Descriptive analysis of the adherence to the acute care protocol for adult female sexual abuse patients seen at the OB admitting section in a tertiary public hospital in the Philippines

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ABSTRACT

Background: There has been an increasing trend in reported sexual abuse patients in the Philippines in the past 20 years. Patient evaluation is critical from health care providers and it is imperative to have an acute care protocol that heath care providers can use in managing these patients.

Objective: To assess the adherence to the acute care protocol as applied to adult female sexual abuse patients who consulted at the Philippine General Hospital OB Admitting Section from March to August 2019

Methods: The study design used was an observational, cross-sectional study via descriptive analysis using a designed questionnaire. Relevant data regarding compliance to the acute care protocol was assessed from patient experience via the questionnaire after undergoing the standard services of the hospital. Data was then documented, tabulated and processed via Microsoft Excel data sheets.

Results: In terms of patient perspective, 96.2 % of all cases (n=27) were provided service by OBGYNs and psychiatrists and 100% were assessed by social workers. Although stated in the protocol, legal and/or police assistance was not provided by the hospital during patient consult.

Conclusion: The institution was able to adhere to the acute care protocol services of patients in terms of obstetric and gynecologic, psychiatric and social worker services but not legal and/or police assistance.

Keywords: sexual abuse patients, acute care protocol, protocol adherence

INTRODUCTION

Based on 2009 statistics by the Philippine Commission on Women, one in 25 women ages 15-49 who have ever had sex experienced forced first sexual intercourse; one in 10 women age 15-49 experienced sexual violence and 8% experienced sexual violence by their husbands. There has also been an increasing trend in reported rape cases in the Philippines with 4,738 in 2012 to a dramatic rise to 10,294 in 2015 (Philippine Statistics Authority Databank, 2015). In the Philippine General Hospital (PGH) alone, the reported sexual abuse cases have dramatically increased from 22 cases in 1998 to 148 in 2018 as reported by the PGH Women's Desk.

There is an increasing rate in number of this niche of patients with specific and sensitive needs. With PGH as the national tertiary training hospital and referral center for such cases, establishing a framework that will be efficient in assessing these patients is critical.

REVIEW OF LITERATURE

Patient evaluation

The evaluation of the sexual abuse patient is a challenge for health care professionals. Appropriate management of the patient will require a standardized evaluation of history and physical examination, an effective coordination with law enforcement for the handling of forensic evidence, and a plausible continuum of care. These patients have medical, psychiatric and emotional needs that have to be addressed while the forensic requirements of the criminal justice system have to be ascertained for them as well. Medical issues for sexual abuse patients include treatment of acute injuries and evaluation for potential sexually transmitted diseases and pregnancy. Emotional needs include acute crisis intervention and referral for appropriate follow-up counseling. Forensic tasks include thorough documentation of pertinent historical and physical

findings, proper collection and handling of evidence, and presentation of findings and conclusions in court (ACEP, 2013).

More often than not, examinations and procedures that health care providers might consider innocuous or routine can be distressing to the sexual abuse patient because of reminiscent trauma recently encountered. Exclusive focus on the body, lack of control, invasion of personal boundaries, exposure, vulnerability, pain and sense of powerlessness are common experiences in the healthcare environment, which may even often mirror the situation of abuse. The need to clearly understand the needs of these patients and creating core competencies that help health care practitioners is warranted to properly respond to the need of these patients (Schacter, 2009).

