Documenting cases of violence against women and girls and recording the health sector response

How to strengthen health administrative data on intimate partner violence and sexual violence in the Region of the Americas

Information kit

PAHO
Pan American Health Organization
World Health Organization
Americas Region

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Washington, D.C., 2024

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Documenting cases of violence against women and girls and recording the health sector response: How to strengthen health administrative data on intimate partner violence and sexual violence in the Region of the Americas. Information kit

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Contents

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Abbreviations and acronyms

HIV	human immunodeficiency virus
IPV	intimate partner violence
IPV-SV Form	Health care form for survivors of intimate partner violence and sexual violence
PAHO	Pan American Health Organization
SIP	Perinatal Information System
STI	sexually transmitted infection
SV	sexual violence
VAWG	violence against women and girls
WHO	World Health Organization

Introduction

Violence against women and girls is a major public health challenge in the Region of the Americas. While preventing violence requires a multisectoral response, the health system has a critical role to play (*1*). One of the strengths of the health system response is its access to valuable data to monitor the response to violence, to sensitize others, and to advocate for change.

Comprehensive health administrative data on violence against women and girls is essential for enhancing the adaptation, implementation, and overall effectiveness of responses to violence (*2*, *3*). By generating comparable statistics on incidents of violence, survivor characteristics, quality of care provided, and long-term outcomes, health care systems can effectively monitor key indicators and make informed, evidence-based decisions to improve responses to violence (*4*).

Aligned with the Pan American Health Organization's (PAHO) Strategy and Plan of Action (*1*), this information toolkit is designed to assist health workers, managers, and policymakers in collecting health administrative data on violence against women.

Objectives:

- Support health workers, managers and policymakers in the collection and use of health administrative data on intimate partner and nonpartner sexual violence.
- Provide an overview of available tools and resources related to health administrative data on intimate partner and nonpartner sexual violence, including a regional template of the health care form for survivors of intimate partner violence and sexual violence.
- Summarize key principles and considerations for adaptation and use of these tools to strengthen health administrative data on intimate partner and nonpartner sexual violence.

Structure

In alignment with PAHO and World Health Organization (WHO) guidelines, this information kit includes six information sheets with brief, practical guidance for strengthening health administrative data on violence. The information sheets complement each other, highlighting different types of resources and practical tips and tools, but they can stand on their own as appropriate in each country's context. They begin by highlighting the significance of collecting health administrative data related to intimate partner violence and sexual violence, followed by a brief explanation of guiding principles. A regionally standardized form for health administrative data collection is provided, along with detailed instructions for its adaptation and use across diverse health care settings and among various survivor populations.

Violence against women and girls and health administrative data: what do we know and why is it important?

Violence against women and girls (VAWG) is arguably one of the most pervasive, yet underrecognized, public health challenges around the world and in the Region of the Americas.

The World Health Organization (WHO) estimates that

1 in 3 women and girls

in the Region **have experienced either physical and/or sexual intimate partner violence** or non-partner sexual violence in their lifetime (*5*).

The Region has one of the **highest rates of lifetime nonpartner sexual violence** at

11%

nearly twice that of the global estimate (6%).

Yet due to the barriers to reporting that survivors face, these numbers do not fully capture the magnitude of violence in the Region.

Regional  Global

Violence can take many forms, all of which are equally unacceptable. Intimate partner violence (IPV) – that is, violence at the hands of a former or current partner – is known to be the most widespread form of violence against women.

In the Region, an estimated **7%** of ever-married/partnered women and girls, **aged 15–49 years,** have experienced **physical and/or sexual IPV in the past year**.

25% already have **in their lifetime** (*5, 6*).

VAWG has manifold consequences. Survivors battle anxiety, depression, posttraumatic stress disorder, eating disorders, and suicidal ideation. Survivors of sexual violence are at risk of unintended pregnancy, infertility, sexually transmitted infections (STIs), and human immunodeficiency virus (HIV). VAWG leads to injuries, headaches, pain syndromes, gastrointestinal disorders, and poor general health. Overall, we know that violence not only severely hurts individuals but also devastates families, communities, and future generations (*6*).

Given the impact of VAWG on health, survivors of violence seek health care more often than those who are not experiencing abuse. Their interactions with health services, from emergency and antenatal care to community-based health services, increase with amplifications in the frequency and severity of the violence they are experiencing (*6*).

While preventing violence requires a multisectoral response, the health system has a critical role to play (*1*). One of the strengths of the health system response is its access to valuable data, including data on the magnitude of violence and its health consequences, data on the types of violence experienced by survivors, and information on survivors' access to support. These data are essential to monitor the response to violence, to sensitize others, and to advocate for change. This great deal of valuable information can come from routinely gathered data in surveillance and health information systems, also known as health administrative data. A strong health information system can help to document cases of VAWG and record the health sector response (see Box 1 for recommendations from the Pan American Health Organization [PAHO] on the collection of health administrative data) (*1*).

Consequences of violence

mental health conditions

sexual and reproductive health issues

injuries, pain and other illnesses

Box. 1 Strategic lines of the PAHO Strategy and Plan of Action to strengthen the availability of data on violence against women and reinforce the health system for this purpose

In 2015, the Governing Bodies of PAHO, made up of ministers of health of PAHO Member States in the Americas, adopted a regional Strategy and Plan of Action on Strengthening the Health System to Address Violence against Women – the first region to do so. One year later, the Strategy informed the development of the WHO Global Plan of Action to Strengthen the Role of the Health System within a National Multisectoral Response to Address Interpersonal Violence against Women and Girls, and against Children. Both strategies stress the importance of accurate, consistent, and comprehensive data on VAWG; for example:

- PAHO's Strategic Line of Action 1 calls for strengthening the availability and use of evidence about violence against women. This includes collecting health administrative and population-based data on the nature of violence, its magnitude, survivors' risk and protective factors, and the consequences of VAWG. Data collection and collation are the first steps in preventing and addressing VAWG because all plans, policies, programs, and laws must be grounded in evidence.

- PAHO's Strategic Line of Action 3 calls for strengthening the capacity of health systems to provide effective care and support to women who have experienced intimate partner and/or sexual violence. This can only be achieved by collecting and monitoring health administrative data that capture care and support given to each presenting survivor.

Source: Pan American Health Organization. Violence against women: Strategy and plan of action on strengthening the health system to address violence against women [resolution CD54/9, rev. 2]. 54th Directing Council of PAHO, 67th session of the WHO Regional Committee for the Americas; from September 28 to October 2, 2015. Washington, D.C.: PAHO; 2015. Available from: https://www.paho.org/en/documents/strategy-and-plan-action-strengthening-health-system-address-violence-against-women; World Health Organization. WHO global plan of action to strengthen the role of the health system within national multisectoral response to address interpersonal violence, in particular against women and girls, and against children in general. 69th World Health Assembly; eighth plenary session, May 28, 2016. Geneva: WHO; 2016. Available from: https://www.who.int/publications/i/item/9789241511537#:~:text=It%20offers%20a%20set%20of,and%20against%20children%2C%20in%20particular.

