of developing skills among health-care providers who encounter survivors reporting for care.

3. The National Mental Health Policy notes that mental health care for survivors is also provided by NGOs such as Families in Action and the Rape Crisis Society.

Women subjected to IPV and/or SV often present with emotional or mental health problems. Some women may experience more severe effects than others. It is important for healthcare providers to be able to recognize these women and connect them to treatment and support. Mental health status should be assessed at the same time as assessing general health.

There are specific ways health service providers can offer help to women to mitigate and prevent mental health consequences. Healthcare providers with the relevant skills can provide some basic mental health assessments and support and may refer patients for medical and psychiatric in-patient health and social work services.

Basic psychosocial support can be offered to all women survivors. In addition to LIVES (see step 2), health workers can explain to their patient that she is likely to feel better with time, help strengthen her positive coping methods and explore the availability of social support. Strengthening positive coping methods of the survivor can be done by speaking to her about her normal routine, her life and activities. Health workers may wish to suggest to her to:

- Build on her strengths and abilities and remind her that the situation will likely get better
- Continue normal activities, especially ones that she enjoys
- Keep a regular sleep schedule
- Engage in regular physical activity
- Engage in relaxing activities and manage stress, to the extent possible, for example through relaxation and breathing exercises
- Avoid using self-prescribed medications, alcohol or illegal drugs to try to feel better

Helping her to consider available social support is another useful technique to mitigate the mental health impact. Health workers can help the woman to identify past social activities or resources that may provide direct or indirect psychosocial support (for example, gatherings with family or friends, visits with neighbours, sports, community and religious activities). The health worker should encourage her to participate. In collaboration with the social worker, the woman can also be connected to other support services that may exist in her community, for example, available self-help groups, civil society organizations etc.

Health workers should monitor the woman for more severe problems and may wish to schedule follow-up appointments or consider referral to other services, including more specialized mental health services and social workers.

It is critical that health workers are aware of potential risks of self-harm and suicide for survivors of violence and consider this risk as part of their assessment. If she is at immediate

risk of suicide or self-harm, she should not be left alone and be referred immediately for specialized care and support. Signs of immediate risk include if she has current thoughts or plan to commit suicide or to harm herself, or a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is during the consultation extremely agitated, violent, distressed or uncommunicative. For other survivors not considered at immediate risk, health workers should speak to the woman about potential risks of self-harm, encouraging her to recognize thoughts of self-harm or suicide herself and come back as soon as possible for help if they occur. Although some health care workers fear that asking about suicide may provoke the woman to end her life, evidence suggests that talking about suicide often reduces the woman's anxiety around suicidal thoughts and helps her feel understood (6).

More information and tools on how to assess and address mental health conditions, including depression and post-traumatic stress syndrome, can be found in the WHO mhGAP intervention guide and its annexes, available at: http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/. The Mental Health and Psychosocial Network of Trinidad and Tobago have developed a National Emergency and Crisis Mental Health Services Directory, including details and contact information for GBV services such as hotlines, shelters, legal services, counselling, support groups and GBV Units of the Trinidad and Tobago Police Service (53). The directory is available at https://www.findcarett.com/, with GBV resources available at https://www.findcarett.com/gender-based-violence/

Women subjected to violence may be referred to a social worker to help identify and address psychosocial and support needs. Based on existing protocols, social workers can conduct an assessment on all women and suggest appropriate interventions, including safety planning, mobilization of social support and referrals to other essential support services. Social workers should be trained in first-line support (LIVES) to enhance their ability to identify and respond to the needs of survivors.

Box 7: WHO recommendations for mental health care of survivors of IPV

- Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depressive disorder or alcohol use disorder) who are experiencing IPV should receive mental health care for the disorder (in accordance with the WHO Mental Health Gap Action Programme (mhGAP) intervention guide, 2010) delivered by health-care professionals with a good understanding of violence against women.
- Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) interventions, delivered by health-care professionals with a good understanding of violence against women, are recommended for women who are no longer experiencing violence but are suffering from post-traumatic stress disorder (PTSD).
- Where children are exposed to IPV at home, a psychotherapeutic intervention, including sessions where they are with, and sessions where they are without their mother, should be offered, if the setting allows this.

Source: (5, 54)