Minimum core knowledge of health care provider

Health care providers practicing in the area of sexual assault should be accordingly knowledgeable in properly dealing with these patients. Specialized instructions regarding the topics listed below should be the minimum core content of any these health care providers (ACEP, 2013):

1. Multidisciplinary Team Concept
2. Dynamics of Sexual Assault
3. Myths and realities
4. Rape Trauma Syndrome, Post-Traumatic Stress Disorder (PTSD)
5. Sexual Assault Forensic Examination
6. Communication skills
7. History
8. Physical assessment
9. Detailed genital examination
10. Physical evidence collection
11. Forensic photography
12. Documentation
13. Criminal Justice System
14. Anatomy and physiology as it relates to sexual assault/abuse
15. Normal male and female genital structures, from birth to reproductive age to the aged adult
16. Effect of hormones on the genital structures
17. Effects of the human sexual response cycle on the body
18. Anatomic sequelae of nonconsensual sexual acts plus associated physical trauma
19. Medical conditions, anomalies, or pathology that may influence the physical examination
20. Psychological aspects of sexual assault
21. Medicolegal forensic examination
22. Patient assessment/patient history
23. Evidence collection: physical examination/ enhanced visualization/evidence collection kits/ preservation of evidence
24. The role of the forensic examiner in the criminal justice system
25. Medical management of sexually transmitted diseases, HIV, and pregnancy
26. Referral services available for the victim

Guidelines in assessing an acute care protocol for sexual assault victims

The Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault of the Department of Health of New York has provided guidelines in assessing protocols administered in emergency departments.

Essential protocol mechanisms

Emergency department managers should review their sexual assault protocols and procedures to ensure the following are in place:

1. Around-the-clock availability of a specially trained sexual assault forensic examiner or other provider trained in the evaluation of sexual assault patients;
2. A rape crisis advocate is contacted;
3. A setting is provided where all health care needs can be met;
4. Immediate availability of appropriate medications (including those for STIs, prophylaxis against pregnancy resulting from sexual assault, HIV prophylaxis, and hepatitis B prophylaxis)
5. Necessary forensic equipment
6. Procedures for securing evidence and maintaining the chain of custody;
7. Appropriate medical and forensic documentation;
8. Appropriate and safe discharge is provided, including: medical transfer, as necessary; necessary and appropriate follow-up care/ referrals; hospital contact person to assist with release or disposal of sexual offense evidence; suitable attire; transportation or other appropriate arrangements as necessary to meet patient needs; and,
9. Follow-up services for medical and counseling referrals.

Protocol review

In addition to ensuring that essential protocol mechanisms are in place, the hospital must also develop and implement written policies and procedures that will establish an internal quality improvement program. This program must identify, evaluate, resolve, and monitor actual and potential problems in patient care. The following components are recommended for inclusion:

1. Chart audit performed periodically on a statistically significant number of sexual assault

patient records. Sexual assault patient records and other appropriate information should be periodically reviewed to answer the following:

- How long did the victim wait from arrival to exam commencement?
- Were appropriately trained staff available to examine the patient?
- Were necessary equipment and supplies available?
- Was a rape crisis advocate called to attend the patient?
- Did the patient receive appropriate medical treatment, including a recommendation of HIV prophylaxis in cases of significant risk exposure?
- Was consent obtained from the patient?
- Did the patient receive appropriate counseling about pregnancy prophylaxis, including the timeframe for effectiveness and the treatment?
- Did the patient request and receive emergency contraception, unless medically contraindicated?
- If the patient did not receive emergency contraception, is the reason documented, i.e. refused or already pregnant?
- Did the patient receive treatment for STIs?
- Did the patient choose to take advantage of all treatment offered? If not, why?
- Was a referral made; if so, to whom?
- Was forensic evidence collected and maintained in a manner which was consistent with laws, regulations and standards, including maintaining the chain of custody?
- Was the patient provided with self-care information and plans for referral?
- Was an appropriate psychological and medical follow-up plan developed for the patient?
- Was the patient provided safe discharge?
- Was patient confidentiality maintained?

2. A system for developing and recommending corrective actions to resolve identified problems;
3. A follow-up process to assure that recommendations and plans of correction are implemented and are effective
4. A system for resolving patient complaints.

