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ຄຊຫມດ
NCAWMC

Standard Operating Procedure for

the Health Sector to Respond to Women and Girls Subject to Violence in Lao PDR

September 2022

Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

Ministry of Health

No. 2466 /MOH
Vientiane Capital, dated: 25 AUG 2022

Ministerial Agreement Endorsement and promulgation of Standard Operating Procedures for Health Facility Response to VAW

- Pursuance to the decree on the roles and responsibilities of the ministry of health No. 570/PM, dated 16 September 2021
- Pursuance to the Minister of Health agreement No. 3000/MOH, dated 29 November 2018 on the Gender base strategy for mother and child health 2019-2021
- With reference to the research and proposal of cabinet No 2286/ภทง, dated 18 August 2022.
-

Mister of Health Agreed:

Article 1: Endorsed and promulgate the standard operating procedures for health facility response to VAW, dated August 2022;

Article 2: for the advancement of women's division, Mother and Child Center, The Cabinet to coordinate with relevant agencies for the dissemination and training to health workers to all hospital and public health facilities nationwide as according to the standard operating procedures for health facility respond to VAW;

Article 3: for the cabinet, departments, center within MOH, university of health science, schools, central hospital, division, provincial health department/capital, and relevant agencies to refer to this SOP and with strict implementation;

Article 4: The MOH Cabinet Office, and related organisations to be aware and shall fully follow this agreement;

Article 5: This Ministerial agreement is effective on the signature date.

Mister of Health

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Foreword

H.E. Dr. Phayvanh Keophaseurt

Vice Minister of MoH
President of NCAWMC of MoH.

On behalf of the Ministry of Health (MOH), I am proud of this Standard Operating Procedure (SOP) for health facility response to violence against women. We have worked in partnership with UNFPA and the Commission for the Advancement of Women and Mother and Child (NCAWMC) to develop a comprehensive framework that will guide our skilled health practitioners all around the country. It is important that when a woman or girl subject to violence comes into contact with a health service provider, they are met with empathy, understanding, referral options and quality clinical care.

The SOP has adapted international guidance to be grounded in the Laos context. The development of the SOP also falls well within national policy implementation and will fulfil priority actions within the National Plan of Action on the Prevention and Elimination of Violence against Women and Violence against Children 2021-2025 (EVAW NAP), especially those under the responsibility of Ministry of health. It also contributes to Laos' international human rights commitments.

I look forward to the roll out of this SOP and the training MOH staff will receive in the target provinces and then nationwide, so we can continue to improve our response to the physical and emotional needs of victims of violence.

With many thanks to the support from UNFPA and KOICA, I will continue to monitor capacity building and implementation.

Dr.Phayvanh KEOPASEUTH

Foreword

Ms Mariam A. Khan

Representative, UNFPA Lao PDR

It gives me great pleasure to share these Standard Operating Procedures for Health Facility Response to Violence Against Women (the Health Sector SOP). The SOP has been developed under the leadership of MOH, the sub-CAW of MOH, and with the support of the NCAWMC team. It draws from global guidance tools, such as the Essential Services Package for Women and Girls Subject to Violence, the Intimate Partner Violence Guidelines, and Mental Health Gap Action Programme Guideline.

Health care professionals play a critical role in detecting and responding to violence against women and girls. Women who experience violence are most likely to come into contact with the health sector, for general health services for themselves or their children, but often also for conditions linked to violence, such as physical injuries or chronic illnesses which manifest due to domestic violence. Even when women don't disclose the violence, trained healthcare providers can be the first and trusted entry point into an institutional response. It is therefore important that health care providers are prepared to detect, screen, and address cases using guidance based on international standards.

This SOP provides clear guidelines on screening/identifying survivors of violence, first-line support, treatment of injuries and psychological and mental health support, collection of forensic evidence, and post-rape care. The SOP also provides an operating framework and clinical guidance for all hospitals and medical facilities in the country. It complements the SOPs being developed for the Social sector and for GBV Coordination & Referral.

UNFPA supports Lao PDR to implement international human rights commitments related to gender equality and the prevention of GBV. The SOP supports the realisation of Laos' commitments to CEDAW, Beijing Platform for Action, ICPD25, and ambitions for the SDGs.

I hope that with the rollout of this SOP, women and girls will receive the much-needed care and support when they access health services. I thank MOH and KOICA for this significant step forward in setting up a system-based response to violence against women and girls in Lao PDR.

Technical Acknowledgements:

The Cabinet Office of the ministry of health is very pleased and would like to acknowledge the completion of the Standard Operating Procedures for Health Facility Response to VAW which is serve as refence and standard operating procedure for violence against women and children or as victim. This SOP also serve as important guiding principles to all level of health facilities with the focus to ensure effective services that are delivered in women-centred care, and also as reference for the training tools and monitoring at all levels.

On behalf of the Cabinet Office of the ministry of health, I would like to take this opportunity to express my sincere thanks and appreciation to the senior level of management of the ministry of health for always provide guidance and facilitated the discussion and feedback for service provider and respond to the need of violence against women and children which is one of the special areas where health workers need to be train for clinical care for victim survivors and to improve health care system.

Our appreciation go to the senor level of management of the ministry of health, the cabinet, vision of the advancement of women and children of MOH, department of health care and rehabilitation, department of hygiene and health promotion, department of planning and cooperation, the national insurance office, five central hospitals (Mahosoth, Mittaphab, Sethathirath, mother and new born child, and children hospital) center for HIV/AIDS and STI, mother and child health center.

In additional, also to expressed our sincere thanks to other stakeholders beside the health sector such as: the office of the national commission for the advancement of women, mother and children, counselling center and protection for women and children (LWU), ministry of justice, ministry of public security, ministry of labour and social welfare, the people supreme court, Vientiane capital people's court, the office of supreme prosecutor, Vientiane capital prosecutor office, 05 and 103 hospital.

Also would like to expressed our sincere thanks and appreciation to UNFPA representative to Lao PDR for your closed support and both technical and financial assistant, as well as international and local consultants in provided technical expertise and comments that we completion of the Standard Operating Procedures for Health Facility Response to VAW.

STANDARD OPERATING PROCEDURES

PART 1 INTRODUCTION

1.1 BACKGROUND

Violence has major harmful effects on women's health and well-being, including on their sexual and reproductive health and their mental health. Violence against women is a serious, but preventable, public health epidemic that is common worldwide. According to WHO estimates, globally approximately one woman in every 3 (35%) has experienced physical and/or sexual violence by an intimate partner or sexual violence by someone else at some point in their lives, most of this by intimate partners (WHO, 2013). Health services provide a unique resource to identify women subjected to violence, provide them with appropriate care, connect them to other support services and, potentially, contribute to preventing future harm. All women are likely to come in contact with health services at some point in their lives. Women subjected to violence are more likely to seek health services in general, often for conditions linked to violence, even if in most cases they do not disclose the violence. For those who do seek professional help for violence, health-care providers are often women's first and most trusted point of professional contact.

Violence against women also has harmful effects on their children's mental and physical health. Furthermore, growing up in a household with violence may lead to violence in later life. Boys who witness intimate partner violence at home are more likely to perpetrate violence later in life, and girls with childhood exposure to intimate partner violence are more likely to experience violence in later relationships, although this is not an inevitable outcome.

In Lao PDR, violence against women and children also still exists in society. The 2014 national prevalence study 'Women's Health and Life Experiences' found that in Lao PDR 11.6% of women have been physically abused by their husbands or intimate partners, 26.2% have been emotionally abused, 7.2% have been sexually abused, (12.9% of young people aged between 15-19). Physical and sexual abuses against women cover 15.3%, out of which 4.2% who have been physically abused and 5.3% sexually abused were girls aged 15 by other people. It is also highly likely that these statistics are under-reported.

To tackle this issue, the Government of Lao PDR prioritizes prevention on violence against women and children as an important issue, adopting and implementing policies, laws and regulations such as Law on the Development and Protection of Women 2004, Law on Prevention and Combating Violence against Women and Children 2014 (The Law), National Plan of Action on the Prevention and Elimination of Violence against Women and Violence against Children from 2014-2020 and 2021-2025. In addition, Lao PDR has become a signatory State to many international Conventions pertaining to the protection of the rights and interests of women and children, i.e. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on the Rights of the Child (CRC), Beijing Platform and Action Plan, and the ASEAN Declaration on the Elimination of Violence Against Women and Elimination of Violence Against Children.

PART 2 PURPOSE OF SOP

These Standard Operating Procedures (SOP) lay down the steps to follow in any health facility in Lao PDR for responding to women and girls disclosing (or otherwise suspected of experiencing) violence. The scope of the SOP includes infrastructural requirements, and standards for the provision of clinical care, that is womensurvivor-centered and effective. These are useful for any level of health facility as survivors may enter the system at any of the facilities

The purpose of this SOP is to provide an overall framework and outline procedures for the approach of health facilities to respond to VAW. The SOP defines standards of care for the provision of care for survivors/victims of sexual and physical violence. It demystifies the medical care, and can be used for training of in-service health care providers and can be included in medical and nursing education. It can also be used as a monitoring tool by health systems to assess quality of care.

PART 3 TERMS AND DEFINITIONS/EXPLANATIONS

Gender-based Violence (GBV) - Based on the Law of Lao PDR the definition of violence against women and children is any behaviour that results in or is likely to result in danger, harm, physical, psychological, sexual, property or economic suffering to women and children (article 2, Law on Preventing and Combating Violence Against Women and Children 2014).

The UN definitions further expands this definition and states “that violence against women as any act of gender-based violence … that occurs in public or private life”.

Internationally, “gender-based violence” is known as an umbrella term for violence directed toward or disproportionately affecting someone because of their actual or perceived gender identity. The term “gender-based violence” (GBV) is primarily used to underscore the fact that structural, gender-based power differentials around the world place women and girls at risk for multiple forms of violence. This includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty, whether occurring in public or private life. While women and girls suffer disproportionately from GBV, men and boys can also be targeted. The term is also used by some actors to describe targeted violence against lesbian, gay, bisexual, transgender, and intersex (LGBTI) populations, in these cases when referencing violence related to norms of masculinity/ femininity and/or gender norms.

Violence Against Women is any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women. This includes threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

Physical Violence includes acts such as slapping, hitting, kicking, beating, pushing, strangling or hurting with a weapon.

Psychological Violence – is an act, negligence or neglect that has an [adverse] psychological effect on women and children such as having many wife, insults, gossip, defamation, scorn, humiliation, undervaluing, adultery, neglect, bias, discrimination, separation from friends or family, disrespectful, defamation, preventing someone from doing something, coercion or threats that harm [a person's] reputation, dignity, shame, self-esteem, cause mental health problems, trauma or suicide.

Sexual Violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including, but not limited to, home and work. It includes sexual assault or rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object.

Property and economic violence: is an act, negligence or neglect that results in damaging property of family, property that belongs to a co-owner, property of individual women and children, or results in damaging the opportunity to earn an income or other economic benefits such as destruct, burning, house and materials destroying, hiding; illegal possession, transfer, use and division [of a person's property or money]; paying low wages for labour or apply the policy unequally compared to men, preventing [women and children] from participation or operation in any work/activity even that women and children has capacity to do and are in a condition to be able to do.