b) Additional care after sexual assault

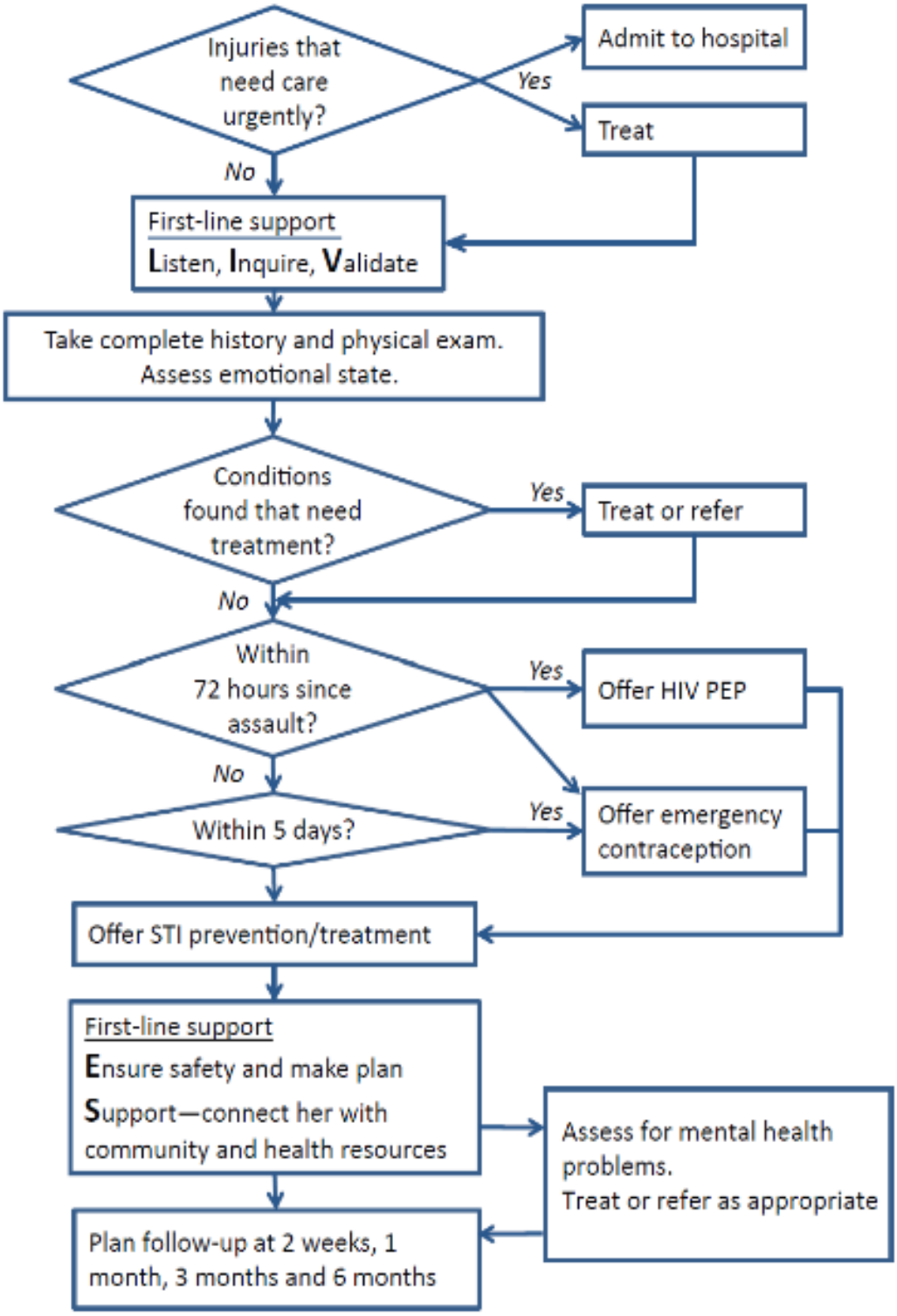
This section provides additional information on care after sexual assault, complementing the information relevant to all survivors of intimate partner and SV described above. In addition to first-line support, treatment of injuries and attention to their mental health and safety needs, survivors of sexual assault often have specific needs, including for example prevention of HIV and STIs and emergency contraception (EC). The timeliness of care after sexual assault is critical, as highlighted in the pathway of care for survivors of sexual assault in Figure 3.

Guidelines for the implementation of post-sexual assault care should follow existing national protocols and guidelines (28) and be aligned with WHO recommendations (5, 6, 17-19). Currently, a comprehensive review of HIV prevention, treatment and care protocols is being undertaken by the Government of the Republic of Trinidad and Tobago with support from PAHO/ WHO, with a view to updating HIV guidelines. Guidelines on forensic specimen collection and the use of drug regimens for post-exposure prophylaxis (PEP) shown below are drawn from the Standard Operating Procedures Manual for Emergency Services 2010.

The pathway starts with identification of the survivor, followed by prioritization of any urgent care needs (if any). It is suggested that the survivor be immediately provided with the first three steps of first-line support (Listen-Inquire-Validate of LIVES), followed by a complete

history and physical exam, including documentation of the assault as appropriate, treatment of physical injuries, including emergency contraceptives in accordance with national guidelines and HIV and STI prophylaxis, followed by the last two steps of first-line support (Enhance safety and Support of LIVES) as well as treatment or referral for mental health conditions and other follow up care (6).

Figure 3: Pathway of initial care after sexual assault



Source: (6)

Take history, conduct physical examination and gather forensic evidence

As for other forms of violence, it is recommended that health-care providers take a history, document health needs and injuries, and record details of the sexual assault to determine what care is appropriate. Further to what is described in part a above, this should include also information about:

- Gynaecological history
- The time since assault and type of assault
- Risk of pregnancy, HIV and other STIs

Health-care providers must demonstrate sensitivity, as women subjected to SV are likely to be traumatized. The health-care provider should explain and obtain informed consent for each of the following:

- the physical examination
- clinical interventions
- any request for forensic evidence
- the release of information to third parties, such as the police and courts.

Conducting a complete physical examination (head-to-toe, including genital and anal examination) is a critical element of post-sexual assault care. As for other forms of violence, the IPV and SV Health Care Form (see Appendix 1) should be used to document all findings carefully. The patient can ask questions, stop the exam at any time or refuse any part of the exam.

In cases of sexual assault, a genito-anal examination is necessary. This is a sensitive examination, particularly the speculum exam and it is the responsibility of the health worker to help the woman feel as comfortable as possible. The genito-anal exam would normally include looking for active bleeding, bruising, cuts or abrasions, redness and/or swelling around the genitals and anal region, both externally and internally, using a speculum. The health worker should also check for foreign body presence. There should be no virginity ("two-finger") testing, which has no scientific validity.

All findings must be carefully recorded. Careful documentation of findings and treatment on the IPV and SV Health Care Form will make it easier for the health worker to provide the best care possible. It will also help to accurately answer any questions by the police or justice

sector if legal proceedings are initiated. Further information on forensic specimen collection is provided in Box 9.

Box 8: WHO recommendations for history-taking, physical examination and forensic examination.

- A good history is the basis for the forensic evidence collection because the history of the assault will guide what forensic specimens to collect.
- Maximize efforts to have only one examination combining physical examination and forensic evidence collection. If the patient agrees to have evidence collected, do this while undertaking the physical exam. If only some health-care providers are legally allowed to conduct the exam, request that they do both the physical exam as well as the forensic part.
- Confidentiality of the survivor must be guaranteed. If there are limitations to confidentiality (such as in situations of mandatory reporting, as outlined in Section II under Principle 2), share this information as early as possible, preferably before she has disclosed.