Emergency department statistics

Statistics of sexual assault victims provided care by their respective centers is vital for community and public health assessment. Accurate data of patients and services rendered will assist the examiner and the facility in documenting the extent of the gap of the problem, determine the cost of the service, identifying gaps in service and concordant growth and expansion of the facility. Data that can be included are:

- The number of personnel who are certified as sexual assault forensic examiners;
- The number of sexual assault victims who present at the hospital for services;
- The response time of the sexual assault examiner from the time the call was made to the time the examiner arrived;
- The number of sexual assault exams performed by sexual assault forensic examiners;
- The number of sexual assault exams performed by personnel other than sexual assault forensic examiners;
- The number of inpatient admissions resulting from sexual assaults;
- The number of patients served by age, racial/ethnic status, and gender;
- Insurance payer status of victims;
- The number of patients accompanied by a rape crisis advocate;
- The number of patients who refused the services of a rape crisis advocate;
- The number of patients who took HIV prophylaxis;
- The number of patients who refused or were ineligible for HIV prophylaxis;
- The number of patients who took prophylaxis against pregnancy resulting from sexual assault;
- The number of examinations where the patient chose to report sexual assault to law enforcement;
- The number of examinations where the patient declined to report sexual assault to law enforcement;
- The number of sexual assault evidence collection kits completed for sexual assault forensic examinations;
- The number of those kits released to law enforcement at the time of the exam;
- The number of those kits released to law enforcement after the exam was completed; and,
- The number of victims who refused to have evidence collected.

Laws related to sexual abuse patients in the Philippines

In the Philippines, violence against women such as domestic violence, sexual harassment and rape were considered to be private crimes. Among such laws is the Anti-Rape Law of 1997, which has reclassified rape as a crime against persons, defining it as public rather than a private crime. It also recognizes marital rape and questions the notion of sexual obligation in marriage. It also states

that rape may occur even without penile penetration and that the use of objects may constitute as sexual assault and also considered a form of rape. This law also increased the penalties against such crimes.

The Rape Victim Assistance and Protection Act of 1998 declares it as the policy of the State to provide necessary assistance and protection for rape victims. This legislation requires a rape crisis center established in every province and city under authorizing the appropriation of funds for the establishment and operation of the rape crisis center. Aside from the provision of services, capacity building/training is also mandated for law enforcement officers, public prosecutors, lawyers, medico-legal officers, social workers and barangay officials on human rights and their responsibilities, gender sensitivity and legal management of rape cases.

Philippine framework for sexual abuse victims

In line with creation of laws to protect constituents who have become victims of sexual abuse, the national government has created agencies such as the Inter Agency Council on Violence Against Women and Their Children and the Philippine Commission on Women. These agencies have created Performance Standards and Assessment Tools for Violence Against Women (VAW) Services in order to define the roles and expectations for an effective VAW service delivery system. Involved in this system are the Department of Health (DOH) who will provide medical assistance; the Department of the Interior and Local Government – Local Government Units (DILG-LGU) together with the Department of Social Welfare and Development (DSWD) mandated to provide the victims temporary shelters, counseling, psychosocial services and/or recovery, rehabilitation programs and livelihood assistance; the Department of Justice (DOJ) and the Philippine National Police (PNP) are to tasked to provide the necessary legal needs these patients require.

If in any case that there will be difficulty in access or inadequacy of facilities or services in certain areas, the multidisciplinary team members must facilitate the referrals to other cities and provinces (Provincial/District Hospital) and even at the regional (DSWD Field Office: Haven for Women) and national (UP-PGH Women and Child Protection Units) levels (PCW, 2009).

Patient flow of sexual abuse patients in PGH

The UP PGH Women's Desk is the national level assisting agency that aids in addressing the needs of sexual abuse patients of the country at a tertiary level. An existing Women's Desk has been mandated which has collaborated with different departments within the hospital to address the different needs of sexual abuse patients.

Based on the existing flow chart of acute case handling of sexual abuse patients in PGH (Figure 1), when a sexual abuse patient consults at the emergency room, she is triaged as either an emergent or urgent case. If the case is deemed urgent, then the appropriate medical or surgical intervention is then given to her immediately; after which, she is then referred to the Women's Desk to receive appropriate holistic care. If the case is emergent, she is then referred to Women's Desk first and then followed by the appropriate medical treatment thereafter.