Gender Identity - Individual's preferred gender role and presentation, as masculine, feminine, both or neither. Gender identity therefore is not determined by chromosomal or anatomical sex of a person.

Genetic Sex and Anatomical Sex - Genetic sex refers to a person's sex chromosomes and anatomical sex refers to genitalia and gonads. It is assumed that appearance of genitalia corresponds to an individual's chromosomal pattern, eg. the Karyotype 46XX goes with the presence of ovaries, uterus and vagina, etc. However, this is not the case with those who are intersex, wherein an individual's anatomical presentation is at variance with chromosomal pattern.

Marginalized Group –Marginalized populations are groups and communities that experience discrimination and exclusion (social, political and economic) because of unequal power relationships across economic, political, social and cultural dimensions.

Sexual orientation - Individual's sexual and/or romantic preference, whether homosexual, heterosexual, asexual, bisexual etc.

Note: sexuality is a spectrum and there is a notion of fluidity of orientation that should be understood by healthcare practitioners.

Homosexuality - a romantic attraction, sexual attraction, or sexual behavior between members of the same sex or gender. As a sexual orientation, homosexuality is "an enduring pattern of emotional, romantic, and/or sexual attractions" to people of the same sex

- Lesbian - A woman who is attracted to other women.
- Gays/Homosexual - A man who is attracted towards other men.
- Bisexual - A person is attracted to both men and women.

Transgender - Individuals whose lived gender identity does not conform to their physiological appearance. It includes cultural categories such as ka tuey and "ladyboys" as well as transitioning or post-operative transpersons. Transgender people may identify with either male or female gender identity, both, or neither.

Informed consent/assent: The foundation of a survivor centered approach is that the victim-survivor is provided information about options, their risks and benefits, and can make their own decision about services they choose to accept.
Adult and child victims have different needs and capacity for decision-making. Adult women have full authority to make decisions for themselves, and have the right to refuse services. This is called informed consent. For children and adolescent, they should be provided information on the processes, but depending on their age and capacity, the final decisions about services, examinations, care and referrals may rest with an adult caregiver/guardian.

Intersex - Non-conformity of an individual's body to prevalent ideas of maleness and femaleness. It is used as a blanket term for different biological possibilities and variations which may include, for instance, a large clitoris, absence of vagina, congenital absence of gonads among others.

Sex work - Is broadly defined as the exchange of money or goods in lieu of sexual services, either regularly or occasionally, involving female, male, and transgender adults.

Perpetrator: a person who commits an act, negligence or neglect that results in physical, psychological, sexual, property or economic damage to women and children (Law on Preventing and Combating Violence Against Women and Children 2014).

Survivor - Survivor is a term for the individual who is subject to violence to abuse. Sometimes they may be referred to as victims. The term "survivor" is preferred to the term "victim" to reinforce the agency and empowerment of affected women and girls. The use of the term "victim" should be used, however, in legal and court situations.[1]

It is noted that for the purposes of the Health SOP, the term "victim-survivor" will be used, to align with the terminology ("victim") used in Law on Preventing and Combating Violence against Women and Children 2014, as well as the preferred empowering term "survivor" which recognises that the person has agency and is capable of making decisions, despite the humiliation, degradation or traumitisation they have experienced.

[1] International Commission for Jurists. Women's Access to Justice for Gender-Based Violence: A Practitioners' Guide, No. 12. 2016. (Geneva).

First -Line Support refers to the minimum level of psychological support and validation to be given by a health care provider (HCP) to all women who disclose violence.
LIVES – Add short definition for LIVES.

Mandatory Reporting refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of known or suspected domestic violence or intimate partner violence. In many countries mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Women Centered Care - refers to services that are delivered in a way that respects the wishes, choices and autonomy of the woman; respects her dignity; is sensitive to her needs and perspectives; and respects and promotes her right to privacy, confidentiality and informed consent. It is underpinned by the principles of women's human rights and gender equality.

Mental Health and Psychosocial Support (MHPSS): The composite term mental health and psychosocial support is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.[2]

The World Health Organization (WHO) conceptualizes mental health as a "state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

PART 4 FRAMEWORK FOR THE SOP

4.1 GUIDING PRINCIPLES

4.1.1 Survivor-centered approach. A survivor-centered approach to violence against women seeks to empower the survivor by prioritizing their rights, needs and wishes. It means that any engagement (response or prevention) priorities the safety, autonomous decision-making, consent, and confidentiality of the survivor. It also means ensuring that survivors have access to appropriate, accessible and good quality services including:

- Healthcare,
- Psychological and social support,
- Security, and
- Legal services.

Placing the rights, needs and desires of women at the centre of focus of service delivery. This requires the consideration of the multiple needs of victims and survivors, the various risks and vulnerabilities, the impact of decisions and actions taken and ensures that actions are tailored to the unique requirements of each individual woman and responds to her wishes.

[2] IASC, Guidelines on mental health and psychosocial support in emergency settings, 2007.

4.1.2 A rights-based approach. Women's human rights are set forth in international human rights agreements. Your country has signed many of these agreements. These rights include the right
to:

- Life – a life free from fear and violence;
- Self-determination – being entitled to make their own decisions including sexual and reproductive decisions; entitled to refuse medical procedures and/or take legal action;
- The highest attainable standard of health – health services of good quality, available, accessible and acceptable to women;
- Non-discrimination – health care services offered without discrimination, and treatment is not refused based on race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation, or political beliefs;
- Privacy and confidentiality – provision of care, treatment, and counselling that is private and confidential; information disclosed only with the consent of the woman;
- Information – the right to know what information has been collected about their health and have access to this information, including their medical records.

Treat all women in a fair and respectful way and do not discriminate. Also, recognize that a woman may face multiple forms of discrimination – not only because she is a woman, but also because of her race, ethnicity, caste, sexual orientation, religion, disability, or other characteristics – or because she has been subjected to violence.

4.1.3 Gender sensitivity and equality.

Gender sensitivity means being aware of how differences in power between women and men determine the way that men and women treat each other, their access to resources to protect their health and often how the health system treats them.

Assuring gender equality in health means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy.

It is important to understand that: violence against women is rooted in unequal power between women and men; that women may have less access than men to resources, such as money or information, and they may not have the freedom to make decisions for themselves; women may be blamed and stigmatized for violence and may feel shame and low self-esteem.

In your practice: As a provider, you must at a minimum avoid reinforcing these inequalities and promote women's autonomy and dignity by:

- being aware of the power dynamics and norms that perpetuate violence against women
- reinforcing her value as a person
- respecting her dignity
- listening to her story, believing her, and taking what she says seriously
- not blaming or judging her
- providing information and counselling that helps her to make her own decisions.

4.2. UNDERSTANDING GBV/VAW

Violence against women, girls and the LGBTI community is a major issue in the health sector, and it is a global public health problem. The root cause of violence against women is gender inequality and the unequal power dynamics between men and women—women may have less access than men to resources, such as money or information, and they may not have the freedom to make decisions for themselves; women may be blamed and stigmatized for violence and may feel shame and low self-esteem as a result of experiencing violence. In this way, violence against women is both a cause of gender inequality, as well as perpetuates gender inequality.

Violence against women is a violation of human rights. Women subjected to violence have the rights to receive the highest standards of health care services. Health care providers have an obligation to exercise this right, and they are in a special position to assist women who have been abused. They can create a secure and confidential environment to facilitate the disclosure of violence information and provide assistance, with compassion, appropriate treatment, and give referrals to other services and resources.

By strengthening response services, victim-survivors are treated with the dignity they deserve, receive quality care, feel supported by their institutions and feel empowered.

4.3 TWO FORMS OF VIOLENCE BASED ON THE LAO LAW:

1. Violence against women and children by a member of the family: is any act, negligence or neglectby a family member that results in physical, psychological, sexual, propertyor economicharm or suffering to women and children who arefamily members irrespective of the setting in which that violence occurs.

2. Violence against women and children by other people: is any act, negligence or neglect by individuals, [or] a group of people who are not family members including authorities and staff members that results in physical, psychologiFcal, sexual, property or economic harm or suffering to women and children in the community setting, public setting, workplaces, educational setting, alternative care setting and other places

PART 5 GUIDELINES FOR ESSENTIAL HEALTH SERVICES [3]

5.1 INFRASTRUCTURE, EQUIPMENT, AND COMMODITIES

The facility should ensure the availability of the following infrastructure, equipment and commodities to provide appropriate care in cases of violence against women (VAW) and girls.

Below is a checklist for you to assess what additional infrastructure or supplies you may need.

Infrastructure and equipment	Yes	No
Private consultation/examination room (patient cannot be seen or heard from outside) that is clean and comfortable		
Toilet or latrine that can be locked from the inside with disposal bin and water supply		
Drinking water inside the private room		
Furniture and supplies	**Yes**	**No**

[3] Article 9-11, *Law on Preventing and Combating Violence Against Women and Children* 2014.

Chairs for victim-survivor, companion, and provider		
Table or desk		
Door, curtain or screen for visual privacy during examination		
Examination Table		
Washable or disposable cover for examination table		
Adequate light source in examination room		
Angle lamp or torch/flashlight for pelvic exam		
Lockable cabinet, room or other unit for secure storage of patient paper files/register		
Lockable medical supply cabinet or lockable room where medical supplies are kept		

Essential drugs and commodities	Yes	No
HIV test kit		
SAFE (Sexual Assault Forensic Evidence) Kits/Rape Kits		
Pregnancy tests		
Emergency contraception pills or IUCD		
HIV post-exposure prophylactics as per country protocol		
Drugs for treatment of Sexually Transmitted Infections (STIs)		
Drugs for pain relief (e.g. paracetamol)		
Local anesthetic for suturing		
Broad-spectrum antibiotics for wound care		
Tetanus Vaccine		

Medical facilities should also ensure the following protocol and guidelines are easily accessible to staff:

- Job aids in language of provider and client population (LIVES and Signs and Symptoms associated with VAW)
- Guidelines and protocols for medico-legal care for survivors/victims of sexual violence
- Register for documentation and register for counseling

5.2 PRIVACY, CONSENT, CONFIDENTIALITY, SECURITY OF RECORDS

5.2.1 Privacy

A private area is designed as a facility room or area where the patient cannot be seen or heard from outside, allowing counseling and clinical services to be provided in private. History of incident and abuse shall be taken in this private area where patient cannot be seen or heard from outside.

If the victim-survivor is accompanied by relatives, the health provider will create an opportunity (such as asking relatives to bring materials) to speak to the victim-survivor alone.

5.2.2 Consent

In case of disclosure of violence, the provider should seek the victim-survivor's consent to proceed with information provision and services (ensuring privacy as described above) for violence.

Oral consent to be sought for those above 10 years, and for those less than 10 years consent of the parent/guardian to be sought, according to the *Law on Preventing and Combating Violence Against Women and Children 2014.*

5.2.3 Confidentiality

Confidential documentation and record-keeping are vital to the safety of patients experiencing intimate partner or sexual violence. Before taking the history, service providers should explain any obligations to report the incident to the authorities and the limit of confidentiality (see Box 1 below on Mandatory Reporting), and then seek consent.

