## Appendix A : Protocol for First Interview

***Researcher:*** _____ ***Patient Code:*** _____ _

**REPORT ON DOMESTIC VIOLENCE EXAMINATION**

**PATIENT INFORMATION:**

Name: _____ Age: _____

Current Residential Address:

_____

_____

Tel No: (h): _____ (w): _____ (cell): _____

Safe to phone? _____

Date of Examination: / / Time of Examination: h

Marital Status: Married in COP ☐ / Married with ANC ☐ / Traditional ☐ Divorced ☐ / Same-sex partner ☐ / Single ☐ / Co-habiting ☐

Children number total: _____ Own: ☐ Step: ☐

Ages and gender of children: Girls: 0-5yrs ☐ / 6-10yrs ☐ / 11-15yrs ☐ / 16-20yrs ☐ / 20yrs ☐

Boys: 0-5yrs ☐ / 6-10yrs ☐ / 11-15yrs ☐ / 16-20yrs ☐ / 20yrs ☐

Whereabouts: House ☐ / Sub-district ☐ / W.Cape ☐ / Out of W.Cape ☐

Patient Accompanied by: relative ☐ / friend ☐ / other _____
Did perpetrator accompany? _____

# ADDITIONAL INFORMATION

Has a criminal charge been laid? ☐ Yes ☐ No

If yes, what charge was laid? Assault ☐ / grievous bodily harm ☐ / rape ☐ / indecent assault ☐ / Contravention of protection order ☐

Name of SAPS station: _____ CAS No: _____

If no, does the patient intend laying a charge?

☐ Yes

☐ No

☐ Unsure

Does patient have a Protection Order? Yes ☐ / No ☐

Name of magistrate court:_____

If no, intends to apply for protection order; Yes ☐ / No ☐ / Unsure

## 1. HISTORY OF MOST RECENT ASSAULT

Location of incident: _____

Date of incident: _____

Time of incident: _____

Relationship of assailant: partner ☐ / ex- partner ☐

_____

Nature of the abuse

| PHYSICAL | | EMOTIONAL | SEXUAL | FINANCIAL | |
|---|---|---|---|---|---|
| Hitting | ☐ | Name Calling | ☐ Unwanted Touching | ☐ Withholding Money | |
| Kicking | ☐ | Yelling/Shouting | ☐ Infidelity | ☐ Taking Money | |
| Use of a weapon | ☐ | Restricting contact with Family / Friends | ☐ STI's | ☐ Controlling All Decisions | ☐ |
| Pushing | ☐ | Threats | ☐ Forced Intercourse | ☐ Other _____ | |
| Choking | ☐ | Controlling her activities | ☐ Other _____ | | |
| Burns | ☐ | Other _____ | | | |

Other

_____

Patient's description of most recent assault (Use exact words as far as possible. Describe severity of assault.)

_____

_____

_____

_____

_____

_____

**2. Other episodes of assault:**

Describe frequency & severity of past abuse, using direct quotes from the patient. Describe mechanism, location and extent of injury and/ or symptoms/conditions.

Frequency over last 2 years: 0-10 ☐ / 11-20 ☐ / >20 ☐

Patient's description - qualitative

How has your previous experience of care been at this health centre?

_____

_____

_____

_____

_____

**3. Emotional Status:**

## Mental Problems Checklist

The questions can be used to test the hypothesis of "mental problems?" The questions were developed in the context of Khayelitsha a Xhosa speaking township.

**1.** Are you thinking too much ?……. ☐
**2.** How are you sleeping at the moment?…… ☐
**3.** Do you feel exhausted or tired even when you are not working hard? ……. ☐
**4.** Do you feel sad or like crying for no reason ?…… ☐
**5.** As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? I.e. listening to music or going out with friends…….. ☐
**6.** Do you sometimes have the feeling as though you are going to hear bad news?…. ☐
**7.** a) Have you ever felt you should cut down on your drinking?……. ☐
b) Have people annoyed you by criticizing your drinking? …….. ☐
c) Have you ever felt bad or guilty about your drinking?…… ☐
d) Have you ever had an eye-opener first thing in the morning to steady your Nerves or to get rid of a hangover?…… ☐

**8.** Have you experienced traumatic events that made you feel extremely threatened or Endangered? Or witnessed someone else in this situation?…….. ☐

If positive to **any one** further assessment may be required – see Mental Problems Flowchart.