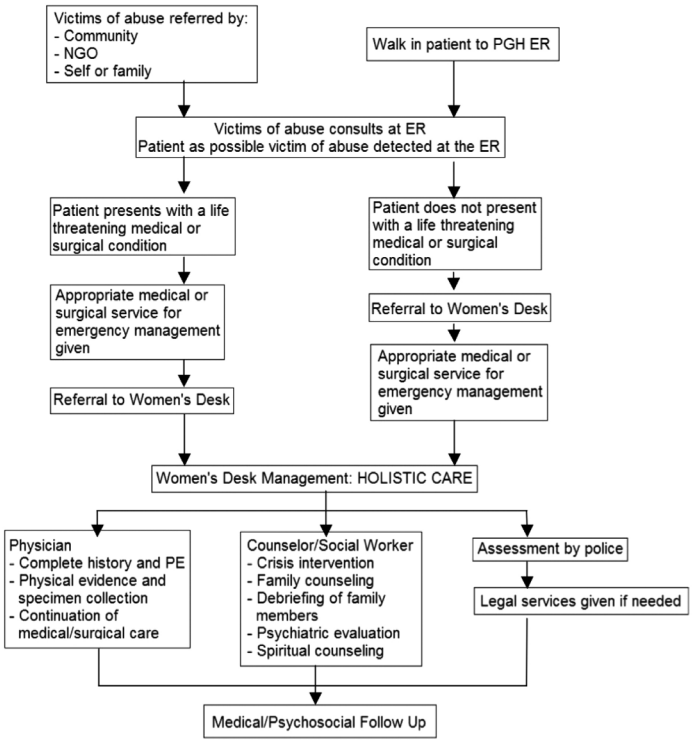

Figure 1. Flow chart of acute case handling of sexual abuse patients in PGH

Once referred to the Women's Desk, it provides holistic care in three ways. It refers to the physician, the social worker and the legal aid and/or the police to address the physical, social and legal needs of the patient.

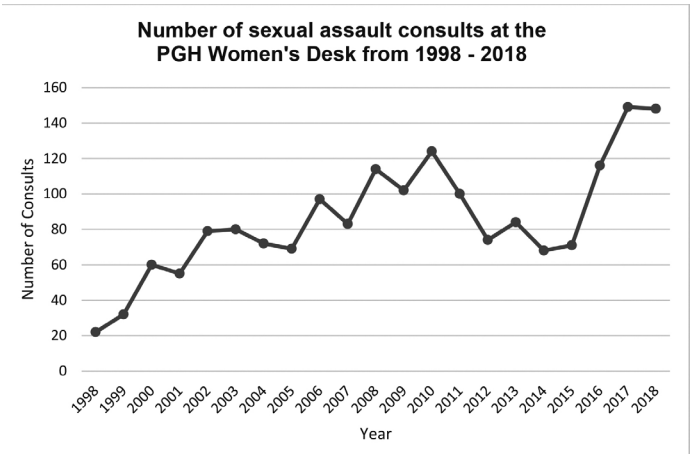

Figure 2. Total number of sexual abuse patient consults as per the PGH Women's Desk per year from 1998-2018

Number of sexual abuse consults seen by the UP PGH Women's Desk

There has been an increasing number of consults at the UP PGH Women's Desk from an initial 22 cases per annum in 1998 to 148 cases in 2018 as seen in Figure 2. This rise in number of consults since its establishment has been associated with the increased national awareness for women's advocacy, especially within the surrounding local communities, that have utilized the PGH Women's Desk as a referral center for sexual abuse cases.

SIGNIFICANCE OF THE STUDY

As stated in international guidelines, in acute care protocols for sexual abuse patients, once essential mechanisms have been ensured, the hospital should be able to develop and implement written policies to ensure an internal quality improvement program whose aim must be to identify, evaluate, resolve and monitor actual and potential problems in the delivery of care for these patients.