Why is investment in health administrative data important?

Collecting data such as:

- Survivor's demographics (e.g., sex, age)
- Type of violence (i.e., physical, sexual, and/or psychological)
- Perpetrator demographics and relationship to survivor
- Type of health complaint and examination conducted
- Treatment provided, including medications
- Referrals and follow-up support services offered

Can help with:

- Monitoring and improving access to and use of health services specific to VAWG;
- Monitoring the quality of the health sector response to VAWG – for example, if first-line support has been provided;
- Facilitating continuity and coordination of care within and beyond the health system;
- Facilitating access to justice for survivors who wish to file reports within the legal system;
- Tracking the short- and long-term health consequences of VAWG, including of long-term IPV and intergenerational/familial violence;
- Tracking cases of VAWG (i.e., answering the who, where, and how), including their use of services, especially for women and girls that are often marginalized and forgotten;
- Offering critical information to health policymakers to plan service delivery, decide on resource allocation, and identify and address capacity gaps in line with national and local priorities and contexts;
- Contributing to regional and global data on VAWG, which, in turn, serve as a powerful tool for raising awareness and increasing resources for the prevention of and response to VAWG (*2*).

Information sheet 2:

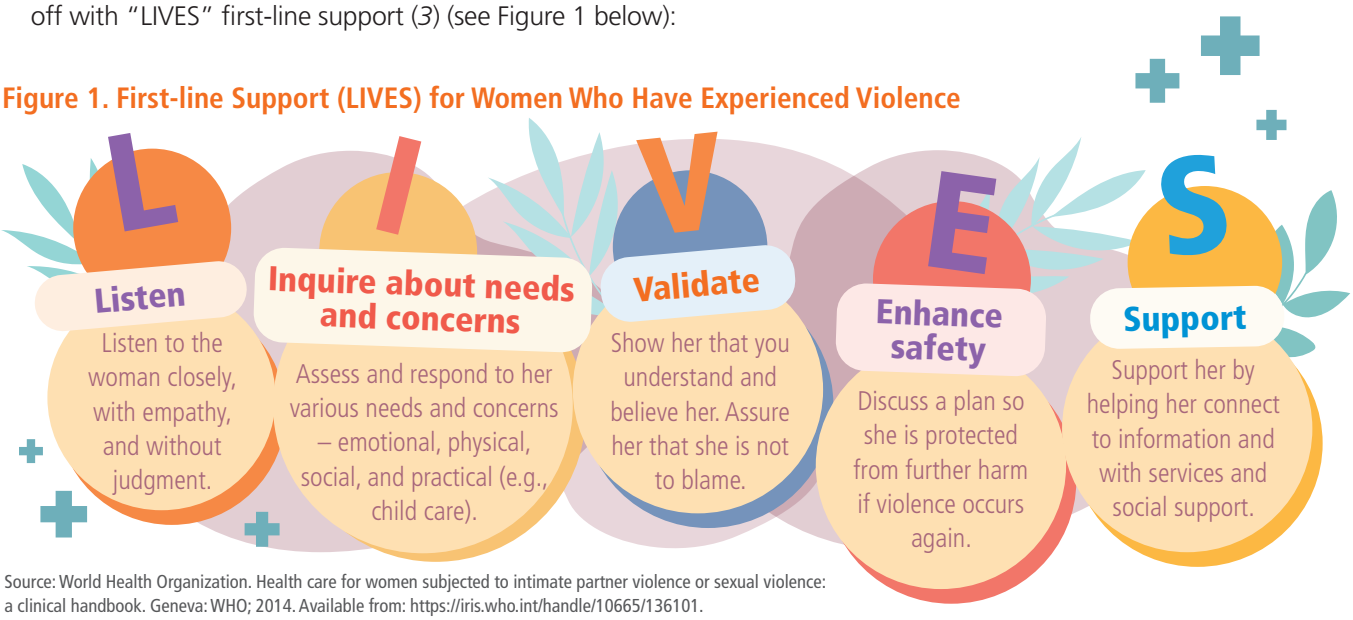
Guiding principles: what to consider when collecting health administrative data on violence against women and girls

A. Survivor-centered care

The interests, needs, and wishes of the survivor must be at the center of the response and any data collection:

- It is negligent to collect data or to provide sexual violence-specific services without addressing the primary health needs of the survivor first.
- A survivor's safety must be the central consideration.
- Health workers not only need to act in the best interest of the survivor, but they must also do no harm (nonmaleficence). For example, they should never re-traumatize the survivor.
- Health care workers can best ensure that they are providing survivor-centered care by starting off with "LIVES" first-line support (*3*) (see Figure 1 below):

Figure 1. First-line Support (LIVES) for Women Who Have Experienced Violence



Source: World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: WHO; 2014. Available from: https://iris.who.int/handle/10665/136101.

B. Respect for and promotion of human rights

Survivors may be in a particularly vulnerable state, so it is paramount to reinforce their rights. To do so, the following principles must be followed (*1*,*3*):

- **Highest attainable level of care:** Even when resources are limited, providers must offer all survivors essential care and support. This includes first-line support, treatment for underlying conditions, and referrals for additional care and services.

- **Nondiscrimination:** Survivors of violence are not all the same; many face multiple forms of discrimination. These same forms of discrimination may also affect their ability to obtain health care – and their experience of health care – because of providers' own beliefs and values about their sex, age, and/or race/ethnicity.

Reminder

Depending upon local and national laws/protocols, there may be limits to confidentiality surrounding violence. For example, in cases where:

- the survivor is a minor
- incest has occurred
- the survivor has a disability or does not have capacity
- a weapon was used.

If limits to confidentiality apply, the survivor must be informed about this **before** they disclose. They must be informed about what information cannot be kept confidential, who needs to be informed, and why this applies.

- **Confidentiality:** Ensuring confidentiality is critical for the safety of survivors. A breach in confidentiality about violence (for instance, sexual violence and IPV and health consequences, such as HIV, STIs, and pregnancy) places survivors at risk of additional violence, and survivors need to know that any information they share will be kept in confidence for them to disclose. This entails designing an information system that allows survivors to exercise autonomy over what information is shared, how, and with whom, and nothing should be shared with outside parties without the survivor's consent – this includes sharing documentation with the authorities or any legal teams.