You must seek and attain consent separately before each step is taken:

1. Recording case history
2. Medical examination
3. Recording medico-legal evidence.

Box 1 : Mandatory reporting: When you must report incidents of GBV as a health care professional

Whilst mandatory reporting of VAW to the police by health service providers is not recommended by international standards, as it can discourage people from seeking help, it is important that you understand the requirements to do so under the law in Laos.

Article 29 of the Law on Preventing and Combatting Violence against Women and Children 2014 (VAWC Law) states: ***"If medical doctors, other health care professionals ... have seen or know about violence against women and children they must notify or report this to their own organization or to the police where the incidence occurred."***

You must provide this information about the requirement to report to the victim/survivor before you provide treatment, and give them the right to refuse treatment and reporting. Informed consent means the survivor is given all the information necessary to make the best decisions for them.

5.2.4 Security of records

Records to be kept secure

It is important to keep records that relate to GBV cases secure. Each facility should keep the following in a securely locked cupboard, locker or locked room:

- patient files
- medico-legal forms
- VAW register
- forensic evidence and
- any other documents with identifying information about the patient.

Security of records in practice:

- Staff members do not leave documents where a patient (unless requested), those accompanying the patient or anyone else might see them.
- When documenting information from women about their experience of violence, staff members avoid asking for or writing this information on records in a public place.
- Staff members do not write a notation indicating intimate partner violence or sexual violence on the first page of a record, which is more likely to be seen if flipped open.
- Any sensitive information that needs to be destroyed is to be shredded by an authorized staff member.

Secure storage of records:

- Designated place for storing file/register.
- Documents are locked up at all times.
- Only a limited number of designated staff members have access to patient records.
- Staff members who need access to records have received training on record confidentiality and storage practices.

5.3 FORENSIC EVIDENCE

5.3.1 Collection of forensic evidence

A. Forensic specimens[4]

The account of the assault will dictate whether and what specimens are collected. If in doubt, collect. Persistence of biological material is variable. It will be affected by time, activities (eg. washing) and contamination from other sources.

The maximum agreed time interval (time of assault to time of collection) for routine collection is:

- skin including bite marks – 72 hours; mouth – 12 hours;
- vagina – up to 5 days;
- anus – 48 hours;
- foreign material on objects (condom/clothing) – no time limit;
- urine (toxicology) 50 mL – up to 5 days
- blood (toxicology) 2 × 5 mL samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate.

Box 2 : Can all medical facilities collect forensic evidence?

This SOP can be used at any level of health facility, as victim-survivors may reach any of the facilities. The forensic evidence collection in cases of sexual violence does not require any high-tech infrastructure - any facility that carries out deliveries/childbirth can carry out a medico-legal examination of rape/sexual violence.

[4] Source: Strengthening the medico-legal response to sexual violence, WHO 2016 (https://www.who.int/publications/i/item/WHO-RHR-15.24).

Box 3 : When should you collect forensic evidence?

Collect forensic evidence 4 conditions are met:

1. The woman wants to go to the police, or it is mandatory
2. It is within the allocated time period, per section 5.3.1
3. The health-care provider is trained on how to collect medico-legal evidence
4. A forensic laboratory is available.

Consent must be obtained before collection of medico-legal evidence.

The 'two-finger test' must NOT be conducted for establishing rape / sexual violence; comments on the size of the vaginal introitus should NOT be made. This is both unscientific and illegal.

Medical facilities must establish a chain of custody for forensic evidence to be laid down: Who collects? Who seals? Where it is kept till the police collect it?

B. Collection of Samples for Central/ State Forensic Science Laboratory [5]

- After assessment of the case, determine what evidence needs to be collected. It would depend upon nature of assault, time lapsed between assault and examination and if the person has bathed/washed herself since the assault.
- If a woman reports within 96 hours (4 days) of the assault, all evidence including swabs must be collected, based on the nature of assault that has occurred. The likelihood of finding evidence after 72 hours (3 days) is greatly reduced; however, it is better to collect evidence up to 96 hours in case the victim-survivor may be unsure of the number of hours lapsed since the assault.
- The spermatozoa can be identified only for 72 hours after assault. So if a victim-survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent for tests for identifying semen.

To document the forensic examination, please see Annex 4 - Medico-Legal Examination Report of Sexual Violence

5.4 DOCUMENTATION AND HISTORY TAKING

Good management of documentation can ensure safety, wellbeing and health of the victim-survivor, and also contribute to attaining justice. Good documentation is key to providing quality care, referral processes and legal proceedings. Additionally, good documentation by health-care providers can help managers and policy-makers to monitor programme quality and, therefore, can be the basis for improving service delivery. Safety, confidentiality and privacy are essential.

[5] Guidelines and Protocols for medicolegal care for survivors/victims of sexual violence, 2014Ministry of Health, Government of India https://main.mohfw.gov.in/sites/default/files/953522324.pdf

Health managers and service providers should action the following:

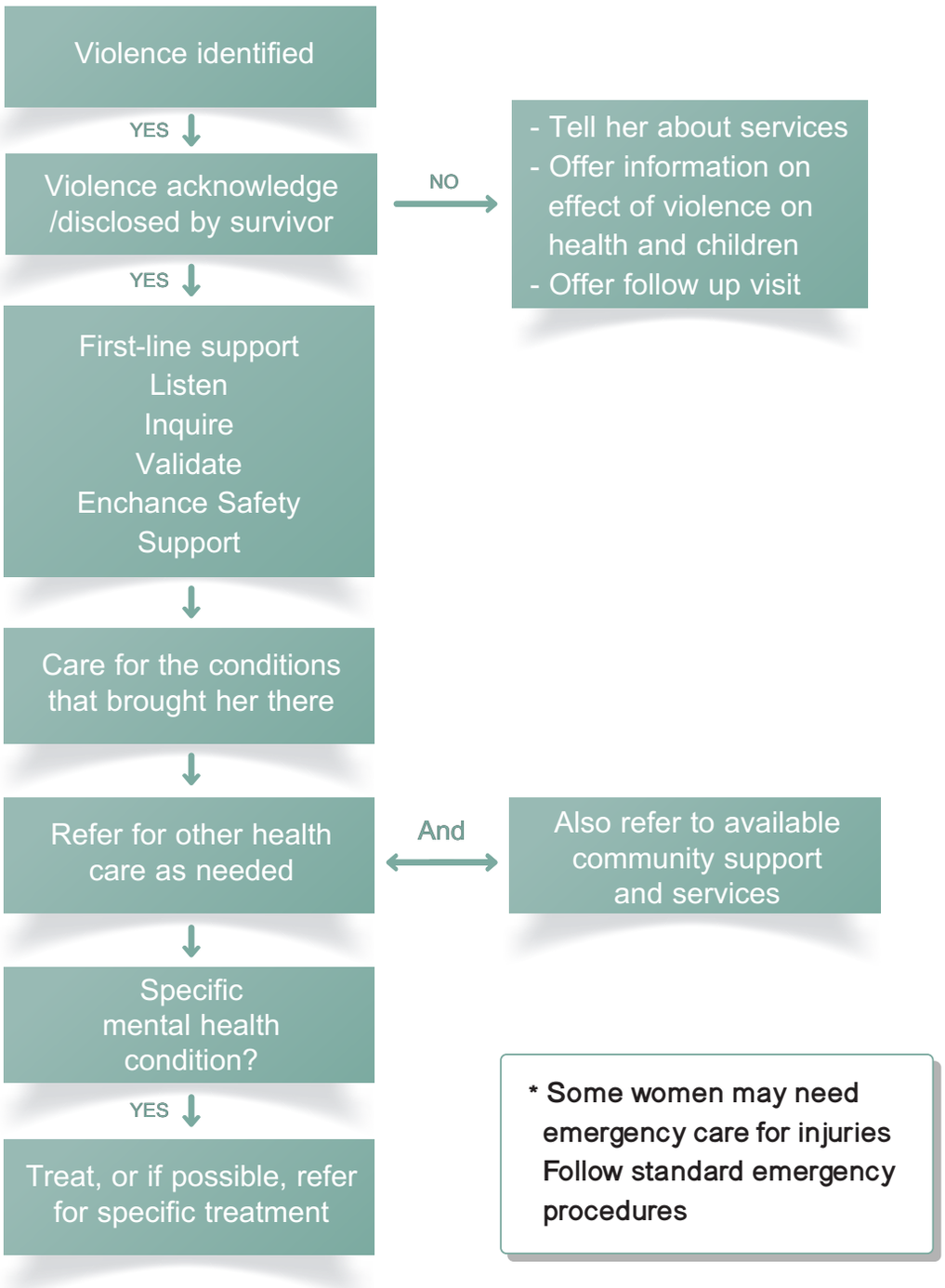
- Health managers need to establish SOPs and ensure it is accessible to the health service providers around the country.
- Develop easy-to-use forms to improve documentation
- Health service provider and staff who collect information should receive training on how to record and keep documents confidential and safe.
- Identify which information that you cannot observe or otherwise access for those who are not providing direct healthcare to victim-survivors of violence.
- Do not identify the victim-survivor's name on folders or any other documents that could be viewed by third parties-use code or symbol to identify the victim-survivor.
- Only permitted staff can have access to case documents, and that should be limited to a "need to know" basis.
- Destruction or deletion of sensitive information should be permitted by approved management.
- Facility has intake forms, chart forms, or registers that collect information about a patient's experience of violence and care.

5.4.1 Documentation Procedure:

1. IPD, OPD, MLC number to be recorded
2. "If brought by police then letter number, reference number, offences registered to be recorded.If brought by police then letter number, CR number, IPC sections to be recorded
3. Date and time of arrival at hospital to be recorded
4. Contact number of victim-survivor to be recorded
5. Safe address of victim-survivor to be noted (first place she would go in case of violence), alongside the present address.

See Annex 1 - Sample VAW Documentation Register

5.5 FLOW CHART OF HEALTH RESPONSE TO VICTIM-SURVIVORS



5.6 IDENTIFYING AND SCREENING FOR CASES OF GBV

Given the expertise and experience of clinicians/health professionals, it is important for front-line health workers, such as doctors, nurses and midwives, to be able to implement themini mum standards of GBV response, such as be able to identify symptoms of GBV, and be equipped to sensitively and ethically ask questions to allow a victim-survivor to disclose.

Health service providers have a very important role in providing information to the victim-survivor, building trust and effectively communicating with the victim-survivor.

5.6.1 How to identify whether a patient may be experiencing violence

Women subjected to GBV often seek health care for related emotional or physical conditions, including injuries and symptoms of stress. Their health problems may be caused by the violence or made worse by it. They may be facing ongoing abuse at home, or they may still be affected by abuse that occurred in the past. Often, a patient will not tell you about the violence due to shame or fear of being judged, or fear of their partner. You may suspect that a patient has been subjected to GBV or DV/IPV if she has any of the following:

- injuries that are repeated or not well explained
- repeated sexually transmitted infections (STIs)
- Bruising, bites, burns or other harsh markings on the face or body
- multiple unintended pregnancies miscarriages or unsafe abortions;
- unexplained chronic pain or conditions (e.g. pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches) repeated health consultations with no clear diagnosis
- ongoing emotional issues, such as stress, anxiety, trouble sleeping, lacking energy, avoiding friends and family, changes in eating habits or depression
- harmful behaviours, such as misuse of alcohol or drugs thoughts, plans or acts of self-harm or (attempted) suicide.