In line with this, the purpose of this study is to assess the adherence in the implementation of the acute care protocol of adult female sexual abuse cases consulting in the OB Admitting Section of PGH. With the current data showing an increasing number of such cases, it is paramount to ensure efficient and effective management of these patients. As the main referral center of the country for this specific set of patients, the effectiveness and efficiency of the acute care protocol for sexual abuse patients in PGH should be evaluated – both for updating and improvement and even possibly replicating the hospital's protocol for other institutions that may become referral centers within the country for managing this set of patients.

This study also aims to add to the scarce amount of studies performed for treatment of sexual abuse patients by giving insight into the implementation process of an assault center.

SCOPE OF THE STUDY

The scope of the study included all adult (18 years old and above) female sexual abuse patients seen at the OB Admitting Section of the Philippine General Hospital from March to August 2019 wherein the acute care protocol for sexual abuse patients practiced by the hospital was carried out.

OBJECTIVE

General Objective

To assess the current implementation of the acute care protocol of sexual abuse patients in PGH for adult females.

Specific Objective

1. Assess the compliance to the current acute care protocol applied in PGH from the perspective of patients through a questionnaire detailing the different steps as described in the protocol as applied to their case
2. Present the summarized qualitative results of the questionnaire i.e. number of patients seen by an OBGYN, social worker, legal counselor, etc.; percentage of patients seen rendered services by OBGYN, social worker, legal counselor, etc.
3. Document the current socio-demographic profile of adult female sexual abuse patients seen at the OBAS of PGH within March to August 2019

MATERIALS AND METHODS

The study design used was an observational, cross-sectional study via descriptive analysis. The study population analyzed were female patients 18 years and above with the diagnosis of disclosure of sexual abuse encountered at the OB Admitting Section of the Philippine General Hospital from March to August 2019. The pediatric age group (less than 18 years old) and male patients with the same diagnosis were not included in the study. The data collection procedure was through a developed questionnaire (Appendix A) given to all patients deemed to be within the inclusion criteria who underwent the services of the OBAS for sexual abuse patients and consented to be part of the study. The data collection steps are presented in Figure 3.

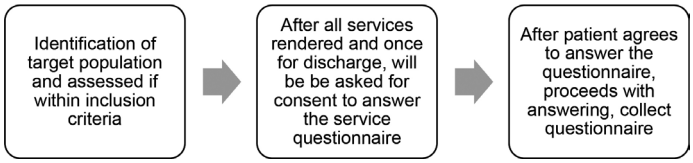

Figure 3. Data collection algorithm

Primary data coming from the questionnaire as answered by the recruited participants were recorded. Relevant data regarding compliance to the acute care protocol was assessed from the patient experience via the questionnaire eliminating data bias from a third party observer. Data acquired from the questionnaire was documented, tabulated and processed via Microsoft Excel data sheets.

Ethical considerations were ensured granted the highly sensitive nature of the population involved and complete anonymity was guaranteed. Strict implementation of anonymity with the patient questionnaire and data storage pertaining to any patient identifier was ensured. The study was also approved and permitted for implementation by the UP Manila Review Ethics Board.

RESULTS AND DISCUSSION

A total enumeration of the population was planned. The total population consisted of 33 patients, wherein 27 agreed to participate, giving an 82% response rate. The questionnaire was analyzed by a psychometrician, indicating that it was a simple, easily understandable checklist with no necessitation for validation.

Sociodemographic profile

Seen in Table 1 is the summary of the sociodemographic profile of the total population. In terms of age, 77.8% (21 of 27) of the population was comprised of the those in the 18-24 year old bracket, followed by 18.5% (5 of 27) in the 25-34 year old bracket and 3% (1 of 27) in the 45 year old and above bracket indicating that the patient population consulting in PGH OBAS are in the younger age bracket.