- **Privacy:** All interventions must promote and prioritize safety and also do no harm. This includes providing every survivor with the privacy they deserve by offering a safe, private, soundproof, and secure location for disclosure, examinations, and treatment, and with regard to the handling and storage of survivors' information. No one should be publicly identified as a survivor, or asked to disclose or answer any personal questions in front of others. Infrastructure should promote safe and private patient flows and consultations, and there should be mechanisms of redress should there be any breaches of privacy (see Box 2).

Box. 2 How to ensure privacy and confidentiality in documenting cases of violence against women and girls

Secure records in practice

- ✓ Staff training on keeping records safe
- ✓ Information about survivors (name and contact information, for example) only visible/accessible to those caring for the survivor
- ✓ No open charts, no charts carried around, and no files left where anyone else can see them
- ✓ No records written in a public place
- ✓ No public notations indicating that the patient is a survivor of violence
- ✓ Use a code (abbreviation, symbol, color) to indicate survivors' charts (do not write "DOMESTIC VIOLENCE SUSPECTED" or "RAPE" on any charts)
- ✓ Any sensitive information that needs to be destroyed is done so by an authorized staff member

Secure records in storage

- ✓ Secure site to store files
- ✓ Documents locked at all times
- ✓ Only a limited number of staff members have access to locked records
- ✓ Staff members with access have received training on confidentiality and safe storage practices
- ✓ Staff members with access have a means to access files that is not available to others (such as a special key or a secret security passcode)

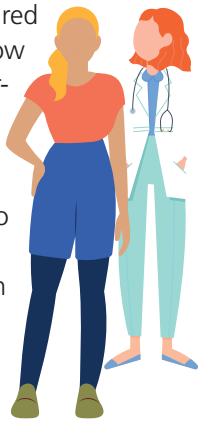
Overall, health systems should institutionalize policy and confidentiality by creating policies that specify:

- Who is responsible for collecting and recording data;
- Where and how that information will be collected and recorded;
- How this information will be stored;
- Who will have access to this information (including in health systems and with parties outside the health sector – i.e., providers in a referral network);
- When and how a survivor's informed consent is gained (which must include information on the limits to confidentiality and when these limits are applicable – e.g., mandatory reporting);
- If survivors are given any medical records to take home and what these medical records include.

Source: World Health Organization. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: WHO; 2017. Available from: https://iris.who.int/handle/10665/259489.

C. Self-determination and autonomy

Survivors' rights to self-determination and autonomy must be respected, including the right to refuse services and/or legal action. Nothing should be documented without a survivor's consent, and the elements required for this will differ based on national law and facility policy. **Informed consent** includes letting survivors know of any legal limits to their confidentiality. It is a continual process, allows time for questions, verifies the survivor's understanding, and explains the how and why of each step of any documentation or treatment (*3*).



Sample questions and statements for informed consent (*3*):

- Do you have any questions about what is going to happen?
- You can stop me at any time – for a question, to pause, or to discontinue.
- Did you understand everything?
- I am going to ask you how you feel about each step of the process.
- You decide everything that is going to happen; I am only here to support you.
- Would you like to share this information with anyone else?
- Would you like a copy to take home?

Information sheet 3:

Health care form for survivors of intimate partner violence and sexual violence: what, how, where, when, and why?

What is the health care form for survivors of intimate partner violence and sexual violence (hereafter "IPV-SV Form")?

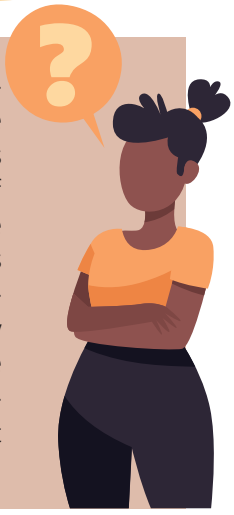
The terms clinical record, patient record, and medical record can be used interchangeably to describe the form for the systematic documentation of a patient's health care. The IPV-SV Form is specifically intended to document the clinical history and care of a patient who is a survivor of intimate partner violence (IPV) or sexual violence (SV). The aim is for the form to serve as a regional template, grounded in standardized definitions and indicators, and include instructions for collecting, aggregating, and reporting data on cases of violence and the health system response to violence.

What is documented in the IPV-SV Form?

The form records information about an experience of IPV or SV, the characteristics and medical history of the survivor, his/her clinical examination and emotional state, laboratory tests performed, legal evidence collected, care received, and referrals to professionals and multisectoral services for further support and care.

What populations can the IPV-SV Form be used with?

This form was designed for the documentation of VAWG, in all its diversity, including women from LGBTQIA+ communities and those who are migrants. Legal provisions and recommendations for care for survivors who are children differ from those who are adults; however, much of the same clinical documentation is relevant to this population. Thus, in the absence of other documentation, health workers and health managers may consider using this form and tailoring its questions (and offered support) so that it is appropriate for younger survivors. Men and boys may also experience IPV, but women and girls are more likely to experience violence, physical abuse, and coercive control at the hands of their partner. While this form focuses on women and girls, it can also support health workers in documenting cases of IPV/SV against other populations.

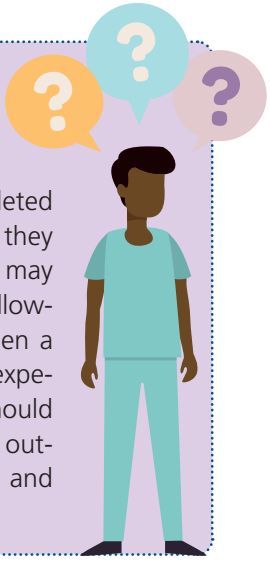


Who can use the IPV-SV Form?

Health workers with the ability to provide comprehensive, skilled, and empathetic care to survivors of IPV/SV. Most often, it would be used by nurses or doctors, but it could also be used by psychologists, social workers, technicians, administrative staff, and managers. Ideally, providers completing these forms should have received training specific to caring for survivors of IPV and SV.

When should the IPV-SV Form be used?

This form should only be completed when a patient has disclosed that they have been subjected to IPV/SV. This may be in an emergency care setting, following an incident of violence, or when a patient discloses that they have experienced violence in the past. It should also be used to follow up with case outcomes, log laboratory test results, and record ongoing care.



Where can the IPV-SV Form be used?

This form should be used in all health clinics and settings where care is provided to survivors of IPV/SV, whether it is the emergency department, perinatal clinic, pediatric clinic, general medicine clinic, etc. All consultations and care should take place in a private, comfortable, and safe place.

How can the IPV-SV Form be used appropriately?

The form must be used with clinical judgment, as not every question, examination, and/or intervention will apply. Medical institutions and health care providers must provide care within their capacity and must be able to guarantee safety and to limit re-traumatization. For example, forensic evidence should not be collected if a laboratory to process the samples is not available in the corresponding jurisdiction. Moreover, the form should only be used if privacy and confidentiality can be ensured.