IMPORTANT! It is not recommended to conduct universal routine screening for intimate partner/domestic violence of all women attending health-care services. Instead, health-care providers are encouraged to have a high level of awareness of the issue and raise it with women who have injuries or conditions that they suspect may be related to violence.

Remember to be alert at times of higher risk, for example when the patient is pregnant, or during emergencies, disasters or conflict contexts.

You may also suspect a problem of violence if a woman's partner or husband is intrusive during consultations, if she often misses her own or her children's health-care appointments, or if her children have emotional and behavioural problems.

5.6.2 What to do if you suspect violence

If you are treating a woman at your healthcare facility and suspect that she may have experienced GBV (or it is ongoing), there are safe and supportive ways that you can start a conversation with her (see the box below).

Before speaking to a patient about GBV, consider the following:

- Never raise the issue of GBV unless a woman is alone. Even if she is with another woman, that woman could be the mother or sister of an abuser.
- If you do ask her about violence, do it in an empathic, non-judgemental manner.
- Use language that is appropriate and relevant to the culture and community you are working in.
- Where possible, use the words that women themselves use. Women in Laos may not articulate their experience as violence or abuse against them, but are more likely to describe the action eg. "My husband kicked me" or "My husband hit me with a stick when he was angry".

Box 4 : Script examples of how you can raise the issue of violence with a patient you suspect may been suspect to violence

Here are some phrases you can use to raise the topic of violence before discussing the question directly:

- "Is there anything you are concerned about at home?"
- "Many women have problems with people they live with at home, such as husbands or relatives that support the husband's behavior. Do you feel safe at home?"
- "What happens if you argue with him? What happens if he gets angry?"

Here are some simple, straightforward questions you can start with, which show that you are open to discussing sensitive topics :

- Depending on answers, keep asking questions and listen to story. If answer "yes" to any of the following questions, propose initial help.
- Are you afraid of your husband (or partner)?"
- Has your husband (or partner) or anyone in the house ever threatened to hurt you or physically abuse you in some way? If so, when did it happen?"
- Does your husband (or partner) or anyone else in the house bully or insult you?"
- Does your husband (or partner) try to control you, for example, by not allowing you to keep the money or leaving home?"
- Does your husband (or partner) force you to have sex or force you to have sexual contact when you do not want to?"
- Does your husband (or partner) threat that he will kill you?"

What to do if you suspect violence, but they do not disclose:

- Do not put pressure on her. Give her time to decide what she wants to tell you.
- Tell her about the available services if she chooses to use them.
- Provide information on the impact of violence on the health of women and their children.
- Offer to schedule another follow-up appointment.

5.7 FIRST-LINE SUPPORT AND SAFETY PLANNING

5.7.1 First-line support

Victim-survivors of violence are often silenced by abusers, family members, others in the community – and even healthcare providers. It is very important you actively listen and support the victim-survivor if they disclose violence to you, to ensure you do not re-traumatise them. You can do this by providing first-line support using the LIVES approach.

First-line support includes basic counselling or psychosocial support that can be implemented using the LIVES approach, which involves:

- **Listening:** Listen closely, with empathy, not judging
- **Inquiring** about needs and concerns: Assess and respond to her needs and concerns – emotional, physical, social, and practical
- **Validate** the victim-survivors' experience: Show that you believe and understand her, for example say "It was very brave of you to tell me your story".
- **Enhance** her safety: Discuss how to protect her from further harm and create a safety plan if necessary
- **Support** her by providing information about her options, connect her with services and social support.

The above will be provided to all patients at the facility. Effective listening and LIVES can be powerful healing tools. For some, they are sufficient. For others, more services will be required.

Box 5 : Questions to assess the immediate risk of violence

Women who answer "yes" to at least three of the following questions may be at an especially high immediate risk of violence.

- Has the physical violence happened more often or become worse over the past six months?
- Has the violence increased in severity or intensity over the years?
- Has he threatened to remarry?
- Has he ever used a weapon or threatened you with a weapon?
- Has he ever tried to strangle you?
- Do you believe he could kill you?
- Has he ever beaten you when you were pregnant?
- Is he aggressively and constantly jealous of you?
- Have you thought of committing suicide? If yes, have you attempted it, or do you have any plan of committing suicide?

5.7.2 Safety assessment and safety plan

A safety assessment and a safety plan needs to be done for all victim-survivors. The table below provides elements of a safety plan and questions you can ask the patient to help them make a plan. The basic principle that "the victim-survivor knows their reality best and should be empowered to lead the development of this plan" should be adhered to. Safety planning can involve developing a plan for separating from an abusive spouse, or taking measures to increase a victim-survivor's safety

Box 6: Developing a safety plan
Adapted from WHO Clinical Handbook (Field-testing version), 2014.

Elements of safety plan	Question to ask the victim-survivor to help them to make a safety plan
Safe place	If you needed to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you? (If the patient has children) How will you get there?
Transport	What documents, keys, money, clothes, phone, telephone numbers or other things would you take with you when you leave?
Items to take with you	Can you put these essential items in a safe place or leave them with someone you trust outside of your home, just in case?
Financial	Do you have access to money if you need to leave in an emergency?
Support	Is there a neighbor you can tell to call the police or bring assistance if they hear sounds of violence coming from your home?

5.8 PROVIDING TREATMENT AND CARE FOR PHYSICAL INJURIES

Treat physical injuries or refer. Immediately refer patients with life-threatening or severe conditions for emergency treatment. Complications that may require urgent hospitalization:

- extensive injury (to genital region, head, chest or abdomen)
- neurological deficits (for example, cannot speak, problems walking)
- respiratory distress
- swelling of joints on one side of the body (septic arthritis).

Patients with less severe injuries – for example, superficial wounds – can usually be treated on site. Clean and treat any wounds as necessary.

The following medications may be indicated:

- antibiotics to prevent wound infection
- a tetanus booster or vaccination (according to local protocols)
- medications for relief of pain
- medication for insomnia (for use in exceptional cases).

5.9 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Every patient who discloses their experience of violence will need first-line support (LIVES), as well as mental health and psychosocial support. In Laos, there are limited options for specialized mental health services. However, frontline healthcare providers can offer basic psychosocial support, also known as Psychological First Aid (PFA), and mental health education. PFA involves stress reduction exercises and activities, as well as to help strengthen the patient's positive coping methods, social support and reducing stress.

Most victim-survivors can be supported by building basic skills in dealing with and providing care related to stress issues. Some women might need additional assessment and treatment from specialists for mental problems symptoms.

Medical staff will need to assess the emotional status of the victim-survivor, to determine whether they have moderate-severe stress or mental health symptoms such as depression, anxiety or PTSD. For more severe mental health issues, such as, moderate to severe depression or post-traumatic stress disorder (PTSD) might need to be referred to the mental health specialist (for example, a psychiatrist or psychologist.

Box 7 : General principles – Mental Health and Psychosocial Support

Be cautious when involving family members and caregivers in mental health assessment and care. Family members and caregivers are often involved in the care and support of people with mental health problems and can be an important source of support. However, some caregivers or family members may be unsupportive, may not keep information confidential, or may be perpetrators of IPV or sexual violence. It can be helpful to involve supportive and "non-offending" family members if the victim-survivor consents, for example a trusted friend.

Involve the woman as much as possible. Even if the woman's functioning is impaired and supportive family members are present, always involve her in the discussion as much as possible. This is in line with the survivor-centred approach.

Explain the limits of confidentiality. Let the woman know that you will maintain confidentiality, except when you perceive a risk to her (e.g. suicide or self-harm) or to others, or if there are legal requirements (see box on Mandatory Reporting on page 10).

5.9.1 Assessing the status of a victim-survivor's mental health

Pay attention to her mental health status, including:

- overall appearance (e.g. taking care of her appearance)
- behaviour (e.g. agitation)
- facial expression, mood (e.g. crying, anxious, without expression)
- body language (e.g. posture, eye contact)
- speech (e.g. fast, slow, silent) and thoughts (e.g. recurrent memories).

Ask general questions about how she is feeling and what her emotions are while taking her history; for example:

- How do you feel?
- Are you having any difficulties coping with daily life?
- To what extent are your difficulties affecting your life, such as relationships with family and friends, or your work or other activities?

5.9.2 Provide information about normal stress reactions to an experience of violence

Normalising the victim-survivor's experience can bring relief to survivors and help them to cope better. Health-care providers should let victim-survivors know the following:

- Most women who have been exposed to violence experience symptoms of emotional distress.
- These reactions are normal and common in people who are have gone through a stressful and frightening experience.
- In most cases, these reactions to an experience of violence will improve over time and she is likely to feel better, especially if she has received practical and emotional support from others.

5.9.3 Address current psychosocial stressors

Identify and discuss issues that are causing stress and having an impact on the victim-survivor's life. Ask:

- What is your biggest worry these days? What are your most serious problems right now?
- How are these problems or worries affecting you?

Assist her to manage stressors:

- Explore and strengthen the victim-survivor's social supports and coping methods.
- Teach stress-management techniques, such as relaxation exercises.
- Work with her to identify potential solutions and coping strategies. In general, do not give direct advice. Encourage the woman to find her own solutions.
- Discuss possible referrals to relevant agencies and community resources.

5.9.4 Explore and strengthen positive coping methods

A victim-survivor's experience of violence can make it more difficult to engage in day-to-day tasks. Talk to her about her life and activities and about how she is coping. Ask: `

- How has (the violence) been affecting you?
- How do you deal/cope with these problems day by day? Explore positive coping strategies that are feasible for her, in a supportive and non-judgemental manner.

Encourage the victim-survivor to:

- build on her strengths and abilities (e.g. ask what is going well currently and how she has coped with difficult situations in the past)
- continue activities, especially ones that she used to find interesting or pleasurable
- engage in relaxing activities to reduce anxiety and tension (e.g. walk, sing, go to the temple, play with children)
- spend time with friends and family who are supportive and avoid isolating herself
- try to engage in regular physical activity
- try to keep a regular sleep schedule and avoid sleeping too much
- avoid using self-prescribed medications, alcohol or illegal drugs to try to feel better.

5.9.5 Stress reduction and relaxation exercises

Box 8 : Two Psychological First Aid exercises healthcare providers can do with their patients

Option A: Slow breathing technique (10 minutes)

- Try to close your eyes. Sit with your feet flat on the floor.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Then breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

Option B: Progressive muscle relaxation technique (10 minutes)

- Curl your toes and hold the muscles tightly. Breathe deeply and count to 3 while holding your toe muscles tight. Then, relax your toes and let out your breath.
- Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count 1-2-3, and then relax and breathe out slowly.
- Hold your leg and thigh muscles tight… 1–2–3
- Hold your belly tight…1–2–3
- Make fists with your hands…1–2–3
- Bend your arms at the elbows and hold your arms tight…1–2–3
- Squeeze your shoulder blades together…1–2–3
- Shrug your shoulders as high as you can…1–2–3
- Tighten all the muscles in your face….1–2–3
- Drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this again. And again one more time. Now, go the other way. Inhale to the left and back, exhale to the right and down. Do this again. And again one more time.
- Then bring your head up to the centre. Notice how calm you feel.