Source: (6, 17)

Box 9: Trinidad and Tobago medical tests for Forensic Sciences Centre

1. Swabs (to be taken within 24 hours of incident) use only dry sterile cotton wool swabs and submit in dry tubes (swabs in media destroy sperm).

- Vaginal — external and internal (low and high). Use only water as lubricant for speculum.
- ANAL - EXTERNAL AND INTERNAL
- Penile — external (from suspect).
- Mouth and other areas, suspicious for presence of sperm.

  - Motile sperm is demonstrable in the vagina up to 6 hours and in the mouth/

anus up to 3 hours after the incident.

- Non-motile sperm is demonstrable in the vagina up to 24 hours, and the mouth/anus up to 6 hours after the incident.

- Absence of sperm does not rule out penetration as some males produce little or no sperm OR the perpetrator may have withdrawn before ejaculation or have used a condom.

2. Blood

- An EDTA — anticoagulated specimen is obtained from the victim — used for grouping — ABO and phosphogluco-mutase (PGM) enzyme. Once the victim's blood group is determined, any other type of blood group substance, identified from vaginal/anal swab, may be that of the suspect.
- Two clotted samples — for VDRL and HIV (after pre-test counselling) — to be submitted to Queen's Park Counselling Centre and Clinic (QPCC&C) and Trinidad Public Health Laboratory. (Rapid HIV test should also be done).

3. Other Baseline Blood Tests (as guided by attending medical officer)

- Blood for testing of source if possible.

- If source known, positive attempt to get information on ARV use and CD4, VL (Consult with treatment centre of source).

- Baseline Rapid HIV test (and/or HIV Elisa), Baseline Hep B, VDRL, CBC, U+E/CREAT, LFT (if the victim is going to receive PEP), UPT. These tests can be drawn after PEP is initiated so that drawing of baseline labs does not interfere with timely administration of PEP.

4. Saliva

Saliva from victim is to be collected in a clean container — used to determine whether or not the person is a secretor of blood group substances. If blood group substances are present in saliva, then they will also be present in vaginal secretions.

5. Others (If Possible)

- Hair (head and pubic) — obtained by combing pubic area and placing in small plastic bags. If possible, comparative clippings from the head should also be submitted.

- Fingernail cutting — depends on history. If victim has scraped suspect with fingernails, then take cuttings and place in small plastic bags.

Remember

Label specimens properly: Name, Gender, Victim/Suspect, Date and Time taken, Type of specimen — vaginal swab, anal swab, etc.

Complete sexual offences form (for Trinidad and Tobago Forensic Sciences Centre) and other investigational requisition forms. Give form and specimens to attending police officer and have officer sign for receipt of same.

Source: (28)

Treat physical injuries, prevent further harm and promote health and wellbeing

Once the health-care provider completes the history-taking and examination, he/she is able to determine the extent of physical injury and the level of interventions needed. In the case of sexual assault, some specific, time-sensitive interventions should be considered.

This section provides clinical guidelines for the provision of care and treatment for pregnancy prophylaxis and HIV/ STI prevention.

Offer Pregnancy Prophylaxis in accordance with national guidelines (28)

Sexual assault may place women of reproductive age at risk of unwanted pregnancy. If Pregnancy Prophylaxis, also known as Emergency Contraception (EC), is used soon after sexual assault, this risk may be avoided.

A woman who has been sexually assaulted is likely to worry about getting pregnant. The health worker should counsel the woman and help her to make an informed choice. She should be offered Pregnancy Prophylaxis as soon as possible and no later than 120 hours after the assault and administered by the attending medical officer. The health worker can help reassure the woman by explaining Pregnancy Prophylaxis to her, helping her to understand what to expect.

In line with WHO recommendations, Pregnancy Prophylaxis is to be taken no longer than 120 hours after unprotected intercourse (6).

Box 10: WHO recommendations for the use of EC in post-rape care

- Offer EC to all women who have been sexually assaulted along with counselling to assist women to make decisions about their choices.
- The use of EC is a personal choice of the woman survivor.
- EC pills must be taken within 120 hours (5 days) of the rape.
- Taking EC will cause no harm if the woman is already pregnant or if EC fails.
- There is no need to screen for health conditions or test for pregnancy before giving EC.
- EC can help to avoid pregnancy but is not 100% effective. Request for the patient to return if next menstrual period is more than 1 week late.

Source: (6)

Prevent and treat Sexually Transmitted Infections (STIs)

Following exposure to SV, health-care providers should assess and discuss the signs and symptoms of STIs, including HIV.

Based on national guidelines (30), survivors of sexual assault should be offered PEP for STIs including HIV and it should be administered by the attending medical officer.

Box 11: WHO recommendations for STI prophylaxis/treatment

- Women who have been sexually assaulted should be given antibiotics to prevent and treat the following sexually transmitted infections (STIs) – chlamydia, gonorrhoea, trichomonas and, if common in the area, syphilis.
- Offer STI treatment on your first meeting with the woman.
- There is no need to test for STIs before treating.
- Give preventive treatment for STIs common in the area (for example, chancroid).

- Give the shortest courses available in the local or national protocol, as these are easiest to take.

Source: (6)

Hepatitis B (6)

The hepatitis B virus can be sexually transmitted. Therefore, women subjected to sexual violence should be offered immunization for hepatitis B.

- Ask if she has received a vaccine against hepatitis B. Respond according to chart below.
- If she is uncertain, test first if possible. If already immune (presence of hepatitis B surface antibody in serum), no further vaccination is needed. If testing is not possible, vaccinate (6).

Table 7: Has she been vaccinated for hepatitis B?