In terms of location, 37% (10 of 27) of the total population were from Cavite, 29.6% (8 of 27) were from Manila, 14.8% (4 of 27) came from Paranaque and 7.4% (2 of 27) came from Makati while 3.7% (1 of 27) each came from Alabang, Pasay and Quezon City. It is important to note however, that although most of the consults in the study population came from the Manila area and other nearby municipalities and cities, the Women's Desk also receive referrals and consults from other provinces which require assistance in handling sexual abuse cases, a number of which are seen as Outpatient Department consults.

In terms of marital status, 70.4% (19 of 27) of patients were single, 18.5% (5 of 27) were with common law partners and 7.4% (2 of 27) were married and 3.7% (1 of 27) was separated. Although most of the study population were single women, sexual abuse may still occur within marriages or common-law partners. The Women's Desk has also indicated in their statistics intimate partner violence, which is duly addressed in a separate protocol.

In terms of educational status, 63% (17 of 27) of the patients reached the high school level, while 18.5% (5 of 27) each for the elementary level and the college level. In terms of employment, 74% (20 of 27) of the patients were unemployed. The monthly family income of 44.4% of patients (12 of 27) was between Php 5,000 – 10,000; 25.9% (7 of 27) had P10,000 – 15,000 monthly family income and 22.2% (6 of 27) had less than P5,000 as monthly family income. None of our patients had

Table 1. Sociodemographic profile of female adult sexual abuse patients seen at the OBAS from March to August 2019.

Demographic variable	Category	Frequency (n=27)	Percentage (%)
Age (years)	18-24	21	77.8
	25-34	5	18.5
	35-44	0	-
	45 and above	1	3.0
Location	Manila	8	29.6
	Cavite	10	37.0
	Parañaque	4	14.8
	Quezon City	1	3.7
	Makati	2	7.4
	Alabang	1	3.7
	Pasay	1	3.7
Marital Status	Single	19	70.4
	Married	2	7.4
	Separated	1	3.7
	With common-law partner	5	18.5
	Widow	0	-
Educational Background	Elementary	5	18.5
	High School	17	63.0
	College	5	18.5
Employment	Yes	7	25.9
	No	20	74.1
Monthly family income (Php)	< 5,000	6	22.2
	5,000-10,000	12	44.4
	10,000-15,000	7	25.9
	15,000-20,000	2	7.4
	≥20,000	0	-

more than Php 20,000 as monthly family income. All of the cases encountered in PGH OBAS consult as charity service cases and reflect that these patients come from a lower socio-economic bracket and correspondingly, lower educational background.

Type of consultation

As seen in Figure 4, out of the 27 consults, 7 patients or 26% of the population were walk-in patients who went to the PGH OBAS on their own accord, and consequently 20 patients or 74% of the population were referred either from a local government unit, another institution or told by family members to consult.

During the establishment of the PGH Women's Desk 20 years ago, seminars about Violence Against Women and Gender Orientation were done in different colleges and specific barangays around Manila. The Barangay Center for Projection of Children units in different districts in Manila were utilized to increase awareness about reporting sexual abuse and women's advocacy. In these seminars, barangay officials were invited together with barangay health workers, social workers and police officers for orientations in promoting awareness of the Women's Desk as a place where women can go to report issues concerning sexual abuse or domestic violence. With the sensitive nature of sexual abuse, the role of the local government and the community plays a vital role in encouraging sexual abuse patients to seek proper consult and look for avenues to address their concerns.

Figure 4. Percentage representation of type of consultation of sexual abuse patients seen at the OBAS

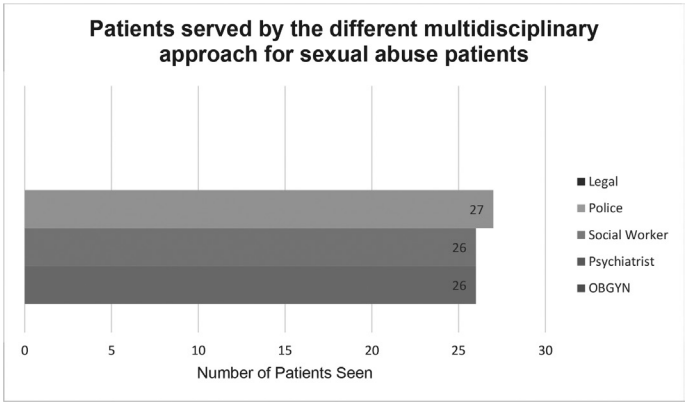

Figure 5. Total number of patients served by each division of the acute care protocol