Healthcare providers should practice the stress reduction and relaxation exercises in Box 8 above, and be able to conduct them with victim-survivors who are presenting as very distressed (eg. highly agitated, hyperventilating etc), or as a coping mechanism. The techniques are also good for self-care for medical staff, who are at risk of vicarious trauma and exposure to stress as frontline workers.

5.10 CLINICAL CARE FOR SEXUAL ASSAULT/RAPE VICTIM-SURVIVORS

Clinicians should develop specific skills to provide clinical care and management to victim-survivors of rape, based on the Laos context, presentations and the patient's specific needs. It is very important in each health facility that first-line support meets standards to record accurate information about rape and management of rape cases.

You need to provide specific information and options on family planning and safe birth control eg. emergency contraceptive pill. For patients living with HIV Aids, they need specific information on how to disclose this information and how to discuss with their partners and potential partners for having safe sex.

Clinicians should develop specific skills to provide clinical care and management to victim-survivors of sexual assault and rape, based on the Laos context, presentations and her specific needs. It is very important in each health facility that first-line support meets standards to record accurate information about rape and management of rape cases.

You will also need to provide specific information and options on family planning and safe birth control eg. emergency contraceptive pill. For women living with HIV Aids, they need specific information on how to disclose this information and how to discuss with their partners and potential partners for having safe sex.

Provide emergency contraception

If emergency contraception (EC) is used soon after sexual assault, it can help a woman avoid pregnancy. Offer EC to any woman who has been sexually assaulted along with counselling so that she can make an informed decision

Prevent sexually transmitted infections

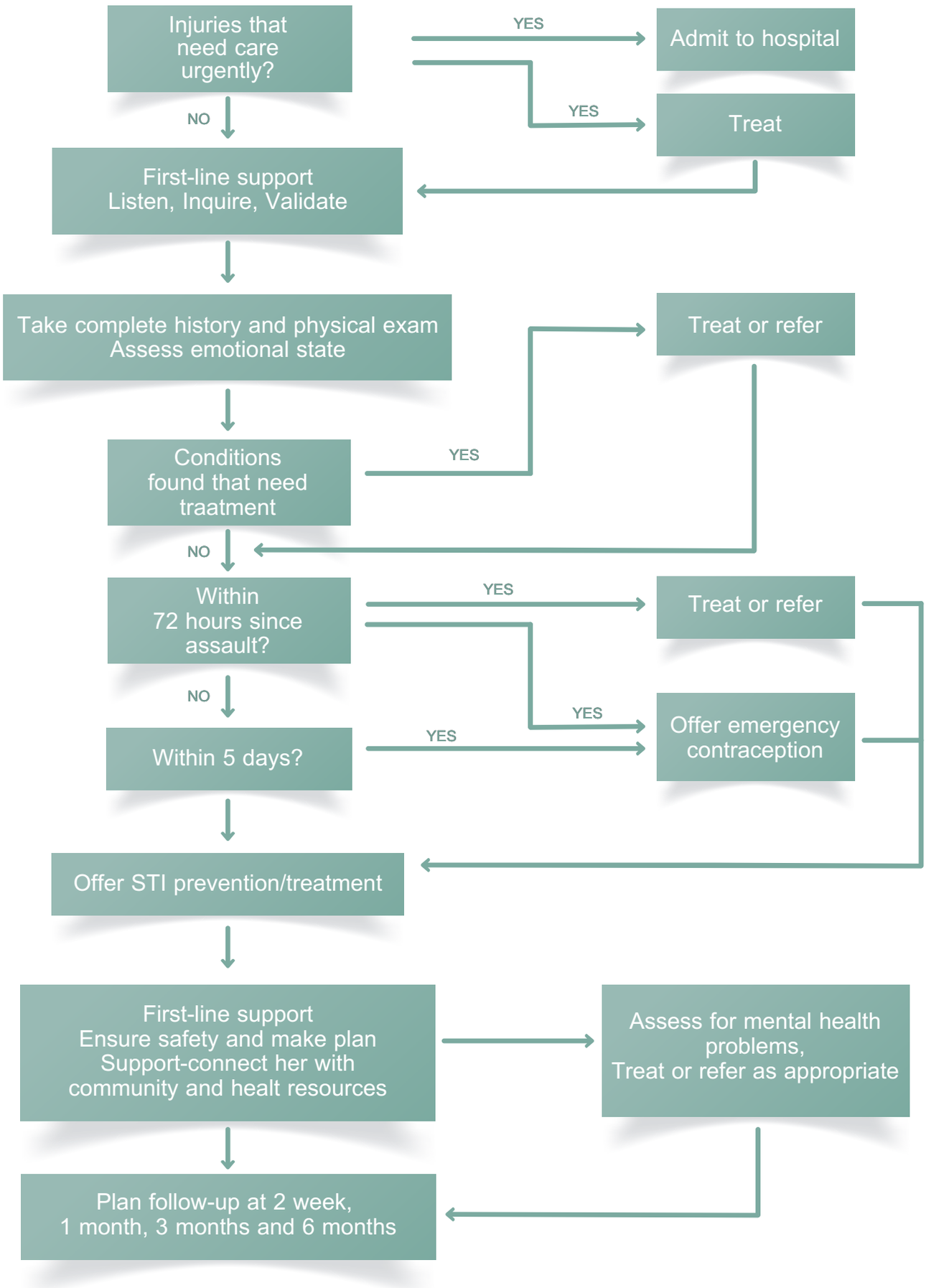
Women who have been sexually assaulted should be given antibiotics to prevent and treat the following sexually transmitted infections (STIs)—chlamydia, gonorrhoea, trichomonas and, if common in the area, syphilis.

- Offer STI treatment on your first meeting with the woman.
- There is no need to test for STIs before treating.
- Give preventive treatment for STIs common in the area (for example, chancroid).
- Give the shorteFst courses available in the local or national protocol, as these are easiest to take.

Prevent HIV

Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. Talk to the woman about whether HIV PEP is appropriate in her situation.
(WHO Clinical Handbook,)

Flow Chart for Clinical Care for Sexual Assault/Rape Survivors



Box 9 : What NOT to do as a healthcare provider responding to violence

For cases of sexual violence, health care providers MUST NOT do the following:

- Two finger test: The 'two-finger test' must NOT be conducted for establishing rape / sexual violence; comments on the size of the vaginal introitus should NOT be made. This is both unscientific and illegal.
- A PV (per vaginal) or a PS (per speculum) examination: PS or PV examination should NOT be routinely done for all survivors of rape / sexual assault; it should be done only when clinically indicated.
- Comment on torn / intact status of the hymen: The status of the hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding, masturbation, etc. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse. Hymen should therefore be treated like any other part of the genitals while documenting findings in cases of sexual violence. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented. Comments such as “Hymen present / hymen intact / old tear to hymen” should not be made.
- Delay treatment or medicolegal examination: When a survivor approaches a hospital and discloses history of sexual violence to a health care provider it is his / her responsibility to ensure prompt / without delay. Treatment should not be conditional upon registration of police complaint.
- Comment on past sexual history: Doctors should not comment on any sexual history not related to the present episode of sexual violence.

For cases of domestic violence, health care providers MUST NOT do the following:

- Ask for history of domestic violence in presence of other members of family or other patients (persons who are not part of medical team).
- Express disbelief, make judgmental comments on history of violence reported by the survivor.
- Interrupt a woman narrating history of domestic violence (saying she should limit to the present health complaint and not how it came about unless asked).
- Disregard any reporting of domestic violence as non-significant or minor.
- Blame the survivor for violence
- Try to justify the abuser’s point of view
- Shame her for her actions including attempted suicide, running away from home, leaving the children behind and leaving home etc.
- Advise her to tolerate it
- Convey a message that life free from violence is not possible / domestic violence is part of life and needs to be accepted.
- Delay treatment or registration of medico-legal documentation: When a survivor approaches a hospital and discloses history of violence to a health care provider it is his / her responsibility to ensure prompt treatment / treatment without delay. Treatment should not be conditional upon registration of police complaint.
- Get angry at her if she refuses help offered in the form of referral to police, shelter, legal assistance etc.
  Intervene on the spot especially by scolding, using stern language with abusive partner / relative – this may further aggravate the situation.
- Turn the woman away, scold her for not taking timely action despite advices if she comes the second (or nth number of) time with the same medical complaint related directly to the violence she faces.
- Force her to register a police complaint or comply with the advices provided to her
- Let the abusive partner / relatives accompany the survivor while she is admitted to the hospital. (For some reason if this becomes necessary, the relative should be asked to wait outside the ward)
- Deny emergency shelter at the hospital to survivor and her small child.

PART 6 RESPONDING TO MARGINALISED AND AT-RISK GROUPS [6]

This section aims to alert health professionals to the specific health care needs of different marginalised groups and equip them to respond to them in an appropriate, comprehensive and sensitive manner in a difficult situation. These guidelines stem from a recognition of the historical stigmatization faced by marginalised groups in accessing health services.

For the purpose of these guidelines, marginalised groups and/or at-risk groups are defined as:

1. Transgender and intersex individuals [7]
2. Those of diverse sexual orientation
3. Individuals who are involved in sex work or in the sex industry
4. Individuals with physical, psycho social and/or intellectual disability
5. Individuals from diverse ethnic or religious groups
6. Marital status – single mothers and widows
7. Returning migrants especially women, girls & LGBTI.

Some of these groups are explained in further detail below regarding clinical management.

6.1 Guiding General Principles for Health Professionals while Working with Marginalised Groups

Guiding general principles for health professionals while working with marginalised and at-risk groups to provide personalised services

1. Complete medical treatment and health care must be offered right at the outset at all health facilities. Health professionals should ensure that they are not biased against people belonging to marginalised groups and must treat them with respect.
2. Health professionals must steer clear from demonstrating shock, disbelief, ridicule and ensure that such conduct does not seep into the doctor- patient relationship.
3. Health professionals must acknowledge challenges and obstacles faced by marginalised groups in accessing health services and create an enabling atmosphere for them in the health Facility.
4. Health professionals must enable victim-survivors to feel at ease to be able to reveal the abuse that they have faced.
5. There must be cultural sensitivity while carrying out medical procedures. Cultural sensitivity refers to a recognition of their ethnicity, class, community, religion-determined behavior and perceptions of the patient.
6. Individuals belonging to marginalised communities are often mistreated and ridiculed by the police. In many instances, complaints from marginalised communities do not even get recorded. Therefore efforts must be made by health professionals to collaborate with the allied agencies such as police to record the complaint at the health facility if victim-survivors express such a desire. Doing so at health institutions would be useful for victim-survivors from marginalised groups as health institutions are perceived as less intimidating compared to police stations
7. Health professionals must ensure that information on referral institutions providing good quality services is available.
8. Documenting information about the different marginalised groups accessing services helps with data collection (eg. the incident, number of times a person accesses services).

[6] Reproduced from Guidelines and Protocols for medicolegal care for survivors/victims of sexual violence, 2014Ministry of Health, Government of India https://main.mohfw.gov.in/sites/default/files/953522324.pdf

[7] Individuals whose gender identity is not based on physiological appearance (transgender) or where an individual's body doesn't fall in the rigid binary of male and female genitalia (intersex).