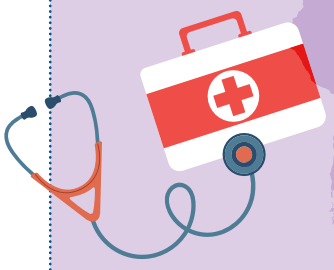
Why use the IPV-SV Form?

The health system plays a crucial role in the response to VAWG. Using this form provides health workers with a guide to offer evidence-based care grounded in human rights. This, together with adequate training, can improve the health and well-being of survivors and can contribute to the prevention of future violence. In addition, the standardized and accurate recording of instances of violence, and the care provided in response, allows for informed and timely decisions to be made, for the quality of care to be evaluated, for key indicators to be monitored, and for evidence-based improvements to be made to policies and protocols. In this way, the IPV-SV Form can facilitate continuous improvement to the care given to survivors.

How can the IPV-SV Form be digitized?

To facilitate its digitization, the IPV-SV Form will be incorporated into the Perinatal Information System (SIP), a set of computer tools to improve the quality of maternal, neonatal, and reproductive health care throughout the Region of the Americas. SIP was developed by the Latin American Center for Perinatology/Women's Health, and Reproductive Health (CLAP/WR) of PAHO/WHO. It has already been used in more than 20 countries in the Region. Other countries that do not use SIP can integrate the IPV-SV Form into their health information system, either by adding a new form or revising an existing form. Regardless of the type of platform, it is essential that the system allows for recording cases and reporting on key indicators, all while maintaining the privacy, confidentiality, and safety of survivors.

How can the IPV-SV Form be implemented at an institutional or national level?



Implementation of the IPV-SV Form should be aligned with strengthening the health system in response to violence. A fundamental component for successful and sustainable adaptation and implementation is obtaining the commitment of health institutional leaders and government authorities. An implementation plan that includes the following is recommended:

- Assessing current capacities of health centers to provide quality care in the area.
- Scoping in line with reality; for example, identifying pilot sites/regions, making an expansion plan, adopting paper-based forms, and exploring asynchronous digitization.
- Training health workers in the use of the IPV-SV Form and in the provision of specific care, in accordance with the national and local policies and protocols.
- Developing a strategy for continuous monitoring of key indicators and a communication plan for disseminating emerging evidence. Appointing and training a dedicated team to do so.
- Creating procedures for identifying the IPV-SV Form's adaptation needs and strategizing how to integrate it within local training plans and institutional policies and protocols.

HEALTH CARE FORM FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE

HEALTH CARE RECORD

Current visit: day | month | year | hour | min

Health Center

Medically stable: no ◯ yes ◯

It is in a safe and private place: no ◯ yes ◯

Informed mandatory reporting: no ◯ yes ◯ n/a ◯

Initial informed consent: no ◯ yes ◯

Informed consent for presence of companion: no ◯ yes ◯ n/a ◯

Language adaptation: no ◯ yes ◯ n/a ◯

Examination language: _____

Interpreter name: _____

In person ◯ Telephone ◯ Videoconference ◯

First contact

Is this it? no ◯ yes ◯

Date: day | month | year

Services IPV/SV: no ◯ yes ◯

Reference *(who referred you)*

Self-reference ◯ Other Health inst. ◯

Family ◯ Support Gropu ◯

Police ◯ Other ◯

Prosecution ◯

Spec.: _____

Lead professional examiner

f ◯ m ◯

Role: _____

Not trained in IPV/SV ◯

Name: _____

Supporting professional

f ◯ m ◯

Role: _____

Not trained in IPV/SV ◯

Name: _____

Function

Assistant ◯

Supervisor ◯

Chaperone ◯

IDENTIFICATION

Identification Informed Consent: no ◯ yes ◯

Identifier

Country

Document Type

No Doc/ didn't show ◯ Other ID

Names: _____ Surnames: _____

Home Address: _____ Safe to contact: no ◯ yes ◯

Telephones: _____ Safe to contact: no ◯ yes ◯

District/Province: _____ Urban ◯ Rural ◯

Email: _____ Safe to contact: no ◯ yes ◯

Date of birth: day | month | year

Age

Able to legally consent to sex: no ◯ yes ◯

Sex

Femail ◯

Male ◯

Inter-sex ◯

Gender

Woman ◯

Man ◯

Non binary ◯

Doesn't say ◯

Other ◯

Spec.: _____

Ethnic Group

Indigenous ◯ Afro-indigenous ◯

White ◯ Indian ◯

Black ◯ Asiatic ◯

Mestizo ◯ Other ◯

Spec.: _____

Religion

Christian ◯ Traditional indigenous ◯

Muslim ◯ Atheist ◯

Buddhist ◯ Agnostic ◯

Hindu ◯ Prefers not to say ◯

Afro-american religion ◯ Other ◯

Literate

no ◯

yes ◯

Education

None ◯ Complete ◯ Years completed

Elementary ◯ Incomplete

Secondary ◯

University ◯

Employment status: _____

Emergency contact

Telephone: _____

Full name: _____ Relationship: _____

Accompanied by

F ◯ M ◯

Telephones: _____

Full name: _____ Relationship: _____

Partner

Married ◯ Separated/ divorced ◯ Never cohabited ◯

Stable union ◯ Single ◯ Other ◯

Lives alone: no ◯ yes ◯

MEDICAL HISTORY

Medical History informed consent: no ◯ yes ◯

Personal

	no	yes
Disability	◯	◯
Surgeries	◯	◯
Allergies	◯	◯
Other	◯	◯
Prescribed medications	◯	◯
Chronic diseases	◯	◯
Mental Health problems	◯	◯
Exposure to family violence	◯	◯

Specify: _____ Chron. Diseases: _____

Family medical history

	no	yes
Diabetes	◯	◯
Obesity	◯	◯
Cancer	◯	◯
Cardiovascular	◯	◯
Sudden death	◯	◯
Mental health problems	◯	◯
Substance abuse	◯	◯
Other	◯	◯

Specify: _____

Vaccines

dT: no ◯ yes ◯ day | month | year

Hep B: no ◯ yes ◯

HPV: ◯ ◯

INCIDENT OF VIOLENCE

Incident of violence informed consent: no ◯ yes ◯

Incident description: _____

WHAT

Type of Aggression

	no	yes
Physical	◯	◯
Sexual	◯	◯
Psychological	◯	◯

WHERE

Incident location: Home ◯ Other ◯

Spec.: _____

WHO

Number of perpetrators: M ___ F ___

Who was the perpetrator?