Services rendered per department in the multidisciplinary approach

As seen in Figure 5, OBGYNs and psychiatrists were reported to have rendered their services to 26 of the 27 patients; social workers were reported to have rendered services to all 27 patients while legal or police assistance was not given to any of the patient consults.

Of all the 27 patients, 26 were reported to have been seen by an OBGYN (96.2%). The patient who indicated that she was not seen by an OBGYN was documented to have been assessed, treated and managed by an OBGYN in her chart. All 27 patients underwent history taking, physical examination, collection of samples for medicolegal purposes via a sexual offense evidence collection kit and laboratory examinations including but not limited to baseline work up for sexual transmitted infections and urine pregnancy test. The patient's perception of not being assessed could possibly be attributed to the lack of introduction by the OBGYN to the patient as such or deficiency in explaining the role of the OBGYN in her management.

Similarly, 26 of the 27 patients (96.2%) were reported to have been seen by a psychiatrist. The patient that indicated to not have been seen by a psychiatrist also had a documented psychiatric evaluation in her chart. Again, this deficiency in patient perception of the evaluation may possibly be due to lack of introduction or explanation of the psychiatrist's role in the management.

All patients reported assessment by a social worker. Patients were rendered crisis intervention, family counseling, debriefing of family members, psychiatric evaluation and spiritual counseling as deemed by the patients.

None of the patients reported being seen by a police officer or offered any medico-legal assistance by a lawyer during their consult. Although part of the flowchart of the Women's Desk, medicolegal assistance is not part of the services that are rendered to sexual abuse patients who consult at PGH. Historically, the UP College of Law previously sent law interns to see cases at the Women's Desk. In the current setting however, patients who now wish to have legal counsel may be assisted by the Women's Desk to acquire this through the local government prosecutor or through non-government institutions.

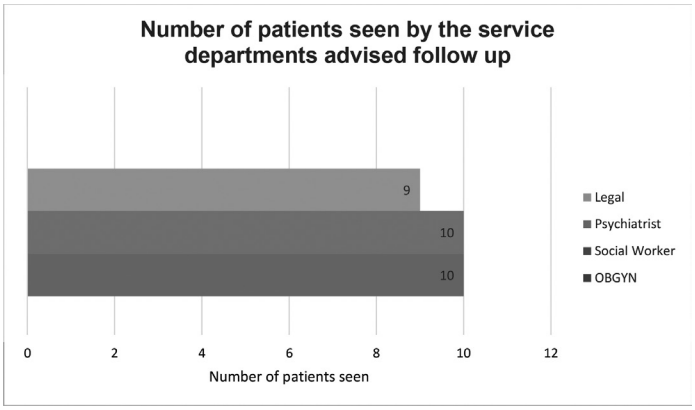

Figure 6. Percentage of patients advised follow up based on departments involved in the acute care protocol

Advice on follow ups

Presented in Figure 6 is a bar graph which represents the follow up advice by all three departments (OBGYN, Psychiatry, Women's Desk/Social Services) for the patient, which was not exclusive or limited to any of the departments. 10 patients were advised follow up by OBGYNs and 10 by social workers; 9 were advised follow up by psychiatrists. One patient indicated that she was advised followed up by all three. All patients were advised follow up by at least one of the departments. Each department render different services to the patient and different follow up consults will mean follow ups for each of the departments.

Follow up consults are important in the sexual abuse patients. In terms of obstetrics and gynecology, work up for potential sexually transmitted diseases, prophylaxis against a possible pregnancy and gynecologic concerns must be addressed during follow ups. Post-traumatic stress disorder, brief reactive psychosis and other psychiatric disorders may need to be addressed during follow ups by psychiatrists. Social workers on the other hand address possible matters pertaining to debriefing and medicolegal concerns.