6.2 SPECIFIC GUIDELINES FOR DEALING WITH CHILDREN

Violence in childhood is a common reality in Lao PDR. The 2017 Lao Social Indicator Survey II (LSIS II) found that 69% of Lao children aged 1-14 are subject to at least one form of psychological aggression or physical punishment in the past one month. The Violence Against Children Survey in Lao PDR (2016) reveals that emotional violence is the most reported form of violence, followed by physical violence. 75% of girls and boys aged 13 to 17 who are sexually abused reported that their first incident happened when they were 13 years old or younger. Children also do not know where to seek help: only 5.2% of girls know where to get help if they are sexually abused, and no girls reported receiving help. The COVID-19 pandemic has exacerbated the pre-existing vulnerabilities of girls and young women in Lao PDR.

Most commonly, abusers are persons who are well known to the child and may even be living in the household. Children are considered easy targets for sexual abuse because they may not realize that they are being abused. Further, children are more easily threatened and less likely to speak out about the abuse.

While the principles of medical examination and treatment for children remains the same as that for adults, it is important to keep some specific guidelines in mind:

For the case of children, the "best interest of the child" principle should be always prioritized. The best interests of the child is a child rights principle, which means that adults must do what is best for the child (Article 3 of the UN Convention on the Rights of the Child, 1989). This also means there is a right of the child to be heard – involve the child in any step throughout the process given due weight to age and level of maturity of the child. They should be able to express or not to express their opinions.

Health care providers should be able to recognize if the child is comfortable speaking up with their guardian inside the room. If not, health care providers may ask the guardian to wait outside the room. See if the child is more comfortable speaking up.

In case the child is under 10 years of age, consent for examination, treatment and collection of forensic evidence needs to be sought from the parent or guardian. There are some circumstances where there may be accompanied by the abuser when they come for medical treatment, so be aware and screen when you suspect abuse. In such situations, a female person appointed by the head of the hospital/institution may be called in to be present during the examination for a female child. For a male[11] child, they should be offered the choice to talk with female or male.

Box 10 : Children and consent/assent

Adult and child victim-survivors have different needs and capacity for decision- making. Adult survivors have full authority to make decisions for themselves, and have the right to refuse services. This is called informed consent.

For children and adolescents, they should be provided information on the processes, but depending on their age and capacity, the final decisions about services, examinations, treatment, evidence collection and referrals may rest with an adult caregiver/guardian (informed assent).

In the case of a child less than 10 years of age, consent should be obtained from a parent or guardian.

[8] UNICEF Lao PDR Child Protection Compendium of Factsheets | UNICEF Lao People's Democratic Republic
[9] UNICEF Lao PDR Child Protection Compendium of Factsheets | UNICEF Lao People's Democratic Republic
[10] The "best interests of the child" should be considered in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities, or legislative bodies. The interests of children and young people should be thought about at all levels of society, and their rights should be respected by people in power.
[11] There has to be a clear criteria for this appointment. The appointment can be also done jointly with the MoLSW, LWU and/or MOPS (police). Also, when it is suspected that the child is with the abuser, the health staff should immediately report to the police and the social welfare sector for the best interest of the child determination (removal of a child from the family may happen).

Further considerations for responding to violence against children

- Considering their wishes and needs, child survivors should be supported to identify an adult whom they trust who will accompany them throughout the process. In the case when such trustful adult is not available in the child's lives, the trained MOLSW or the LWU designated to cover the work on child protection should be supporting the child.
- Do not assume that because the child is young he/ she will not be able to provide a history. History seeking can be facilitated by use of dolls and body charts.
- Use simple/ child-friendly language. Interviews are to be conducted by well-trained healthcare providers in a child-friendly as well as gender sensitive manner and in a safe and child-friendly environment.
- Believe what is being reported by the child. There are misconceptions that children lie or that they are tutored by parents to make false complaints against others. Do not let such myths affect the manner in which you respond to cases of child sexual abuse.

Box 11 : Reporting violence against children

According to the MOLSW's Child Protection Case Management SOPs, it is required for the health sector to immediately report to the social welfare sector and police and receive referrals from the social welfare sector in case of violence against children, both physical and sexual.

For cases of physical and sexual violence against children, refer to the MoLSW's Child Protection Case Management SOPs for reporting, referrals and providing immediate support to child victim/ survivors of violence.

- Specific needs of children must be kept in mind while providing care to child victim-survivors.
- Doses of treatment will have to be adjusted as required in terms of medical treatment. For psychological support, it is imperative to speak with the carer/s of the victim-survivor in addition to the victim-survivor themselves.
- Health professionals must make a note of the following aspects while screening for sexual abuse. Assurance of confidentiality and provision of privacy are keys to enabling children to speak about the abuse. However genital and anal examination should not be conducted mechanically or routinely. A few indicators for routine enquiry are
    - Pain on urination and /or defecation
    - Abdominal pain/ generalized body ache
    - Inability to sleep
    - Sudden withdrawal from peers/ adults
    - Feelings of anxiety, nervousness, helplessness
    - Weight loss
    - Feelings of ending one's life.

6.3 PERSON WITH DISABILITY

Persons with disability includes those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Women and children with disability are particularly vulnerable to violence, discrimination, stigma and neglect. In fact, persons with disabilities may be repeatedly victimized, especially by caregivers. Some global studies suggest that girls and young women with disabilities face up to 10 times more GBV than those without disabilities.[12]

Women with disabilities are often unable to report sexual abuse because of the barriers to communication, as well as their dependency on carers who may also be abusers. When they do report, their complaints are not taken seriously and the challenges they face in expressing themselves in a system that does not create an enabling environment to allow for such expression, complicates matters further. Laos has ratified the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) in 2008, which mandates that country must make specific provisions to end discrimination and violence faced by persons with disabilities. It also

[12] UNFPA, Global Study on Ending Gender-based Violence and Realizing Sexual and Reproductive Health and Rights, July 2018.

mandates that healthcare systems must make necessary provisions to ensure access to health care to persons with disabilities. However, our health systems in general are not friendly to persons with disabilities.

Guidelines for examination:

- Be aware of the nature and extent of disability that the person has and make neces sary accommodations in the space where the examination is carried out.
- Do not make assumptions about the victim-survivor's disability and ask about it before providing any assistance.
- Do not assume that a person with disability cannot give history of sexual violence himself/herself. Because abuse by those close is common, it is important to not let the history be dictated by the caregiver or person accompanying the victim-survivor. History must be sought independently, directly from the victim-survivor herself/him self. Let the person decide who can be present in the room while history is being sought and examination conducted.
- Make arrangements for interpreters or special educators in case the person has a speech/hearing or intellectual disability. Maintain a resource list with names, addresses and other contact details of interpreters, translators and special eductors in and around your hospital, who could be contacted for assistance. Even while using the services of an interpreter, communicate with the person directly as much as possible, and be present while the interpreter or special educator is with the person.
- Understand that an examination in the case of a person with a disability may take longer. Do not rush through things as it may distress the victim-survivor. Take time to make the victim-survivor comfortable and establish trust, in order to conduct a thorough examination.
- Recognize that the person may not have been through an internal examination before. The procedure should be explained in a language they can understand. They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Ensure that adequate and appropriate counselling services are provided to the victim-survivors. If required, the services of an expert may be required in this regard, which should be made available.

Informed Consent: All persons are ordinarily able to give or refuse to give informed consent, including persons with mental illness and intellectual disabilities, and their informed consent should be sought and obtained before any medical examination. Some specific steps may be required when taking informed consent from persons with psychosocial disabilities or those with intellectual disabilities. If it is deemed necessary, such persons should:

a) be provided the necessary information (what the procedure involves, the reason for doing the procedure, the potential risks and discomforts) in a simple language and in a form that makes it easy for them to understand the information;
b) be given adequate time to arrive at a decision;
c) be provided the assistance of a friend/colleague/care-giver in making the informed consent decision and in conveying their decision to medical personnel.

The decision of the person to either give consent or refuse consent with the above supports, to the medical examination, should be respected.

6.4 PEOPLE WITH DIVERSE ETHNICITY OR RELIGION

Sexual violence is mostly perpetrated by those in a position of power upon those who are relatively vulnerable. This position of power may be a function of a person's gender, religion, ethnicity, sexual orientation and/or other factors.

Specific guidelines must be kept in mind.

- Do not pass any explicit or implicit comments, or in any other way communicate your personal opinion, about the person's ethnicity or religion while medically treating them.
- Do not ask the person who is being given medical treatment any gratuitous questions about her religion/ethnicity, except those that are relevant to the nature of violence she has faced or the kind of treatment she requires.
- Do not make assumptions about the person's life, the number of children she has, the kind of treatment that she may be willing to undergo etc. Some victim-survivors may be willing to talk about the role that their ethnicity or religion has played in the violence acts towards them. The victim-survivor's experience should be listened to and recorded in the Medical Report.
- Make arrangements for interpreters so that victim-survivor can speak in their native language (eg. Hmong, Khmu among others). Maintain a resource list with names, addresses and other contact details of interpreters and translators in and around your hospital, who could be contacted for assistance.

6.5 SEX WORKER

While women remain the largest group involved in sex work people involved in sex work could include men, transgender individuals and children. It is important to bear in mind that just because sex workers exchange sexual acts for money or goods, does not mean that they cannot be sexually assaulted. Any non-consensual intercourse with a sex worker still amounts to rape. Sexual abuse by clients, police, pimps, brothel owners and others is commonly encountered by sex workers. Coercion to perform sexual acts by use of verbal threats, physical force and forced unwanted sexual acts by clients have been reported by sex workers as some of the types of sexual violence that they face.

Non-consensual intercourse:

engaging in sexual activity with another person, regardless of gender, that he/she did not agree to participate in.

Guidelines for examination:

- While examining sex workers reporting sexual violence, it is important to keep in mind that: Sex workers face a number of challenges due to the nature of their work when they approach the healthcare system. They have already faced a significant amount of discrimination from various agencies of society at every walk of life and hence, their decision to approach the health care for treatment or examination should be considered a courageous one.
- A sex worker has the right to receive treatment as any other citizen and healthcare professionals are required to provide it irrespective of their occupation or for any other reason (article 4, the Law on Health Care 2014).
- Do not make assumptions about the person's health. Myths such as, "Sex workers are all addicts/HIV positive" are just that – myths. These propagate an unhealthy assumption of this group which may lead to further marginalization.
- Sex workers can be of any gender. No statements blaming the victim-survivor or his/her profession for the violence faced should be made.
- Only information of the current episode of violence that the victim-survivor is reporting, must be documented. Any information of past sexual encounters is irrelevant to the current incident of sexual violence and should not be noted.

6.6 PERSON OF DIVERSE SEXUAL ORIENTATION

Sexual orientation refers to a person's sense of identity based on sexual attractions, related behaviour, and membership in a community of others who share those attractions. The "normative" sexual orientation in our society is 'heterosexual', meaning that persons are expected to be attracted to others of the opposite sex. However, people may have various other sexual orientations. A person identifying with a homosexual identity for instance, is sexually attracted to a person of the same sex. There is widespread belief that homosexuality is a 'disease'; generally, a 'mental illness' that needs to be cured or that homosexuality is a 'sin'. These ideas have no basis in fact and are responsible for deep-seated prejudices in society against LGBTI people which often lead to a number of violent acts against them, including sexual violence.