Immunization status	Treatment guidelines
No, never vaccinated for hepatitis B	1st dose of vaccine: at first visit. 2nd dose: 1–2 months after the first dose (or at the 3-month visit if not done earlier). 3rd dose 4–6 months after the first dose.
Started but has not yet completed a series of hepatitis B vaccinations	Complete the series as scheduled.
Yes, completed series of hepatitis B vaccinations.	No need to re-vaccinate.

Source: (6)

- Use the type of vaccine, dosage and immunization schedule that is used in your area.
- A vaccine without hepatitis B immune globulin (HBIG) can be used.
- Give the vaccine intramuscularly in the deltoid region of the arm (6).

Prevent HIV

IPV and sexual assault against women places women at increased risk of HIV both through direct risk of infection and by creating an environment in which women are unable to adequately protect themselves from HIV. IPV may also affect disclosure of HIV status or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies (55-57). Asking women about IPV could therefore be considered in the context of HIV testing and counselling (19).

HIV Post Exposure Prophylaxis (PEP)

In addition to HIV testing and counselling, it is important to offer women PEP either directly or through referral to a HIV clinic to reduce the risk of HIV (58). PEP to prevent HIV should be started as soon as possible and no later than 72 hours after possible exposure to HIV (6). The health worker should talk to the woman about whether PEP would be appropriate in her situation, using the guidance in the following table.

Table 8: According to WHO, when should PEP be considered?

Situation/Risk Factor	Suggested Procedure
Perpetrator is HIV-infected or of unknown HIV status.	Give PEP
Her HIV status is unknown.	Offer HIV testing and counselling
Her HIV status is unknown and she is NOT willing to test.	Give PEP and make follow-up appointment
She is HIV-positive.	Do NOT give PEP
She has been exposed to blood or semen (through vaginal, anal or oral intercourse or through wounds or other mucous membranes).	Give PEP
She was unconscious and cannot remember what happened.	Give PEP
She was gang-raped.	Give PEP

Source: (6)

Box 12: WHO recommendations for the use of PEP for HIV prevention following sexual assault

- Test for HIV at the initial consultation and offer re-testing at 3 or 6 month intervals or both. If she tests positive, refer her for HIV treatment and care.
- PEP should be started as soon as possible, and no later than 72 hours after the assault. A 28-day prescription of ARVs should be provided.
- If she decides to take PEP, support her adherence to the protocol by explaining what it entails, the importance of intake at regular intervals and flagging possible side effects.

Source: (6, 17)

In some locations, post-rape treatment kits of the Ministry of Health in partnership with the United Nations Population Fund may be used to strengthen survivors' access to integrated sexual and reproductive health and GBV services, including HIV PEP.

See Section IV for further guidance about delivering services to survivors of IPV and SV in emergency situations.

Treat and/or refer for mental health

Women experiencing SV may have specific emotional or mental health challenges as a consequence. There are specific ways health service providers can offer help and techniques to women to reduce stress and assist SV survivors to manage the psychological effects. It is important to be able to identify women with emotional and mental health challenges and to help them obtain care.

Box 13: WHO recommendations for mental health care in the first-3 months after sexual assault

- Assess for mental health problems (symptoms of acute stress/Post-Traumatic Stress Disorder, depression, alcohol and drug use problems, suicidality or self-harm)
- Treat depression, alcohol use disorder and other mental health disorders as guided by existing national protocols and following WHO evidence-based clinical protocols for mental health.

Source: (6)

Box 14: WHO recommendations for mental health care 3 months or more after sexual assault

After an assault, basic psychosocial support may be sufficient for the first 1-3 months, at the same time monitoring for more severe mental health problems. This includes:

- Offering first-line support (LIVES) at each meeting
- Helping strengthen her positive coping methods
- Exploring the availability of social support
- Teaching and demonstrating stress reduction exercises
- Providing regular follow-up

If a woman has any other mental health problems (symptoms of depression, alcohol or drug use problems, suicide or self-harm), additional care should be provided based on existing national protocols and following WHO evidence-based clinical protocols for mental health problems.

Source: (6)

The psychological effects of violence may last much more than 3 months and long-term MHPSS follow-up may be needed for some survivors. It is important to recognize that the forms of psychosocial and emotional support applicable may differ for IPV and SV. Post-traumatic stress disorder interventions for SV survivors are quite specialized and traditionally provided by psychologists, which presents an opportunity to strengthen linkages and referrals across specialized care units in the health sector.

Provide follow-up care

After the first-line support, it is additionally recommended that health-care providers follow-up at 2 weeks, 1 month, 3 months and 6 months with survivors of sexual assault.

Table 9: WHO guidelines for follow-up visits after sexual assault

Injury	STI	Mental Health	Planning
• Check that any injuries are healing	• Check that the patient has completed the course of any medication given for STIs. • Check adherence to PEP if she is taking it. • Discuss test results.	• Continue first line support. • Assess the patient's emotional state and mental status. If any problems plan for psychosocial support and stress management.	• Remind the survivor to return for 1 month follow-up and make appointment.

1-month follow-up visit

STI	Mental Health	Planning
• Offer HIV testing and counselling. • Make sure that pre- and post-test counselling is available and refer to HIV prevention, treatment and care.	• Continue first-line support and care. • Assess emotional state and mental status. Ask if the patient is feeling better. If there are new or continuing problems, plan for psychosocial support and stress management. • For depression, alcohol or substance use, or post-traumatic stress disorder refer to national guidelines for treatment or if possible, refer to specialized mental health-care provider.	• Make next routine follow-up appointment for 3 months after the assault

3-month follow-up visit

STI	Mental Health	Planning
• Same as one month follow-up for STI (if not already done).	• Same as one month follow-up for mental health	• Make next follow-up appointment for 6 months after the assault.