LIMITATIONS OF THE STUDY

The study only includes female sexual abuse patients who consulted at the OB Admitting Section. The statistics reflected in the Women's Desk data for sexual abuse patients also include consults that are not acute in nature (>72 hours from assault) or those that consult at the OPD.

The questionnaire as assessed by a licensed psychometrician was a simple checklist of services provided, answering only yes-or-no questions and did not provide an avenue for qualitative data such as a graded quality of service.

RECOMMENDATIONS

The acute care protocol applied to sexual abuse patients at the OBAS was derived from its history – pertaining to the fact that the previous set up of the ER, the specificity of a physician, the incorporation of the psychiatrist, and the availability of legal services may not be the same set up that can be offered in the current setting. It is recommended that the protocol be improved or updated based on the capacities that it can perform.

It is also suggested that the different components of the acute care protocol be assigned specific job descriptions in order to clearly delineate its roles to guide both the health service provider in rendering the service and to clarify to the patient the role of each in her management.

As discussed earlier in minimum core knowledge of health care providers in managing cases of sexual assault, basic knowledge of the dynamics of sexual assault, forensic examination and documentation, anatomy and physiology as it relates to sexual abuse, knowledge of the national criminal justice system and the role of the forensic examiner and medical management of these cases relating to sexually transmitted diseases and pregnancy are vital. A recommendation for further study is to assess the basic knowledge of medical officers, in particular OBGYNs, who have the opportunity to assess these patients first in the acute setting.

As part of the essential protocol mechanisms that should be available in managing sexual abuse patients in the acute setting, PGH has rendered availability of physicians and paramedical staff to aid in providing services to in the setting of the OB Admitting Section. Appropriate diagnostic screening tools as well as provision of prophylaxis for sexual transmitted diseases are also accessible. There is also available sexual abuse evidence collection kits as well as an established maintenance of the chain of custody by the Women's Desk. PGH being a tertiary hospital also offers follow up services for medical and counseling referrals during consult and on follow up basis. HIV and Hepatitis B prophylaxis, although available in other protocols abroad, are currently not available in our setting and can be explored to further better services.

Recommendations based on literature suggest a chart audit of a significant number sexual abuse patient records assessing time of arrival to exam commencement, receiving properly medical treatment, acquisition of consent, collection of forensic evidence and identification of corrective actions. In the development of this study, although a chart review was originally planned, the current charting method do not necessarily identify all this data. Guidelines in proper documentation and charting may

be developed in order to aid in accumulation of statistics relevant for improvement of services (i.e. time of arrival to time of evaluation, checklist included in chart for actual health services provided).

A system for developing and recommending corrective actions to resolve identified problems, such as in this study, may be implemented to assure corrective measures and create a follow up system necessary in improve delivery of service to sexual abuse patients.

CONCLUSION

Sexual abuse patients are a unique niche of patients with specific needs. Institutions especially relegated to attend to the needs of these patients must have acute care protocols in place in order to serve these patients properly. Acute care protocols that have been designed must have essential protocol mechanisms and should also have timely protocol reviews in order to identify, evaluate, resolve, and monitor actual and potential problems in patient care.

The PGH Sexual Abuse Acute Care Protocol is delivered via an interdisciplinary system which involves the departments of OBGYN, Psychiatry, Social Services and the Women's Desk. The current acute care protocol shows 96.2% of patients are seen by OBGYNs and psychiatrists and 100% have been seen by social workers, however none were provided legal services, despite it being indicated in the hospital flowchart.

With PGH as the main referral institution for cases of sexual abuse, it is paramount to have an acute care protocol documented and periodically assessed in order to best manage patients. Consecutively, having an established acute care protocol as advised by international governing bodies, which have been applied and studied in PGH, may be reproducible in other institutions to promulgate women's advocacy and the care of sexual abuse patients in the national level. ■

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