	no	yes
Partner	◯	◯
Family member	◯	◯
Other Known	◯	◯
Unknown	◯	◯
Lives with the perpetrator	◯	◯

WHEN

Current incident date: day | month | year | hour | min

> 72 hs ◯ > 5 days ◯

Reasons for delay in care

	no	yes
Restricted by perpetrator	◯	◯
Affordability	◯	◯
Physical or geographic impediment	◯	◯
Health problems	◯	◯
Lack of information	◯	◯
Lack of support structure	◯	◯
Other	◯	◯

Spec.: _____

Witnesses

no ◯ yes ◯

Assistance after incident

Known ◯ Unknown ◯

Police ◯ Not applicable ◯

HOW

	Perpetrator	Patient
Drugs	◯	◯
Alcohol	◯	◯
Unknown	◯	◯
None	◯	◯

Survivor condition: Conscious ◯ Inconscious ◯

PHYSICAL AND/OR SEXUAL *(if applicable)*

Act of physical aggression

	no	yes
Hitting	◯	◯
Biting	◯	◯
Hair pulling	◯	◯
Strangulation	◯	◯
Cuts	◯	◯
Burns	◯	◯
Other	◯	◯

Spec.: _____

HOW

	no	yes
Neglect	◯	◯
Force	◯	◯
Knife	◯	◯
Firearm	◯	◯
Restraints	◯	◯
Other	◯	◯

Spec.: _____

SEXUAL ASSAULT *(if applicable)*

Type of sexual assault

Penetration	Vagina	Anus	Mouth	None	Unknown
Penis	◯	◯	◯	◯	◯
w/ejaculation	◯	◯	◯	◯	◯
Finger	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯
Unknown	◯	◯	◯	◯	◯

POST ASSAULT

	no	yes
Vomited	◯	◯
Brushed teeth	◯	◯
Urinated	◯	◯
Defecated	◯	◯
Ate/drank	◯	◯
Changed clothes	◯	◯
Bathed	◯	◯
Sanitary product	◯	◯
Emergency Contraception	◯	◯

PREVIOUS INCIDENTS no ◯ yes ◯

Types of aggression

	no	yes
Physical	◯	◯
Sexual	◯	◯
Psychological	◯	◯

Date of most recent incident: day | month | year

Perpetrator(s) ___

Same aggressor ◯

Restraining order ◯

Consequences

	no	yes
Injuries	◯	◯
HIV	◯	◯
Pregnancy	◯	◯
STI	◯	◯
Other	◯	◯

Spec.: _____

Access to care? no ◯ yes ◯ n/a ◯

Description of previous incidents:

_____

_____

_____

_____

_____

_____

_____

EMOTIONAL STATE

Appearance

	no	yes
Disheveled	◯	◯
Distracted	◯	◯
Restless	◯	◯
Intoxicated	◯	◯

Speech

	no	yes
Clearly	◯	◯
Slow	◯	◯
Silent	◯	◯
w/difficulty	◯	◯
Fast	◯	◯

Demeanor

	no	yes
Calm	◯	◯
Angry	◯	◯
Apathetic	◯	◯
Neglected	◯	◯
Apprehensive	◯	◯
Anxious	◯	◯

Suicidality and self-harm

	no	yes
Lack of sleep	◯	◯
Halluciations or nightmares	◯	◯
Feelings of hopelessness or worthlessness	◯	◯

	None	Thoughts	Plans	Actions
Suicide	◯	◯	◯	◯
Self-harm	◯	◯	◯	◯

PHYSICAL EXAM *(If applicable)*

Supporting professional present no yes | Informed consent for Physical Examination and care no yes

General state

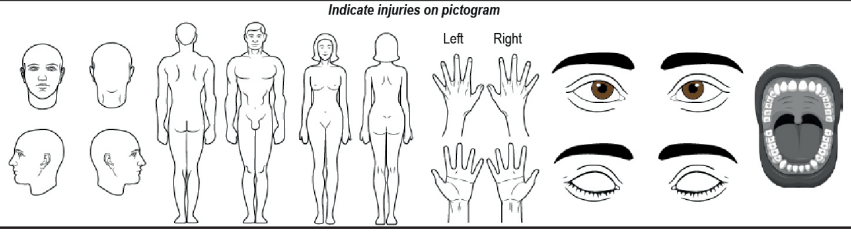
Weight (kg) | Height (cm) | Heart rate | Resp. rate

Blood pressure | Temperature °C | Pain no yes

Types of Injury no yes

Hemorrhage
Bruises
Erythema/Edema
From foreign object

Indicate injuries on pictogram



Description of injuries:

SEXUAL/OBSTETRIC/GYNECOLOGICAL HISTORY *(If applicable)*

Pregnant no yes n/k
Unintended no yes n/k
Menstruating no yes
Last Menstruation day month year

Menarche (age)
Menopause (age)
Sex.debut (age) Involunt.

Gravidity
Delivery
Live births

Abortion
Cesarean Sections
Living

End of latest pregnancy day month year

Contraceptive use

no yes n/a *(trying to conceive)*

Injections Condom
Pills IUD
Implant None
Tubal ligation

Interfered by your partner? no yes

Have you had any STI? no yes n/k

	Diagnostic		Diagnostic
HIV	day month year	Chlamydia	day month year
Syphilis	day month year	HPV	day month year
Gonorrhea	day month year	Herpes	day month year

Previous STI treatment no yes

GENITAL EXAM *(If applicable)*

Supporting professional present no yes | Informed consent for genital exam no yes

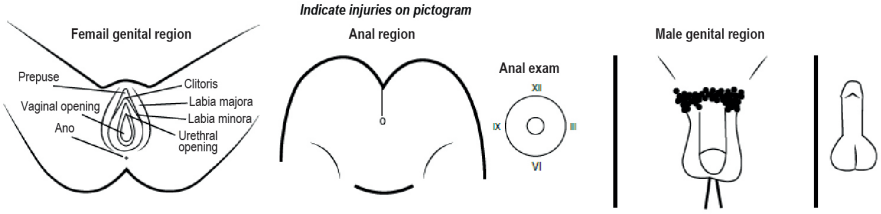
Genital injuries no yes

Vulva/Scrotum
Cervix
Vagina/Penis
Introitus/hymen
External anal area

Types of injury no yes

Hemorrhage
Bruises
Erythema/edema
Cuts
From foreighn object

Indicate injuries on pictogram



Description of injuries:

CARE PROVIDED

Immediate Care

no yes
LIVES

Prophylaxis provided

no yes
EC >120 hs
HIV >72 hs
Syphilis
Gonorrhea
Chlamydia

Additional care

no yes n/a
Wound treatment
Other

Specify

Laboratory Tests / Results

	no	yes	-	+	n/k		no	yes	-	+	n/k
Pregnancy						HIV					
Syphilis						Other STI					

Specify

Free to patient? no yes

POLICE REPORT

Reporting is not mandatory unless required by local law

Is it mandatory? no yes

Report filed Undecided Decided not to report

day month year

SAFETY ASSESSMENT

no yes
Was a safety assessment performed?
Is there an immediate risk?
Was a security plan created?