6-month follow-up visit

STI	Mental Health	Planning
• Same as one month follow-up for STI (if not already done).	• Same as one month follow-up for mental health.	• Confirm safety plan

Source: (6)

Step 4: Referrals and networks

It is critical that survivors can safely and quickly access health, psychosocial, protection, legal, social and economic services and support. This requires an effective system of care, comprised of a network of identified actors and service providers and an established referral pathway detailing the manner in which survivors can access essential services.

A woman who has been subjected to violence may have different needs from most other health-care patients. In particular, she may have various emotional needs, be fearful and need reassurance and additional physical care. Safety may be an ongoing concern and specialized mental health support may be needed. For example, for women who are at high risk, requiring immediate safety, health-care providers should make appropriate referrals to shelters or safe housing, or work with her to identify a safe place she can go to.

These, in addition to the need for non-medical support from legal, social and economic services require that all health facilities develop formal referral mechanisms to link women to other resources for needs that the health system cannot meet. Timely referral and linkages to non-health care resources and support networks (both formal and informal) are critical components in provision of care for women experiencing violence.

The guiding principles presented in Section II, especially those concerning confidentiality and protection of information about the survivor, should orient the referral process. As noted above, the survivor should be told about any mandatory reporting to law enforcement authorities at the beginning of her encounter with health personnel (see Section II, Principle 2) and should provide informed consent for all other sharing of information. Only information which is strictly necessary to criminal proceedings or ongoing care by other agencies should be shared. A data sharing protocol should be developed for the ethical management of patient information between health and other service provider agencies for cases of IPV and SV (59).

To assist women in accessing services, it is helpful for the health-care worker to provide warm referrals, which means that the worker contacts and/ or accompanies the survivor to the person or people providing the referral service.

Box 15: Guidelines for referral systems

- Procedures between services for information sharing and referral are consistent, known by agency staff, and communicated clearly to survivors.
- Services have mechanisms for coordinating and monitoring the effectiveness of referrals processes.
- Services refer to child specific services as required and appropriate.

Source: (59)

Strengthening referrals and networks

It is important to establish formal referral mechanisms to link survivors to both internal and external resources such as social workers, counsellors, psychologists, police and social welfare officers. It is critical that the referral mechanism allows for feedback, letting the health provider know whether the survivor reaches the referral resource (14).

For referrals within the health-care system, it is recommended that health-care providers set up a system to monitor how many clients actually receive the services to which they have been referred. To do this it is recommended that Regional Health Authorities establish a system for allowing staff from different facilities to share information and provide follow-up for clients who have been referred.

For external referrals, it is also recommended that health facilities establish a system for following-up clients who were linked to non-health services and a mechanism for feedback. Monitoring the quality of services that survivors receive outside the health sector and any link back to the health system is also important. In the absence of effective case management across sectors, health sector staff can accompany patients to the external service provider and also follow-up with patients (once it can be done safely), to try to stay in contact with survivors who may be at high risk.

It is advised that health-care providers compile a list of services providers, including non-governmental/community-based programmes and government services such as police, public prosecutors, legal aid attorneys and forensic medical examiners, as well as information on services related to custody, divorce, property settlements and protection orders. Contact with schools may also be important, to assure the continued education of children affected by family violence. A referral directory of services should be made available in every health-care setting. If adequate external referral services are unavailable in the community, health-care providers could establish basic services in the health centre, such as crisis intervention, emotional support, and support groups for women. In each health-care setting it is also

recommended to develop an integrated network of referrals, where everyone in the network understands the roles and responsibilities of other members.

If the survivor is facing economic hardship, a useful source of information for referrals may be the Catalogue of Services for the Economic Empowerment of Women developed under the Spotlight Initiative in Trinidad and Tobago, available at: https://lokjackgsb.edu.tt/catalogue-of-services/ (60). The National Emergency and Crisis Mental Health Services Directory provides details of mental health and other relevant services such as legal services, shelters and GBV Units of the Trinidad and Tobago Police Service (https://www.findcarett.com/) (53).

Box 16: WHO guidelines for strengthening networks

- Multi-agency collaboration is necessary, since the health-care facility will not be able to meet women's multiple and complex needs.
- In order for networks to be successful, there should be an understanding of each provider's roles and responsibilities.
- Health-care facilities should be part of a network of organizations that can assist women affected intimate partner violence and/or sexual violence.
- There is a need for networks to meet regularly to review issues, strengthen networks and integrate responses across sectors to strengthen service provision.
- It is important to consider what can be done if there are no referral services or limited resources. It may be necessary to have a core group of professionals within the health-care facility who receive more intensive training (e.g. basic counselling skills, risk assessment and safety planning) to whom women can be referred.
- Components of a successful network include: broad partnerships between agencies; active local core groups; joint training; integrated systems of referral; integrated information systems; and common behaviour-change communication activities.

Source: (16)

The continuum of prevention services

Health programmes can play a useful role in broader efforts to prevent IPV and SV. By being engaged in community outreach and advocacy activities, health organizations can strengthen the alliances or networks working on GBV and raise the visibility of the issue on the national agenda (14). The efforts of a range of organizations are needed to bring about changes in cultural norms and laws and policies related to GBV.

Health-care settings also provide an important opportunity for prevention working in collaboration with multiple stakeholder agencies to help address the factors contributing to violence. In coordination with other agencies, the health-care sector has a role in primary, secondary and tertiary prevention (14).

The recommendations of this section are based on Trinidad and Tobago stakeholder consultations and United Nations guidance documents, such as the RESPECT framework for preventing VAW (24). According to the review of evidence that informed the RESPECT framework, elements of more promising interventions focus on women's safety; addressing unequal gender power relations; using participatory approaches that stimulate critical reflection on power and strengthen voice and agency; and facilitating partnerships across organizations and sectors. Each letter of RESPECT stands for one of the following seven strategies: Relationship skills strengthened; Empowerment of women; Services ensured; Poverty reduced; Environments made safe; Child and adolescent abuse prevented, and Transformed attitudes, beliefs and norms. This requires a multi-sectoral approach in which the health sector can play a key role, especially in making environments safe and ensuring provision and access to services (14, 24).