Guidelines for examination:

Even though the examination of a lesbian, gay or bisexual individual is not physically any different from that of a heterosexual person, a doctor should be especially sensitive to the former group's anxieties and concerns when it comes to such examinations:

- There should be no judgment on the person's sexual orientation in general or as a cause of the assault.
- Confidentiality of their sexual orientation should be maintained. One should not discuss or mention it to the other staff members unless needed for treatment reasons.
- The health professional should not express shock, wonder, or any other negative emotions when a person reveals their sexual orientation. The speech and behavior of the health professional should remain inclusive.
- Old injuries or fact that a person is 'habituated to anal sex' should NOT be recorded.
- Treatment should NOT be denied to any person based on/due to their sexual orientation.
- The doctor and hospital staff should be understanding towards the victim-survivor and should provide care and treatment with sensitivity.
- The doctor or the hospital staff should not give any advice or 'offer solutions' to 'cure' them of their sexual orientation.
- Lesbian, gay, bisexual and transgender persons are likely to be targets of hate crimes and may want to talk about the role their sexual orientation played in making them vulnerable to sexual violence. Their experience should be given a sincere hearing and validated. The victim-survivors should be assured that it was not their fault that they were sexually assaulted.

6.7 TRANSGENDER AND INTERSEX PERSON

Medical practitioners must recognize that transgender and intersex people are vulnerable to sexual violence due to the marginalization and discrimination they face, but this is not recognized in the law (Law on Preventing and Combating Violence Against Women and Children 2014, penal code). Under such circumstances, it is all the more essential that sexual violence faced by transgender/intersex people is recognized as such by health professionals who often serve as the first point of contact for a victim-survivor of sexual violence. It is not uncommon for transgender and intersex persons to experience ridicule in the health facilities. Health professionals are often ignorant of the variations in biology and gender identity and also tend to 'pathologize' them.

Guidelines for examination:

- Gender identity is not constituted by anatomy, especially appearance of genitals. Primacy should be given in the record to the victim-survivor's stated gender identity and appropriate names and pronouns used.
- Intake forms and other documents that ask about gender or sex should have options as male/female/others.
- Genital anatomical variations of transgender and intersex people must be included in the examination pro forma templates.
- Transgender and intersex people may be unwilling to report the case to law enforcement for fear of being exposed to inappropriate questions and abuse, therefore adequate care should be provided for those who do approach health institutions.
- Information on the intersex variations or transgender status of the victim-survivor must be treated as confidential and not be revealed without the victim-survivor's consent.
- The inadvertent discovery during examination or history taking that a person is trans gender or intersex must not be treated with ridicule, hostility, surprise, shock, or dismay. Such reactions convey that the person is being judged and is likely to make them uncomfortable in the health care setting.
- It is important to be aware of the possible health consequences that the sexual violence may have resulted in. For instance, transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating. Similarly, intersex variations which include non-typical genital appearance may still put some intersex women at risk of pregnancy. Health professionals must be aware of these variations and must anticipate health conse quences accordingly.
- Some transgender or intersex victim-survivors may want to talk about their perceptions of the role their gender identit y might have played in making them vulnerable to an assault. Though Lao law does not recognize gender identities outside the binary male-female, it is important for the health professionals to record the victim-survivor's account of the assault as part of the procedural history-taking, making note of the victim-survivor'sperception of the reasons for the assault, if so stated.
- Information about referral agencies that provide services to transgender or intersex victim-survivors of sexual violence must be available.

PART 7 ROLES OF HEALTH CARE PROVIDERS AND OTHER STAFFS MEMBERS

Healthcare providers have clear roles and responsibilities outlined in various Lao laws, as well as minimum international standards they should meet.

7.1 LAO LAW

7.1.1 According to the Law on Preventing and Combating Violence against Women and Children 2014, article 37 says:

Victims who has experienced physical and emotional violence will receive medical and psychological assistances.

1. Receive clinical examination, treatment and medical certificate

2. Receive psychological counseling and mental health treatment.

A female victim should receive medical examination by a female health provider, and if the examination is conducted by a male provider, a female nurse or female social worker should be present.

If the forensic examination is required by the polices or related officers, consent of victim should be sought.

If victim is under 10 years old, consent of the parent or guardian should be sought.

All medical examination results and information of the victim should be kept confidentially; except in case of reporting to relevant agencies/organisations.

7.1.2 The Law on Health Care 2014 at article 24 states that health care professionals shall have following rights and duties: (there are 13 items in total)

1: To provide consultations

2: To provide diagnoses…

6: To give medical advice…

10. To maintain the confidentiality of patients

11. To issue a medical certificate

7.1.3 Article 34 relates to maintaining the confidentiality of patients:

All health care professionals shall strictly maintain confidentiality in respect of illnesses or details of living or deceased the ethics of health care professionals (there are 9 items in total)

1.Respect for human life and the diginy of patient or thier relatives without discrimination, including not damaging the reputation of a deceased person …

4. Listening to the opinions, purposes and decisions of patients on the basis of the laws and regulations and the rules of the medical profession

5. Providing primary assistance to patients in danger by performing first aid in good faith and when they are in the position to do so, without refusing or escaping from that situation

6. The duty to persuade patients to cooperate in the treatment, [and] to encourage them for their own interests and not for the interests of the health care professionals

7. Being patients, good attitude, courteous and impartial towards patients and their relatives, regardless of their behaviors patients, for the patients benefit, except for those cases provided by laws or regulations.

Article 37 outlines

9. Perform the duties with fairness, consciousness and high responsibility

7.2 INTERNATIONAL STANDARDS

Beyond domestic law, healthcare providers also have roles and responsibilities to meet minimum international standards including:

- Identify Abuse: Look for signs and symptoms revealing abuse; ensure privacy and assure confidentiality for victim-survivor
- Acknowledge / respect the victim-survivor's disclosure of abuse: Health care providers should be nonjudgmental and never question / express disbelief when history of abuse is disclosed to them. Disclosure of abuse irrespective of time gap since the incident, nature of abuse, presence or absence of injuries, has to be treated with utmost seriousness. Medical officer should look for signs and symptoms associated with VAW (where applicable), privacy and assure confidentiality for victim-survivor.
- Enquire about history: the healthcare provider should inquire about details of the current incident of violence as well as past history of violence.
- Some suggestions for asking:
    - Your injuries do not look like they are accidental. I am concerned that your symptoms may have been caused by someone hurting you. Did someone cause these injuries?
    - Your complaints seem to be related to stress. Do you face any tensions with your partner/ at home?
    - Are you afraid of your husband or partner?

- Provide First-line support through LIVES: empathic Listening, Inquiring about needs and concerns, Validate response to victim-survivors' experience, Enhance her safety, support connection to information, services and social support;
- Provide medical Support: Take a thorough history; assess for effects of current and past histories of violence; attend to all injuries with medical referral;
- Provide psychosocial support: Refer the victim-survivor to LWU for psycho social support; after providing LIVES / first line psychosocial support at the point of first contact with healthcare providers
- Complete documentation: Document current and past episodes of violence in medical paper, refer for MLC if relevant, in case of sexual violence fill in the proforma as per national guidelines.
- Ensure / Advise follow-up: It is important to recognise that referring the victim-survivor out to a different department is NOT the end of follow-up and responsibility. Where required, the doctor should explain the need for follow up for further treat ment / to address ongoing clinical needs (e.g., for injury, health conditions, STIs, repetition of pregnancy test, pregnancy, mental health and planning.)
- Be aware of procedures for recording of dying declaration for any cases of burn injuries or other severe cases of assaults.
- Ensure that Discharge summary should

    a) include all treatment that was provided to the victim-survivor and relevant investigation results should be recorded. MO must cross check appropriateness of treatment provided.
    b) include dates of follow up for each checkup / investigation / procedure.
    c) NOT mention in any direct way if the client / patient is a DV / SV victim-survivor.

Follow Up: The health provider should follow-up with victim-survivors to see whether she has accessed referral services and to ensure ongoing clinical needs, such as follow-up for injury, STIs, pregnancy, mental health and planning.

7.3 SUPPORT TO OTHER SERVICES- REFERRALS

Active and up-to-date referral networks and referral practices help survivors reach specialised care in a timely manner. Healthcare practitioners are required under the law to refer victim-survivors to other sectors and organisations, as she wishes (see Box 12 below).

Box 12 : Legal requirements for healthcare providers to make referrals to other sectors

Article 30. Response and Referral System

Organizations or police who received the report or notification about the incident of violence against women and children must immediately intervene to stop the violence and assist the victim, ask, interview, collect data and assess the situation of the victim. If necessary, [they shall] coordinate with other concerned agencies to refer the victim and accompanied children [if there is accompanied children] to ensure that the victim receives thenecessary protection and assistance as stipulated in Article 32 of this law.

Article 32. Necessary Protection and Assistance

After seeing and receiving the report on the incident of violence against women and children, the concerned agencies and sectors must protect and assist the victim of violence and accompanied children as follows:

- Social welfare assistance
- Counseling assistance
- Assistance in a safe temporally shelter
- The assistance on care of children
- Medical assistance
- Legal assistance
- Economic assistance
- Education and vocational training assistance
- Assistance with re-integration into family and society .

A referral pathway needs to be created, agreed upon and resources allocated for its operationalisation. Healthcare providers should make referral agreements with known ministries/organisations.

Referral pathways should:

— respect self-determination
— minimize points of care and retelling the story
— maintain confidentiality and safety

Assured referrals will be facilitated to inform referral facility of condition and case of patient, follow up, as well as documentation. Referral linkages will include transportation, communication about transfers, stabilization and treatment,

Multi-sectoral referral:
Linkages to other VAW services will be provided to victim-survivor (such as legal assistance, psychological services, etc). The designated staff in charge, will complete a referral directory of available VAW services with the following information:

- Name and contact address and phone number
- Services available
- Hours of operation
- Cost of services

If the survivor wants to receive **legal assistance**, health providers should refer them to the Ministry of Justice, or organisations that offer Legal Aid (eg. ADWLE, BABSEACLE etc).

If the survivor is seeking **safe shelter or temporary accommodation**, refer them to LWU, MoLSW and other organisations that provide shelter (eg. VFI, Sengsavang).

If the survivor wants to report to the **police**, contact the Ministry of Public Security.

For contact information for referrals, refer to the **GBV Service Directory.** And the Coordination Standard Operating Procedure (SOP)

7.4 ROLES OF DIFFERENT STAFF MEMBERS

Clear delineation of specific roles and responsibilities for GBV prevention and response including agreed upon reporting and referral systems

Monitoring Committee at District Hospital

- This Monitoring Committee is to be comprised of 1 Nodal Person; designated Staff-in-Charge from each intervention block/facility; representatives from medical and nursing staff from key departments (emergency/casualty, obstetrics and gynecology); NGO/UN
- The Monitoring Committee will be responsible for review of cases of gender based violence at health facilities for care per standards; review for follow-up of violence cases; identification and resolution of systems-level gaps; and raising issues to block and district officials as needed.
- Mechanism for review: document minutes of meetings, review of cases per documentation register.
- Frequency of meetings: The Monitoring Committee is to meet monthly at the district level.