Dependents

Name	Age	Sex	Lives with perpetrator	Risk of violence
		F M IS	no yes	no yes
		F M IS	no yes	no yes
		F M IS	no yes	no yes
		F M IS	no yes	no yes

REFERRAL TO

	no	yes	CONTACT DETAILS Name of professional / Role / Agency	Consent to share information
Mental Health				no yes
Social Assistance				no yes
Support Group				no yes
Other Health Services				no yes
Specific Support Service				no yes
Shelter or Refuge Center				no yes
Police Authorities				no yes
Special Unit for Gender-based Violence Crimes				no yes
Financial Support System				no yes

LEGAL EVIDENCE COLLECTED

	no	yes	Date of Exam	Sent to lab	Lab / Authorities
Clothes			day month year	day month year	
Saliva			day month year	day month year	
Hair			day month year	day month year	
Nails			day month year	day month year	
Pubic hair			day month year	day month year	
Genital Swab Vaginal / perivaginal / cervical / Penis			day month year	day month year	
Anal Swab Anal/Perianal			day month year	day month year	

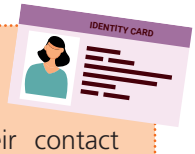
Information sheet 4:

Quick guide to using the IPV-SV Form: how health workers can use it properly

HEALTH CARE FORM FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE

- Before starting any examination or care, you should ensure the following:
  - That the survivor is **medically stable** and has no life- or limb-threatening injuries that require immediate treatment.
    - The survivor should be conscious, able to provide informed consent, and not under the influence of substances.
      - ✓ This may mean that the survivor receives other emergency treatment first or that the examination is delayed. In such cases, speak to your colleagues to ensure that they consider working in a way to preserve evidence, so that the survivor can still opt for forensic evidence collection, if they wish.
  - With a survivor who is medically stable, conscious, and not under the influence of drugs or alcohol, you should first obtain **informed consent** (this usually will require a signature or thumbprint, depending on your locality and on the survivor's abilities – ensure accommodations as necessary).
    - Informed consent is an ongoing conversation about what the survivor can expect, including what steps will be taken and why they will be helpful in their care. Survivors can ask questions throughout the process and can refuse any step of documentation, examination, and/or treatment.
    - You will notice that the IPV-SV Form asks for informed consent several times: this is because informed consent is an ongoing process and must be confirmed before each step of documentation, examination, and treatment.
  - Evaluate whether the survivor feels comfortable and safe with the person accompanying them. Make sure that this person is not the perpetrator.
    - You may need to distract the companion or make up an excuse to speak with the survivor alone to assess this.
  - Make sure everything is done in a **safe**, **private**, **and comfortable space** where nothing shared can be overheard.
  - Provide any required and requested accommodations, such as translation services or giving verbal instructions.
- Remember **LIVES** throughout the entire process: **L**isten actively and carefully, **I**nquire about their needs, **V**alidate their experience – violence is never the survivor's fault and is never justified, **E**nhance their safety, including the safety of their children, and provide follow-up care and **S**upport.

IDENTIFICATION



- If the survivor shares their contact information, make sure it is safe to contact them at that address and/or phone number.

MEDICAL HISTORY

- Remember that the questions you ask should guide the clinical care you provide to the survivor. Limit yourself to asking questions that are clinically relevant to their current care and their follow-up. The survivor may choose to share more information with you – active listening is a way to show that you care.
- Be sure to assess whether the survivor is allergic to any medications, so that emergency contraception and/or prophylaxis can be safely provided.
- Assess whether they have baseline conditions that would affect laboratory test results/examination.
- It is important to know their family medical history to understand what the survivor might be at risk of/exposed to.

INCIDENT OF VIOLENCE

- This will probably be the most sensitive part of the examination, so make sure to give the survivor enough time and remember to provide emotional support. **LIVES!**
- The survivor is not required to answer any questions that she or he is not comfortable with.
- Ask only questions that are necessary to guide clinical treatment. Avoid probing for details that would not guide care, to minimize the risk of re-traumatization. While documentation can be used to support legal cases, remember, this is a clinical exam – not a legal exam.
- Ask the questions in the section on physical and sexual assault depending on what happened (and do not ask inapplicable questions).
- It is important to know what the survivor has done since the incident, as this can influence the quality of the forensic evidence collected.

PREVIOUS INCIDENTS

- This section is relevant both for survivors seeking emergency care and those who disclose a history of violence.
- It is critical to document known consequences of previous incidents of violence, to determine whether survivors received tailored care after those incidents, and to ask whether they wish to receive care at this time (especially if the incident was in the past).

EMOTIONAL STATE

- Some of these are observations that you can make without having to ask the survivor (e.g., on appearance).
- Assessing their risk of suicide is crucial to ensure the safety of survivors and to develop an appropriate protection plan.
  - Asking them about thoughts of suicide and/or self-harm will not encourage them to act but will help identify their risk, so as to provide the necessary support.

PHYSICAL EXAMINATION (*if applicable*)

- Protocol compliance: Depending on your jurisdiction, you may be required to have a professional chaperone for the examination.
- Examination focus: The examination should be guided by the survivor's description of the incident.
- Injury documentation: Mark the location of any injuries, including chronic ones, on the pictogram and then describe them in the text box.

OBSTETRIC / GYNECOLOGICAL HISTORY (*if applicable*)

- Assesses whether the survivor is pregnant, wanting to become pregnant, and if they are able to use contraception consistently.

GENITAL EXAMINATION (*if applicable*)

- Perform this examination with the assistance or chaperoning of another professional, if required.
- The examination should be guided by the description of the incident provided by the survivor.
- **In no case should a hymen examination be performed to determine a survivor's virginity, only to observe and document injury.**

CARE PROVIDED

- Provide the necessary care based on the examination, medical history, and details of the incident. Make sure the survivor gives informed consent for each intervention you offer.

POLICE REPORT

- Reporting to the police may be mandatory in some contexts, hence it is crucial to provide the survivor with detailed information about their options and available resources.

SAFETY ASSESSMENT

- Use the information obtained during the interview to identify potential risk situations. Work in collaboration with the survivor to develop strategies to protect their physical and psychological safety and well-being.

DEPENDENTS

- Learn from the survivor about their dependents to assess whether they are at risk of violence.
- Take steps to protect these individuals as well. This may include referral to health services, social support and other protection services, as appropriate.