Primary prevention refers to efforts to prevent violence from occurring in the first place. To enable primary prevention, health-care providers should receive training about the epidemiology of physical, sexual and psychological VAW, including the magnitude of the problem, patterns of violence in the surrounding community, and the impact of violence on women's health. Opportunities to increase primary prevention include integrating messages about violence as part of routine health-promotion activities. Communications materials can, for example, include videos for clients and providers, pamphlets that discuss issues related to violence, and referral cards with information about local services for survivors. Prevention education and counselling on the issue of IPV and its health consequences can be carried out during the delivery of routine care in antenatal and other SRH services. It is also important to think about prevention work with adolescents and young people who use health-care services. Partnering with other agencies can increase community awareness of the risk factors for VAW through behaviour-change communication activities.

Secondary prevention focuses on early identification of survivors. This can take place by health-care workers carrying out clinical inquiry as outlined above, then supporting disclosure and following further steps in the Pathway of Care outlined earlier in Section III. A variety of departments may be involved, such as Accident and Emergency departments and SRH,

maternal and child services. Responding to physical, mental and reproductive health-care needs, and referral to appropriate services, are all critical aspects of secondary prevention.

To support this, the organization's policies and protocols should incorporate the issue of GBV (14). Health personnel should be trained to recognize the direct and indirect consequences of GBV.

Tertiary prevention serves to mitigate negative impacts of violence that has already occurred. Examples include long-term counselling and establishment of support groups, HIV PEP and EC for sexual assault survivors.

Referral to social, economic and legal support can be regarded as an important aspect of tertiary prevention. Given that women experiencing physical violence will likely seek health services at some point, health-care providers are favourably positioned to refer survivors to other services to address their immediate needs and prevent future incidents of violence from occurring.

Section IV: Delivering Services in Emergencies

GBV and the COVID-19 pandemic

Evidence shows that women and girls are most vulnerable during emergencies. During the COVID-19 pandemic, movement restrictions including “quarantine measures” coupled with increases socioeconomic stress have increased the risk of IPV, while creating new barriers in access to needed support for survivors (20). In the midst of stay-at-home restrictions in Trinidad and Tobago in 2020, there was a 140% increase in cases of abuse of women and girls reported to the TTPS as compared with the same period the previous year, indicating a potential increase in risk (61). As in other emergencies, it is critical for the health sector to continue to provide a range of prevention, treatment, and follow-up support. PAHO/ WHO has recommended to Member States that health services for survivors of violence are framed as essential services that must continue in the context of COVID-19 (62).

The health sector response to GBV during COVID-19 should be informed by some general standards and recommendations on responding to GBV and SRH in emergencies, as outlined below.

Responding to GBV and SRH in emergencies

In response to the heightened risks of GBV and barriers to access to services in emergencies, humanitarian agencies have collaborated to develop sets of recommendations to respond to these challenges. The Inter-Agency Steering Committee is the primary mechanism for inter-agency coordination of humanitarian assistance. Through the Committee and its Working Groups, two complementary sets of guidance have been developed, led by the United Nations Population Fund (UNFPA):

1. Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies (41)

2. Minimum Initial Service Package (MISP) for SRH in Crisis Situations (39)

The Minimum Standards require multisectoral collaboration and include sets of foundational standards, mitigation, prevention and response standards, and coordination and operational standards. Box 15 provides some selected standards of special relevance for the health sector.

Box 17: Selected Minimum Standards for Prevention and Response to GBV in Emergencies, of high relevance to the health sector

COLLECTING AND USING DATA
STANDARD: Quality, disaggregated, gender-sensitive data on the nature and scope of GBV and on the availability and accessibility of services informs programming, policy and advocacy.

HEALTH CARE
STANDARD: GBV survivors, including women, girls, boys and men, access quality, life-saving health-care services, with an emphasis on clinical management of rape.

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT
STANDARD: GBV survivors access quality mental health and psychosocial support focused on healing, empowerment and recovery.

SAFETY AND SECURITY
STANDARD: Safety and security measures are in place to prevent and mitigate GBV and protect survivors.

REFERRAL SYSTEMS
STANDARD: Referral systems are in place to connect women, girls and other at-risk groups to appropriate multi-sector GBV prevention and response services in a timely and safe manner.

Source: (41)

The Minimum Initial Service Package, developed by the Inter-Agency Working Group for Reproductive Health in Crisis (IAWG) in partnership with stakeholders, is a set of minimum lifesaving SRH interventions based on international standard of care and evidence that reproductive health needs in emergency and humanitarian settings increase (39). It is one of the Sphere humanitarian standards[4] and is aligned with the lifesaving criteria of the United Nations Central Emergency Response Fund (CERF) to be implemented at the onset of every emergency (63).