If positive to **2, 3, 4, 5** then consider **depression.**
If positive to **1, 2, 6** consider **anxiety disorders.**
If positive to **7** consider **alcohol use disorders.**
If positive to **8** consider **post traumatic stress disorder.**

## Mental Problems Checklist

These questions can be used to test the hypothesis of "mental problems?" The questions are taken directly from the ICD-10 Classification.

**1.** Low mood or sadness?…….. ☐
**2.** Loss of interest or pleasure?……. ☐
**3.** Decreased enery and / or increased fatigue?……. ☐
**4.** Have you had any problems with sleep?……. ☐
**5.** Feeling tense or anxious?…….. ☐
**6.** Worrying a lot about things?…….. ☐
**7.** a) No. of standard drinks in a typical day when drinking?…… ☐

b) No. of days / wk having alcoholic drinks?…….. ☐

**8.** Have you experienced traumatic events that made you feel extremely threatened or Endangered? Or witnessed someone else in this situation?……☐

If positive to **any one** of these questions further assessment may be required – see Mental Problems Flowchart

Positive to **1, 2, 3** or **4** consider **depression**
Positive to **5** or **6** consider **anxiety depression**
If **7** is 21/wk or more for men or 14/wk or more for women consider **alcohol use disorders**

In the last year have you used any of the following substances?

1. Dagga
2. Mandrax
3. Tic
4. Tobacco / cigarettes / pipe
5. Cocaine / crack
6. Heroine
7. Benzene or solvents
8. Sniffed Glue
9. Ecstasy

| | | | | |
|---|---|---|---|---|
| Depression requiring further assessment? | Yes | | No | |
| PTSD requiring further assessment? | Yes | | No | |
| Anxiety disorder requiring further assessment? | Yes | | No | |
| Alcohol/subs use disorder requiring further assessment? | Yes | | No | |

**4. Medical Information:**

| | | | | |
|---|---|---|---|---|
| Pregnant? | | Yes | | No |
| Normal menses in last month: | | Yes | | No |

Other medical symptoms coded as per ICPC:

_____

STI SYNDROMES:

Vaginal Discharge Syndrome ☐
Genital Ulcer Syndrome ☐
Lower Abdominal Pain ☐

Moluscum Contagiosum ☐

Genital Warts ☐

Pubic Lice ☐

Herpes Simplex Virus ☐

**5. Examination:**

General Appearance:

_____

Height: _____ Weight: _____ Body Build: _____

Description of Injuries: _____

_____

_____

_____

_____

_____

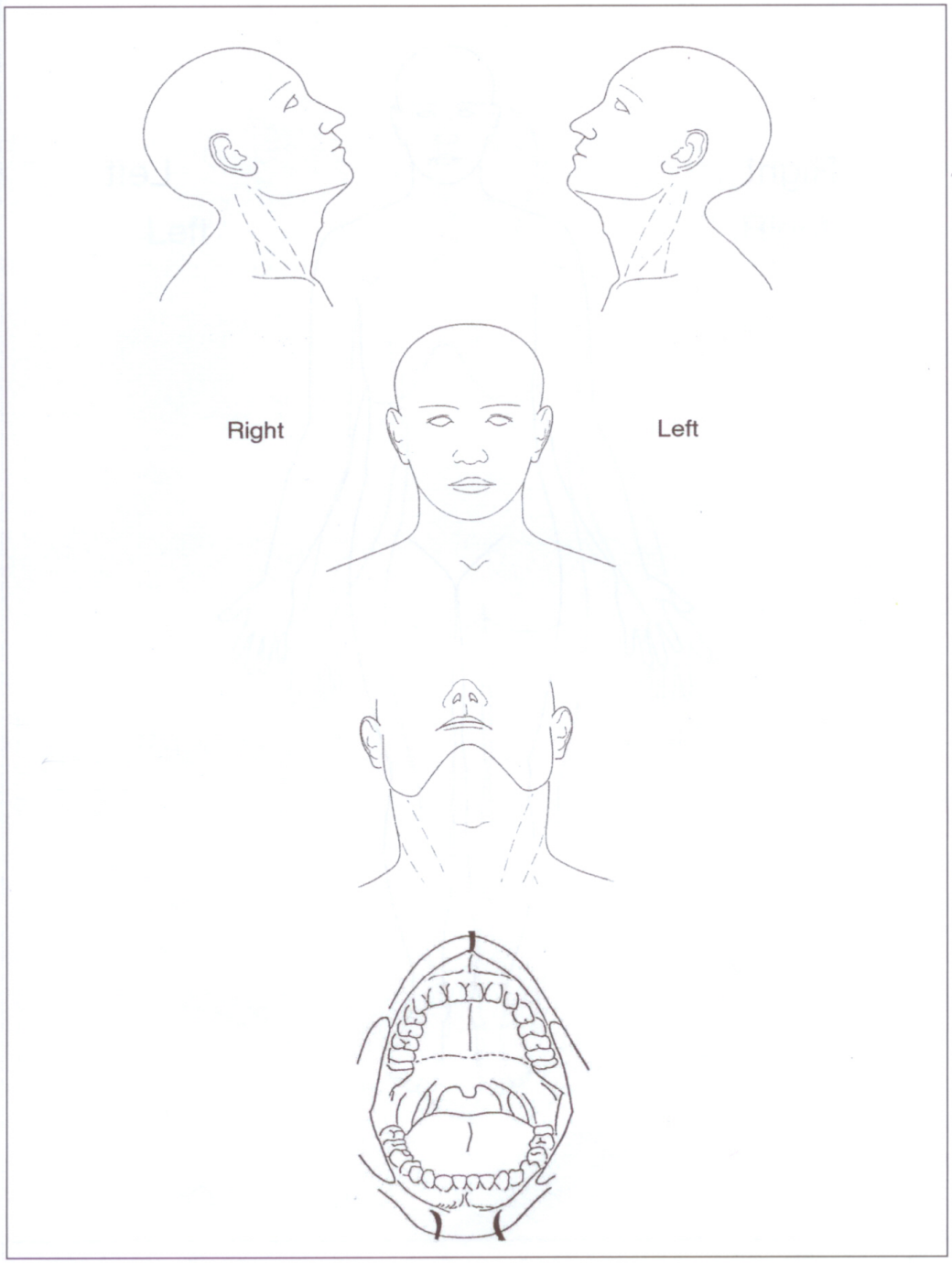
_____

_____

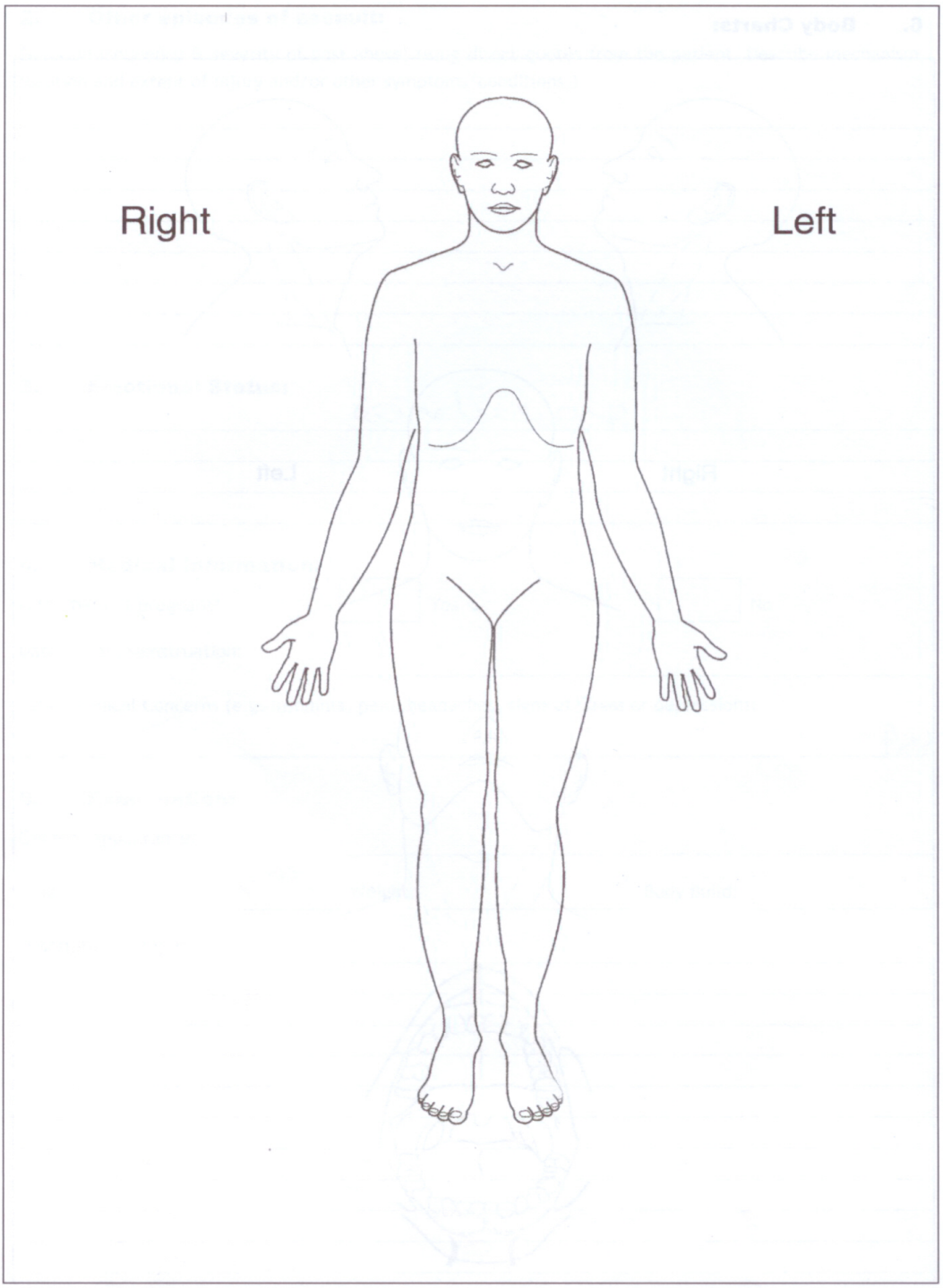
_____

Patient Name: _____ Folder No. _____

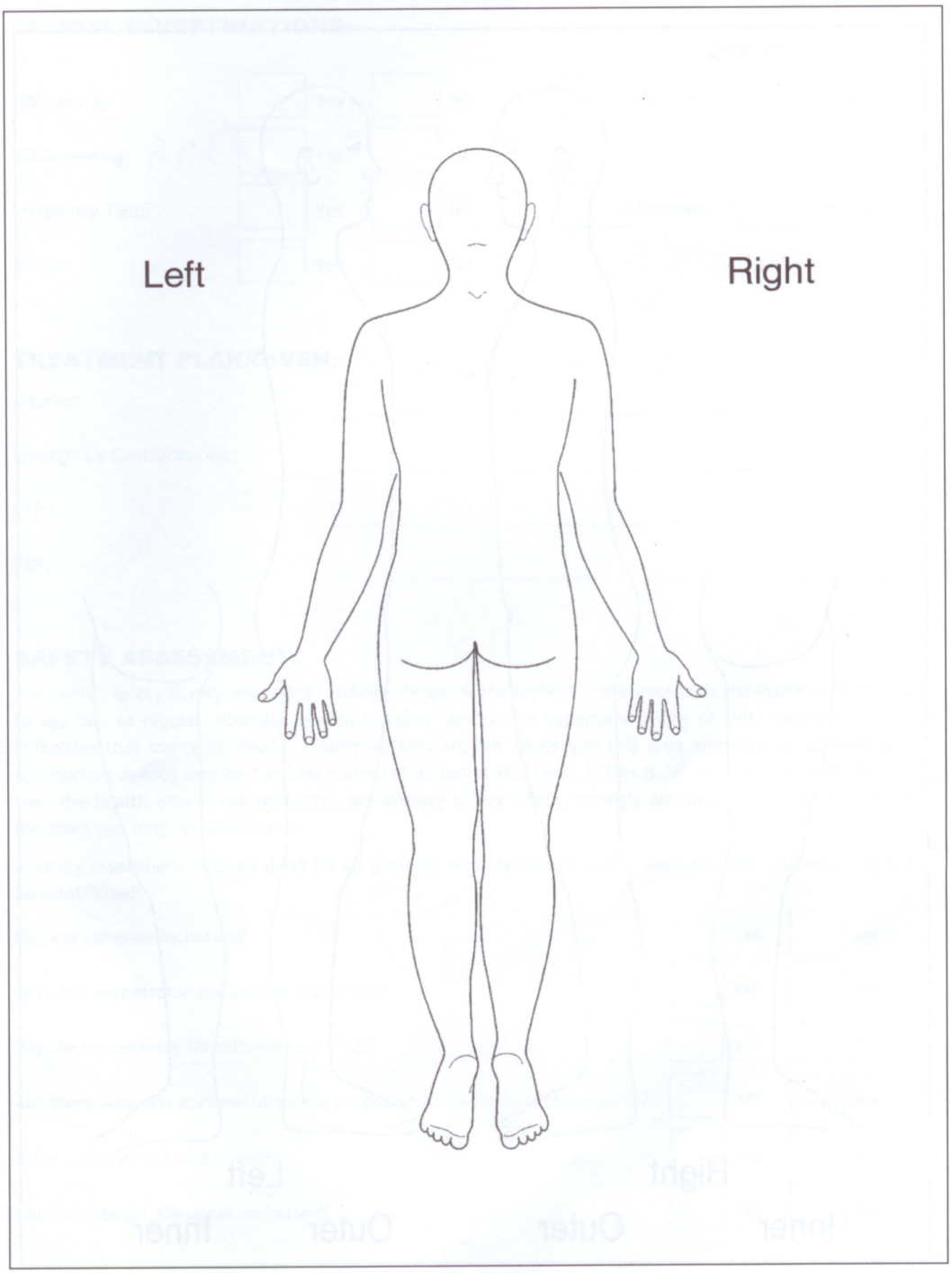
**6. Body Charts:**



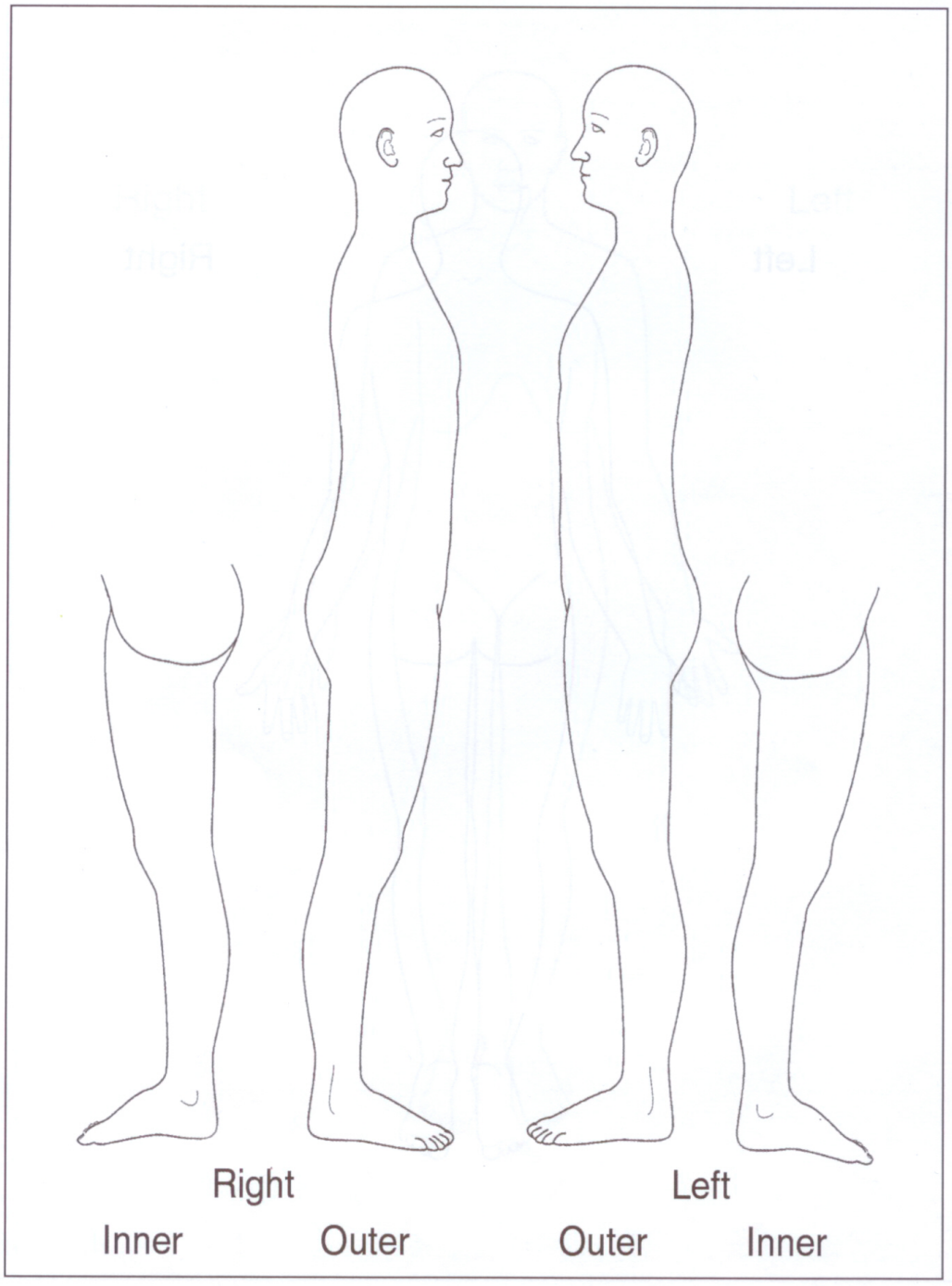
Patient Name: _____ Folder No. _____



Patient Name: _____ Folder No. _____



Patient Name: _____ Folder No. _____



**SPECIAL INVESTIGATIONS NEEDED:**

**Year/Date**

**1. Prior VCT** _____ ☐ Positive ☐ Negative ☐ Not done

**How did your partner react when you disclosed your status?**

_____

_____

_____

_____

_____

_____

_____

**3. Do you want testing now?** Yes ☐ No ☐

RPR: ☐ Yes ☐ No

Pregnancy test: ☐ Yes ☐ No

X-rays: ☐ Yes ☐ No

**TREATMENT PLAN/GIVEN:**

Injuries: ☐ Yes ☐ No

Emergency contraception ☐ Yes ☐ No

STI's: ☐ Yes ☐ No

PEP: ☐ Yes ☐ No

Other medical conditions:

_____

**SAFETY ASSESSMENT:**

A safety assessment must be done for all patients who disclose domestic violence. Record answers to the following questions. The answers to the questions can be assigned a value for risk assessment. Assign a value for the answers as follows: No = 0 Yes = 1

***Add up the total to provide a risk rating:*** ***0 – 3*** ➔ ***Caution***

***4 - 7*** ➔ ***High Risk***

8 – 11 ➔ Severe Risk

| | | | | |
|---|---|---|---|---|
| Has he threatened you with physical violence? | ☐ | Yes | ☐ | No |
| Has he threatened the children with physical violence? | ☐ | Yes | ☐ | No |
| Is there a firearm in the house? | ☐ | Yes | ☐ | No |
| Has he threatened to kill you? | ☐ | Yes | ☐ | No |
| Has he threatened to kill the children? | ☐ | Yes | ☐ | No |
| Does the patient think he is capable of killing her? | ☐ | Yes | ☐ | No |
| Were alcohol and / or drugs consumed prior to the last incident of abuse? | ☐ | Yes | ☐ | No |
| Was SAPS intervention necessary? | ☐ | Yes | ☐ | No |
| Is he presently in the home? | ☐ | Yes | ☐ | No |
| Has the abuse escalated in either frequency or severity? | ☐ | Yes | ☐ | No |
| Have you ever received medical treatment for injuries sustained as a result of abuse? | ☐ | Yes | ☐ | No |

Score: 0-3 ☐ / 4-7 ☐ / 8-11 ☐ **TOTAL RATING** ☐

**SAFETY PLAN:**

Help the client think and plan the following:

- **?** What will you do when you leave the health facility?
- **?** Will you seek help from SAPS and/ or courts?
- **?** How will you ensure your children's safety?
- **?** Where can you go if you need to leave home?
- **?** Who can you trust to tell about the domestic violence?
- **?** Where can you leave money, clothing, copies of documents and valuables if necessary?

**?** Will you accept a list of important telephone numbers referrals to help with longer-term safety planning?

Advise patient to hide a readily packed bag with essential items such as:

- Your ID book.
- Children's birth certificates, hospital cards and other important documents.
- House and car keys, money and bank card.
- Clothes for you and your children.
- Important telephone numbers.
- Copy of the protection order and suspended warrant of arrest if you already have one.

She may also make a list of other things to take with her, for example:

- Children's favourite toys.
- Children's school books and uniforms.
- Toiletries (toothbrush, deodorant, etc).
- Other valuable personal items, for example, photos and jewelry.

***REFERRAL LEGAL AND SOCIAL ISSUES***

Referrals made? ☐ Yes ☐ No

OPTION 1: _____

OPTION 2: _____

OPTION 3: _____

OPTION 4: _____

OPTION 5: _____

Magistrate court for protection order ☐ Yes ☐ No

Police station for criminal charge ☐ Yes ☐ No

NGO for counseling ☐ Yes ☐ No

NGO for legal support ☐ Yes ☐ No

PGWC social worker ☐ Yes ☐ No

Shelter ☐ Yes ☐ No

Other:

_____

**INFORMATION LEAFLET:**

Safe to give a leaflet ☐ Yes ☐ No

**FOLLOW UP:**

Appointment made for follow-up?

Date & Time:

_____

Signature:

_____

Health Facility:

_____

Date:

_____