REFERRALS

- List follow-up services and support that the survivor needs and detail which ones have been offered.
- Do not forget informed consent for any information sharing and/or onward referrals.

Information sheet 5:

How to adapt the IPV-SV Form to your country and context

The form presents a regional template that can be adapted to the context of each country. The regional format represents a starting point that aligns with regional indicators for a robust health system response, in line with PAHO's strategy and plan of action (*1*).

It is recommended key actors in the health sector be involved in the adaptation process, including:

Representatives of the Ministry of Health working on violence and other related health programs (such as sexual and reproductive health, mental health, HIV and STI prevention, etc.);

Representatives of health authorities working on administrative health data;

Representatives of the health system, including health workers and managers, as well as civil society organizations working in the health sector.

The adaptation process should include a review of national laws and policies, including the country's clinical protocol, to align the form with current regulations.

It should also ensure that the IPV-SV Form collects data in a manner consistent with current national measurements and indicators, to facilitate the obtaining of comparable statistics over time.

In terms of cultural relevance, it is important to recognize that survivors of violence are very diverse and to consider all the intersections of their identities, adapting the questions/aspects of this form to the needs and preferences of each population group in the country.

It is suggested that the analysis process include the creation or revision of the training program for health personnel in the use of the IPV-SV Form and care centered on the survivor of IPV-SV, since the success of the adaptation will depend on the correct adoption by the health personnel. In this regard, it is recommended to keep staff informed about best practices and updates, to ensure effective adaptation.

Finally, as part of the process, it is vital to consider the technological resources available in the localities where the form is to be implemented and establish the most appropriate system.

Paper form or digital form on local devices: in areas with limited access to technology or the Internet.

- **Asynchronous digitization:** Develop a procedure to digitize the information collected on paper, in a place where there is Internet. This may include hiring administrative staff, using scanners, and secure storage systems.
- **Manual replication:** If the application allows it, develop a procedure for frequent backups of the database on the local device and integration to the national database.

Digital form: in areas with reliable Internet access.

- **Mobile connection:** Use devices with Internet connection capability over cellular networks if the fixed connection is limited.
- **Data synchronization:** Ensure that information is synchronized securely and in real time with central data storage systems.

Suggested list of questions to identify how to adapt the IPV-SV Form

Legislation and protocols

- What are the current national laws and international protocols related to the care of survivors of IPV/SV?
- Under what conditions is reporting IPV/SV to the authorities mandatory in your country?
- Are there specific requirements for informed consent documentation (existing form, signature requirement, etc.)?
- Is the presence of two health professionals mandatory during the physical examination?
- Is the presence of two health professionals mandatory during the genital examination?
- Is it required or suggested that the health personnel who perform the examination be of a certain sex or gender?
- Are other conditions necessary for the performance of the physical and genital examination made explicit?
- Is the form (including examination and treatment options) in line with the national protocol?
- Is there already a form for legal evidence documentation for these cases?

Cultural and local context

- Taking into account the indicators you want to evaluate and the population in question, are the lists of options for ethnicity, religion, language, etc. suitable?
- Is the terminology used in the quick guide and form suitable for health workers and the local population?
- Would you include specific components that address the particularities of IPV and SV in the local context?
- Do you think that the way of asking the questions about the patient's emotional state is appropriate?
- Review the list of reasons for delayed care. Do you need to add any other options for your region?

Clinical aspects

- Is the list of medical history records suitable for your country?
- Do you think that any other conditions related to IPV/SV should be added?

Care

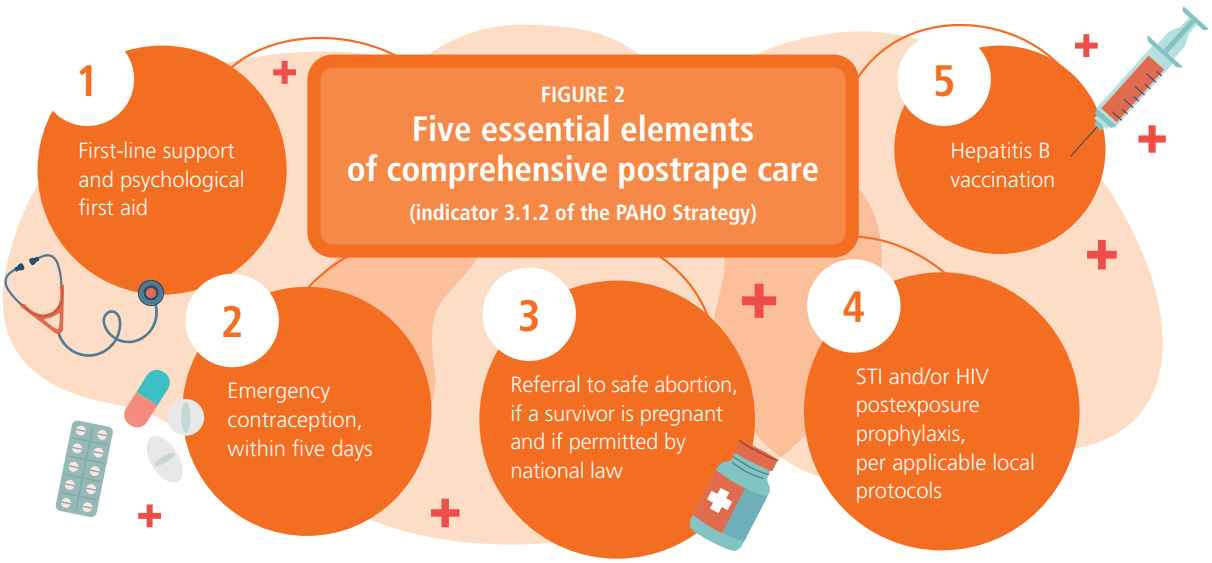
- Please review the CARE section carefully. Is there the capacity to provide all the care?
- Do medical institutions have a private and safe space for the care of cases of violence?
- Is there a national health care training plan in response to IPV and SV?
- Is it free? Is it mandatory for all health personnel?
- Are there human resources with specific training in care in response to IPV and SV in all institutions?
- Is emergency contraception available?
- Is prophylaxis for HIV and other STIs available?
- Is there laboratory capacity for conducting examinations? Is there laboratory capacity for the treatment of legal evidence?
- Is there a protocol and are there the means to transport legal evidence to the laboratories, maintaining the chain of custody and properly preserving the samples?

Other

- Is the list of consultation and referral options appropriate for your region?

Toward an enabling environment: how to use the data to strengthen quality of care

Strong health information systems that collect data on VAWG are essential to monitor the quality of the response to violence so as to then build upon and improve such a response. In line with national health policies and protocols, health policymakers and health managers can design and monitor selected indicators that indicate a strong health system response to violence (*1*, *2*, *4*).