The overall aim of the MISP is to ensure the delivery of essential SRH services during emergencies. The MISP Is a set of priority activities for reproductive health to be implemented in the initial phase of emergency and has six objectives:

1. To ensure the health sector identifies an organization to lead implementation of the MISP
2. To prevent SV and respond to the needs of survivors
3. To prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs
4. To prevent excess maternal and new-born morbidity and mortality
5. To prevent unintended pregnancies
6. To plan for comprehensive SRH services, integrated into primary health care as soon as possible

Strategies to increase access to GBV essential health services during emergencies

During emergencies, it is critical that access to GBV health services remains available while keeping health-care providers and their patients safe. If the emergency involves a disease that is highly communicable during everyday interaction (such as COVID-19), it is recommended that health-care providers continue to provide quality services while helping to facilitate access and minimizing in-person contact between patients and providers. Health-care providers should be aware of the increased risk of GBV during emergencies and strive

4. The Sphere Project – or 'Sphere' – was initiated in 1997 by a group of humanitarian non-governmental organisations (NGOs) and the International Red Cross and Red Crescent Movement. Their aim was to improve the quality of their actions during disaster response and to be held accountable for them. They based Sphere's philosophy on two core beliefs: first, that those affected by disaster or conflict have a right to life with dignity and, therefore, a right to assistance; and second, that all possible steps should be taken to alleviate human suffering arising out of disaster or conflict. The Sphere Project framed a Humanitarian Charter and identified a set of minimum standards in key life-saving sectors which are now reflected in the Handbook's four technical chapters: water supply, sanitation and hygiene promotion; food security and nutrition; shelter, settlement and non-food items; and health action. The Core Standards are process standards and apply to all technical chapters.

to maintain first-line support, timely care for physical, sexual, reproductive and mental health, and sharing of information about available support and establish referrals to other essential services (64).

The timeliness of services for SV has been identified as a particular challenge in the context of COVID-19, especially in the case of movement restrictions. This means that there should be an agreement between health and security/police actors to overcome this barrier.

Access to essential services during times of emergencies such as the COVID-19 pandemic can be facilitated through the following interventions.

- Include IPV when designing, implementing and monitoring health emergency preparedness and response plans.
- Strengthen access to phone and online services such as hotlines, mHealth and telehealth.
- Innovate ways to provide information and support, e.g. through pharmacies, supermarkets, etc.
- Technology can be leveraged to implement alert systems that can be linked to GBV service provision.
- Entry points and systems can be created for survivors to access and signal a need for support. These must ensure that safeguards are in place to ensure that support can be activated without abusers being aware.
- Train health sector staff on how to identify survivors and how to provide first-line support.
- Provide guidance to shelters, care homes and other institutions to facilitate ongoing support to survivors.
- Prevent harm to children – e.g. by supporting parents, preventing long-term child-family separation, and establishing safe and acceptable alternative care arrangements in case of illness or death of a caregiver.
- Update referral pathways and share information on available support with survivors and communities and engage them in developing responses. Communication messages can show how to access GBV services during the emergency.
- Mobilize communities to promote gender equality and zero tolerance for violence.
- Coordinate with other sectors to address the risk factors of violence (e.g., harmful use of alcohol) and to protect women and children in the context of COVID-19 (40, 62).

The Government of the Republic of Trinidad and Tobago has put in place a number of measures to respond to GBV that are consistent with this guidance (65). These include:

- A Domestic Violence Hotline (800-SAVE) for survivors of IPV
- The implementation of the TTPS Gender-Based Violence Units, staffed with specially trained police personnel
- The implementation of the government-led Gender Impact Assessment of COVID-19
- A Response Plan developed in collaboration with the UN Spotlight Initiative team to ensure the uninterrupted provision of key essential services for survivors of family violence in Trinidad and Tobago during the COVID-19 pandemic.
- The inclusion of gender based violence hotlines, services and information in the FINDCAREtt National Emergency and Crisis Mental Health Services Directory (66).

The Response Plan developed by the UN Spotlight Initiative team includes the allocation of budgetary resources to provide front-line personnel from civil society organizations - specifically the Family Planning Association of Trinidad and Tobago, Rape Crisis Society, the Medical Research Foundation and the Coalition Against Domestic Violence - with the necessary tools to provide:

- Tele-medicine services, including GBV prevention and response, counselling and peer support for young people utilising a mobile app
- Remote GBV case management services
- Remote psychological support for survivors of rape and other forms of SV
- Clinical management of sexual assault services, including STI testing and treatment and providing EC in accordance with national guidelines and PEP prophylaxis
- Service provision to persons living with HIV.

Section V: Recommendations to Strengthen Health Capacity and Services

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To eliminate violence against women and girls

This section presents recommendations from stakeholder discussions and arising from the guidelines presented above to address the gaps and mobilize resources needed to strengthen the health sector response to IPV and SV. It aims to enable the enhancement of health services delivery and institutional capacity (staff and health systems). Recommendations are presented in the following tables for strengthening the delivery of care for survivors at national level (i.e. the Ministry of Health), subnational level (i.e. the RHAs) and for health-care facilities (staff capacity). A set of recommendations is also provided to strengthen prevention by the health sector.

Key sources for recommendations for health managers and policy makers include the WHO manual for strengthening health systems to respond to women subjected to IPV and SV (16) and the PAHO/ WHO Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women (25).

Strengthening the delivery of care for survivors of IPV and SV

Table 10: Recommendations to strengthen health services for survivors of IPV and SV[5]

Health Service Levels	Recommendations
National Level: Ministry of Health	• **Champion the cause** and build awareness within the health sector and line ministries of the need for a health sector response to GBV. • **Assign focal point or working group** with responsibility for developing the national health sector response to GBV. • **Strengthen multi-sectoral and multi-agency policy planning and coordination** of the health response to GBV.

5. More detailed recommendations for health managers and policy makers are available in the WHO manual for strengthening health systems to respond to women subjected to IPV and SV (13) and the PAHO strategy and plan of action on strengthening the health system to address violence against women (22).

Health Service Levels	Recommendations
	• **Implement accountability measures** such as regular monitoring and evaluation of the health system's performance in delivering quality services. • Increase the collection and availability of **epidemiological and service-related data on IPV and SV,** through nationally representative population-based surveys and strengthening of health information systems. • Develop **Standard Operating Procedures (SOPs) and protocols** which outline a standard package of services with defined roles and responsibilities of health-care providers to identify and respond to IPV and SV**.** • **Include procedures for documentation in SOPs,** including data collection and management and reporting to law enforcement services. • **Integrate prevention and response services for GBV into SRH** services as recommended in the Trinidad and Tobago National Sexual and Reproductive Health Policy, 2020. • **Integrate GBV into other associated health policies and plans** concerning issues such as mental health, HIV and disabilities.

Health Service Levels	Recommendations
Subnational: Regional Health Authorities	• **Build a coordinating team with a network of health-care providers** trained to support survivors of IPV and SV (within and outside government health care institutions), review issues and standardize protocols and norms. • **Strengthen coordination of services among providers at the various levels of service delivery,** including primary care and hospital-based services. • **Develop and implement a GBV health information management system,** including data on characteristics of survivors, the health impacts of violence, and care and referrals provided. Utilise the information to monitor and evaluate the health systems response and implement appropriate remedial measures. • **Strengthen linkages within the RHA geographical area with relevant non-health agencies** (e.g. shelters, police, and legal networks). • **Ensure the availability of mental health and psychosocial support,** including specialized psychological care for women subjected to sexual assault. This entails strengthening referrals and linkages across specialized care units. • **Streamline processes for reporting cases of sexual assault to police/law enforcement.**

Health Service Levels	Recommendations
Within institutions (health-care providers)	• **Train and sensitize health-care providers to enable them to provide care and support** in line with Section III of the current Clinical and Policy Guidelines. • **Educate and train staff on referral pathways and** the integration of IPV and SV into health care, particularly SRH care. Develop directories of services and communication resources such as web pages, posters and brochures with information on referral services.

Strengthening prevention of IPV and SV in the health sector

Table 11: Recommendations for the health sector to strengthen prevention of IPV and SV

Health Service Levels	Recommendations
National Level: Ministry of Health	• **Develop a change management process for implementation of the current National Clinical and Policy Guidelines,** along with a governance framework and engagement with stakeholder agencies within the health sector and across sectors.
Subnational: Regional Health Authorities	• **Involve local communities and civil society organisations in prevention** through participatory education in person and online and by provision of information by health facilities via products such as web pages, posters and leaflets. • **Integrate prevention messaging into patient consultations,** including counselling. • **Build/ strengthen communication tools to target specific audiences,** including youth.
Within Institutions (Health-care providers)	• **Train and sensitize health-care providers using evidence** about factors contributing to IPV and SV, the extent of the problem, and the impacts on health. • **Develop primary, secondary and tertiary prevention services** as outlined above under “The continuum of prevention services” in Section III. • Because of limitations on time spent with patients, **integrate counselling and education about GBV** with routine counselling and health education activities.

Appendix 1:
Recommended clinical record form for documenting cases of IPV and SV in Trinidad and Tobago

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EMOTIONAL STATE

Appearance (no / yes)
- Disarray (clothing, hair, etc.)
- Distracted-restless
- Intoxicated

Mood (no / yes)
- Calm
- Very sad
- Angry
- Anxious

Speech (no / yes)
- Clear
- With difficulty
- Slow
- Crying
- Fast
- Silent

Suicidal attempt (no / yes)

(no / yes)
- Self harming thoughts
- Action taken
- Flash backs of the incident
- Repeated bad thoughts

LAB TEST

Pregnancy (– / + / dk)	Genital swab (no / yes)	Anal swab (no / yes)	Blood group (no / yes)	Rh (– / + / not done)	HIV / STI (– / + / dk)
month day year	month day year	month day year			
Result received month day year	**Result received** month day year	**Result received** month day year	**Result received** month day year	**Result received** month day year	**Result received** month day year
Name laboratory:	**Name laboratory:**	**Name laboratory:**	**Name laboratory:**	**Name laboratory:**	**Name laboratory:**

LEGAL EVIDENCE COLLECTED

Pubic hair (no / yes)	Head hair (no / yes)	Nails (no / yes)	Clothing (no / yes)	Saliva (no / yes)	Semen (no / yes)
Date collected month day year	**Date collected** month day year	**Date collected** month day year	**Date collected** month day year	**Date collected** month day year	**Date collected** month day year
Date sent month day year	**Date sent** month day year	**Date sent** month day year	**Date sent** month day year	**Date sent** month day year	**Date sent** month day year
Laboratory:	**Laboratory:**	**Laboratory:**	**Laboratory:**	**Laboratory:**	**Laboratory:**
Current location of evidence:	**Current location of evidence:**	**Current location of evidence:**	**Current location of evidence:**	**Current location of evidence:**	**Current location of evidence:**

IMMEDIATE CARE

1st line support (no / yes)

(no / yes)
- STI PEP
- HIV PEP → *> 72 hs.*
- Emerg. contraception → *> 120 hs.*

(no / yes)
- Wounds
- Tetanus vac
- Hep B vac
- Other

FURTHER HEALTH CARE NEEDS

Further (no / yes)
- STI
- HIV
- Contraception

(no / yes)
- Wounds
- Hep B vac
- Surgery
- Mental health
- Other

SAFETY ASSESSMENT

(no / yes)
- Safe place to go
- Safety plan developed

POLICE REPORT

- Done
- Decided not to report
- Undecided

Date month day year

Detail:

DEPENDENTS *(One line for each)*

Total number

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

Name: **Age** | Resides w/perpetrator (no / yes) | At risk (no / yes) | **Sex** F / M

REFERRAL TO (no / yes)	CONTACT DETAILS ····→ NAME OF PROFESSIONAL / POSITION / AGENCY	CONSENT TO SHARE INFORMATION (no / yes)
Social services		
Financial support		
Medical social worker		
Mental health care		
Police		
Housing / shelter		
Support group		

Next visit agreed (no / yes) month day year

NOTES:

This color means **WATCH** (does not necessarily indicate risk or inadequate practices)

Section VI: References

Spotlight Initiative
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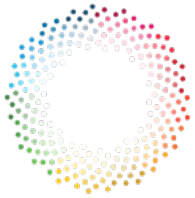

Spotlight Initiative

To eliminate violence against women and girls

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