Source: Pan American Health Organization. Violence against women: Strategy and plan of action on strengthening the health system to address violence against women [resolution CD54/9, rev. 2]. 54th Directing Council of PAHO, 67th session of the WHO Regional Committee for the Americas; from September 28 to October 2, 2015. Washington, D.C.: PAHO; 2015. Available from: https://www.paho.org/en/documents/strategy-and-plan-action-strengthening-health-system-address-violence-against-women; World Health Organization. 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 in general. 69th World Health Assembly; eighth plenary session, May 28, 2016. Geneva: WHO; 2016. Available from: https://www.who.int/publications/i/item/9789241511537#:~:text=It%20offers%20a%20set%20of,and%20against%20children%2C%20in%20particular.

Using PAHO's definition of comprehensive postrape care (*1*) (see Figure 2) as an example, tracer indicators to assess progress on postrape care may include:

1 Number of patients with record reporting SV as compared to number of patients with record of having received first-line support.

Justification: First-line support, "LIVES," is the minimum level of care, decreed by WHO, that should be provided to all survivors of SV. It can still be offered in the absence of other resources.

2 Number of patients with record reporting SV as compared to number of patients with record of having received emergency contraception within five days of assault.

Justification: Becoming pregnant due to SV is one of the main concerns of survivors and carries life-altering consequences for the survivor, their family, and any future children. Survivors have the right to have children, when and under the conditions of their choosing. This includes the right to prevent pregnancy.

3 Number of patients with record reporting SV as compared to number of patients who received a referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law.

Justification: Becoming pregnant due to SV is one of the main concerns of survivors and carries life-altering consequences for the survivor, their family, and any future children. Comprehensive postrape services include referral to safe abortion if a woman is pregnant as a result of rape where such services are permitted by national law.

4 Number of patients with record reporting SV as compared to number of patients who received STI and/or HIV postexposure prophylaxis.

Justification: Survivors of SV are at risk of contracting life-altering STIs and/or HIV. This can be prevented with postexposure prophylaxis for those who are at risk.

5 Number of patients with record reporting SV as compared to number of patients who received a hepatitis B vaccination.

Justification: Survivors of SV are at risk of contracting life-altering hepatitis B. This can be prevented with a postexposure vaccination for those who are at risk.

This kind of data comparing the number of cases recorded in the health system with those receiving essential postrape care can help health policymakers and managers in identifying gaps in the rollout of national guidance, help to target training efforts to those topics or facilities most in need, and identify priority areas for intervention (*2*, *4*).

Depending on your national and local health systems, you might add additional quality indicators aligned with your priorities. Some examples of additional quality indicators (that, similarly, can be extracted from the recommended health administrative record) may include:

1 Number of patients with record reporting SV as compared to number of patients who received onward referral to services outside of the health sector (such as housing/shelter, financial, etc.).

Justification: The response to VAWG requires multisectoral collaboration, and survivors will have ongoing needs outside of those that the health sector can address.

2 Number of patients with record reporting SV as compared to number of patients for whom the examining provider has received training specific to IPV/SV.

Justification: An appropriate response to VAWG will require that front-line providers receive training specific to IPV/SV so that they can provide the highest standard of care, which is appropriate, compassionate, and comprehensive.

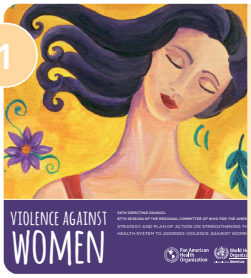
3 Number of patients with record reporting SV as compared to number of patients who receive onward referral to mental health services.

Justification: Survivors of IPV/SV face manifold consequences to their mental health and well-being, including suicidality, self-harm, anxiety, depression, and posttraumatic stress disorder. Survivors will require follow-up psychological support beyond that given in an emergency/acute setting.

Overall, adopting this health administrative record, or borrowing its essential elements to adapt your own health administrative record, can ensure that survivors of IPV/SV are provided with comprehensive and compassionate care; can support health workers as they provide quality care for survivors; can give health managers and policymakers the tools to create and monitor a holistic response to VAWG; and can ensure that health systems have the appropriate information necessary for evidence-based and data-driven policy and programming.

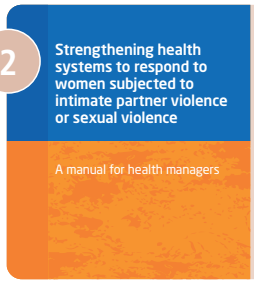
Resources

This information kit draws on the following existing PAHO/WHO resources and recommendations on health administrative data.



1. Pan American Health Organization. Violence against women: Strategy and Plan of Action on Strengthening the Health System to Address Violence Against Women. Washington, D.C.: PAHO; 2015.

   Available from: https://www.paho.org/en/documents/strategy-and-plan-action-strengthening-health-system-address-violence-against-women.



2. World Health Organization. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. Geneva: WHO; 2017.

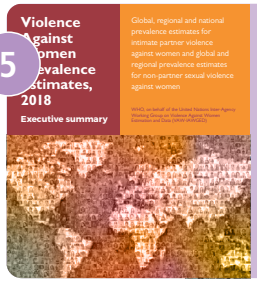
   Available from: https://iris.who.int/handle/10665/259489.

3. World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: WHO; 2014.

   Available from: https://iris.who.int/handle/10665/136101.

4. United Nations Entity for Gender Equality and the Empowerment of Women, World Health Organization. Improving the collection and use of administrative data on violence against women: global technical guidance. New York: UN Women and WHO; 2022.

   Available from: https://www.unwomen.org/en/digital-library/publications/2022/05/global-technical-guidance-for-collection-and-use-of-administrative-data-on-violence-against-women.



5. World Health Organization. Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Executive summary. Geneva: WHO; 2021.

   Available from: https://iris.who.int/handle/10665/341338.

6. World Health Organization. Caring for women subjected to violence: a WHO curriculum for training health care providers. Geneva: WHO; 2019.

   Available from: https://iris.who.int/handle/10665/330084.

Good health administrative data facilitate the adoption, adaptation, and improvement of the response to violence against women and girls. Generating comparable statistics on cases of violence and the quality of health care offered allows health professionals and those responsible for health management and policy-making to monitor key indicators and make decisions based on scientific evidence.

This toolkit includes information sheets that introduce and explain the importance of collecting health administrative data for cases of intimate partner violence and sexual violence and proposes a form for collecting these data and instructions for their correct use. It aligns with existing Pan American Health Organization/World Health Organization recommendations and tools and provides practical guidance to health sector staff in the implementation of this guidance and the strengthening of health administrative data.

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Pan American Health Organization
World Health Organization
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