PART 8 IMPLEMENTATIONOF SOP

The following preparedness actions are suggested for effective implementation of this SOP:

- Orientation to all medical officers including RMOs about role of health care providers in health system response to victim-survivors of violence
- Orientation to all nursing staff about role of health care providers in health system response to victim-survivors of violence
- Orientation to other support staff at the hospital (attendants, technicians, security personnel, others) about role of health care providers in health system response to victim-survivors of violence
- Appointment of a nodal officer / assigning responsibility to a particular senior person to ensure regular monitoring and supportive supervision of teams for implementation of SOPs.
- Establishing a monitoring committee with representation of doctors and nurses who play an active role in provision of care and services to the victim-survivors of sexual violence – this would include representatives from obstetrics and gynaecology, general surgery, paediatric medicine, medical records department, emergency medical services (for all departments concerned)
- Set up a core group of hospital staff across cadres that can facilitate ongoing refresher / orientation trainings for staff at hospitals
- Display posters in prominent places to encourage the victim-survivors to seek help and to sensitise the providers.

APPENDICES

COMPANION GUIDES AND KEY RESOURCES

- Gender-Based Violence Quality Assurance Tool: Minimum Care Version. Standards for provision of high quality post-violence care in health facilities. 2014: http://resources.jhpiego.org/system/files/resources/GBV-Quality-Assurance-Tool-Min-Care-Version-EN.pdf
- WHO. Responding to intimate partner violence and sexual violence against women: Clinical and policy guidelines. 2004: https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/
- MOHFW. Guidelines and protocols medico legal care for survivors victims of sexual violence. 2014: https://mohfw.nic.in/reports/guidelines-and-protocols-medico-legal-care-survivors-victims-sexual-violence
- WHO. Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers. 2017: https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/

Annexes

Annex 1 Sample VAW Documentation Register

Serial No:
Name of healthcare provider:

Designation:

Woman disclosed/reported violence	
Provider suspects violence	

Victim/survivor details

Name:	**Date**
Economic and social status (to consider for eligibility of support policies)	**Safe Contact details:**
Age (in completed years):	**Address:**
Specific needs/vulnerabilities: ☐ None ☐ Physical disability ☐ Intellectual disability ☐ Mental or psychosocial disability ☐ Unaccompanied minor ☐ Translation/interpreting services ☐ Other, please specify	**Ethnicity/religion:**

Referred by:

☐ **Self**	☐ **Family/Acquaintance**	☐ **Other health facility**
☐ **Police**	☐ **NGO**	☐ **Others (specify)**

Presenting Signs & Symptoms _____

_____

Identified Signs & Symptoms for violence _____

_____

_____

Type of Violence

☐ **Physical**	☐ **Emotional/ psychological**	☐ **Sexual** ○ **Rape** ○ **Sexual assault** ○ **Forced marriage**	☐ **Financial/economic** ○ **Denial of resources, opportunities or services**	**Others (non-GBV) (specify)**

Relationship with the perpetrator/s

☐ **Intimate or domestic Partner/Former partner/spouse**	☐ **Marital family (eg. Mother-in-law) (specify)**	☐ **Natal (birth) family/primary caregiver (specify)**	☐ **Friend/neighbour/community member**
☐ **Children/schoolmate**	☐ **Stranger/no relation**	☐ **Teacher/employer**	☐ **Unknown/ others (specify)**

Number of alleged perpetrators

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ More than 3, specify_____

☐ Unknown

Alleged perpetrator sex

☐ Male
☐ Female
☐ Both

Age of alleged perpetrator

☐ Adult
☐ Minor
☐ Adult and minor

Treatment and support provided

☐ **First line support LIVES**	☐ **Injuries and wound care**	☐ **Medico- legal case**
☐ **Safety assessment and plan (Specify)**	☐ **Internal referral to other department (Please mention the name of the department)**	☐ **Others (specify)**

External referrals

☐ **Clinical care at higher facility**	☐ **Shelter**	☐ **Legal aid**
☐ **Crisis intervention counselling**	☐ **Livelihood support**	☐ **Child protection**
☐ **Police**	☐ **Others (specify**	

Signature

FOLLOW- UP

Follow- up number	Date	Reason for follow-up	Services provided

Annex 2 Template for Referral Directory

Level of Service	Type of Services	Facility	Services Offered	Location	Name of Focal Point	TelephoneNumber	Details, hours, fees, etc.

Level of Service	Type of Services	Facility	Services Offered	Location	Name of Focal Point	TelephoneNumber	Details, hours, fees, etc.

Annex 3: Initiative Examination Form (In-using at LAO PDR Hospital)

LAO PEOPLE'S DEMOCRATIC REPUBLIC PEACE
INDEPENDENCE DEMOCRACY UNITY PROSPERITY

Ministry of Health
Hospital.....

No ...../……
Vientiane Capital, Date

Certificate of Examination

1. Demographic Information

First Name and Surname:	Age:.....Date of Birth:...../...../.....Female ☐ Male ☐
Address:	Village: House Number: Unit: District: Province:
Occupation:	Nationality:
Organization involved in the case:	Location of Examination, time: Date of examination:
Examination Period	Within 72 Hours ☐ More than 72 Hours ☐

2. Patient Examination Results

	Physical Examination Results
Weight, Height	
Overview	
Mental Health	
Specific Wound	
	Genital and Rectal Examination Results
External Genitalia Shape	
External Urethral Meatus	
Labia Majora/Labia Minora	
Hymen	
Perineum	
Vaginal Discharge	
Vagina Examination	
Rectal Examination	
Evidence of Laboratory Test Result	

Summary	…… …… …… ……
Director of Hospital	Human Trafficking Committee Doctor who examined the body **1.** **2.** **3.**

Where to send documents:
1. Department of Medical Administration, 01 Copies
2. Responsible Police Officer, 01 Copies
3. Concerned departments 01 copies
4. Secretariat of the HTC of MOH, 01 copies.

Annex 4: International Forensic Examination Form

CONFIDENTIAL

Medico-legal Examination Report of Sexual violence

1. Name of the Hospital …… **OPD No.** ……. **Inpatient No**……..……..

2. Name ……..……**D/o or S/o (where known)**……..…..…

3. Address……

4. Age (as reported) ……..……. **Date of Birth (if known)**
……..……..……..……..……..……..……..……

5. Sex (M/F/Others)
……..……..……..……..……..…..……..

6. Date and Time of arrival in the hospital
……..……

7. Date and Time of commencement of examination……..
……...……

8. Brought by……. **(Name & signatures)**

9. MLC No. …….. ……**Police Station**……..
……

10.. Whether conscious, oriented in time and place and person……

11.. Any physical/intellectual/psychosocial disability
……..……

(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal

I……D/o

or S/o……..……

hereby give my consent for:

a) medical examination for treatment Yes ☐ No ☐

b) this medico legal examination Yes ☐ No ☐

c) sample collection for clinical & forensic examination Yes ☐ No ☐

I also understand that as per law the hospital is required to inform police and this has been explained to me.

I want the information to be revealed to the police Yes ☐ No ☐

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in ……. language with the help of a special educator/interpreter/support person (circle as appropriate) ……...

If special educator/interpreter/support person has helped, then his/her name and signature……

Name & signature of survivor or parent/Guardian/person in whom the child reposes trust in case of child (<12 yrs)

……

……

……

With date, time & place

Name & signature/thumb impression of Witness

……

……

……

With Date, time and place

13. Marks of identification (Any scar/mole)

(1) ……..

(2) …… ……..

Left Thumb impression

14. Relevant Medical/Surgical history

Onset of menarche (in case of girls) Yes☐ No☐ **Age of onset**…….……..…… **Menstrual history – Cycle length and duration ……..……** Last menstrual period…….
Menstruation at the time of incident - Yes/ No, Menstruation at the time of examination - Yes/ No
Was the survivor pregnant at time of incident - Yes/No, If yes duration of pregnancy ……. weeks
Contraception use: Yes/No……. If yes – method used: …….
Vaccination status – Tetanus (vaccinated/not vaccinated), Hepatitis B (vaccinated/not vaccinated)

15. A. History of Sexual Violence

(i) Date of incident/s being reported	(ii) Time of incident/s	(iii) Location/s
(iv) Estimated duration : 1-7 days …….. 1 week to 2 months…….. 2-6 months…….. >6 months….. **Episode: One……. Multiple ……..……Chronic (>6 months) ……Unknown……**		
(v) Number of Assailant(s) and name/s…….....…….....…….....		
(vi) Sex of assailant(s)…….....Approx .Age of assailant (s)…….....……		
(vii) If known to the survivor – relationship with the survivor.....…….....…….....		
(viii) **Description of incident** in the words of the narrator: Narrator of the incident: survivor/informant (specify name and relation to survivor) ……		

(if this place is insufficient use extra page)

15 B. Type of physical violence used if any (Describe):

Hit with (Hand, fist, blunt object, sharp object)	Burned with
Biting	Kicking
Pinching	Pulling Hair
Violent shaking	Banging head
	Dragging
Any other:	

15 C.

i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing)…….

ii. Use of restraints if any ……..

iii. Used or threatened the use of weapon(s) or objects if any……..

iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for blackmailing, etc.) if any: ……..

v. Luring (sweets, chocolates, money, job) if any: …….

vi. Any other:…… …….

15 D.

i. Any H/O drug/alcohol intoxication:

ii. Whether sleeping or unconscious at the time of the incident:

……

15 E. If survivor has left any marks of injury on assailant/s, enter details:

……

15 F. Details regarding sexual violence:

Was penetration by penis, fingers or object or other body parts (Write Y=Yes, N=No, DNK=Don't know) **Mention and describe body part/s and/or object/s used for penetration.**

	Penetration			Emission of Semen		
Orifice of Victim	By Penis	By body part of self or assailant or third party (finger, tongue or any other)	By Object	Yes	No	Don't know
Genitalia (Vagina and/or urethra)						
Anus						
Mouth						

Oral sex performed by assailant on survivor	Y	N	DNK
Forced Masturbation of self by survivor			
Masturbation of Assailant by Survivor, Forced Manipulation of genitals of assailant by survivor	Y	N	DNK
Exhibitionism (perpetrator displaying genitals)	Y	N	DNK
Did ejaculation occur outside body orifice (vagina/anus/mouth/urethra)?	Y	N	DNK
If yes, describe where on the body			
Kissing, licking or sucking any part of survivor's body	Y	N	If Yes, describe-
Touching/Fondling	Y	N	If Yes, describe
Condom used*	Y	N	DNK
If yes status of condom	Untorn	Torn	DNK
Lubricant used*	Y	N	DNK
If yes, describe kind of lubricant used			
If object used, describe object:			
Any other forms of sexual violence			

*** Explain what condom and lubricant is to the survivor**

Post incident has the survivor	Yes/No/Do Not know	Remarks
Changed clothes		
Changed undergarments		
Cleaned/washed clothes		
Cleaned/washed undergarments		
Bathed		
Douched		
Passed urine		
Passed stools		
Rinsing of mouth/Brushing/ Vomiting (Circle any or all as appropriate)		

Time since incident……..……

H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence…...……...…

H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence……..

H/o painful urination/ painful defecation/ fissures/ abdominal pain/pain in genitals or any other part since the incident of sexual violence

16. General Physical Examination-

i. Is this the first examination ……...

ii. Pulse…….....

BP……..……

iii. Temp.…….Resp. Rate…….……..…….…..

iv. Pupils ……

v. Any observation in terms of general physical well-being of the survivor…….……

17. Examination for injuries on the body if any

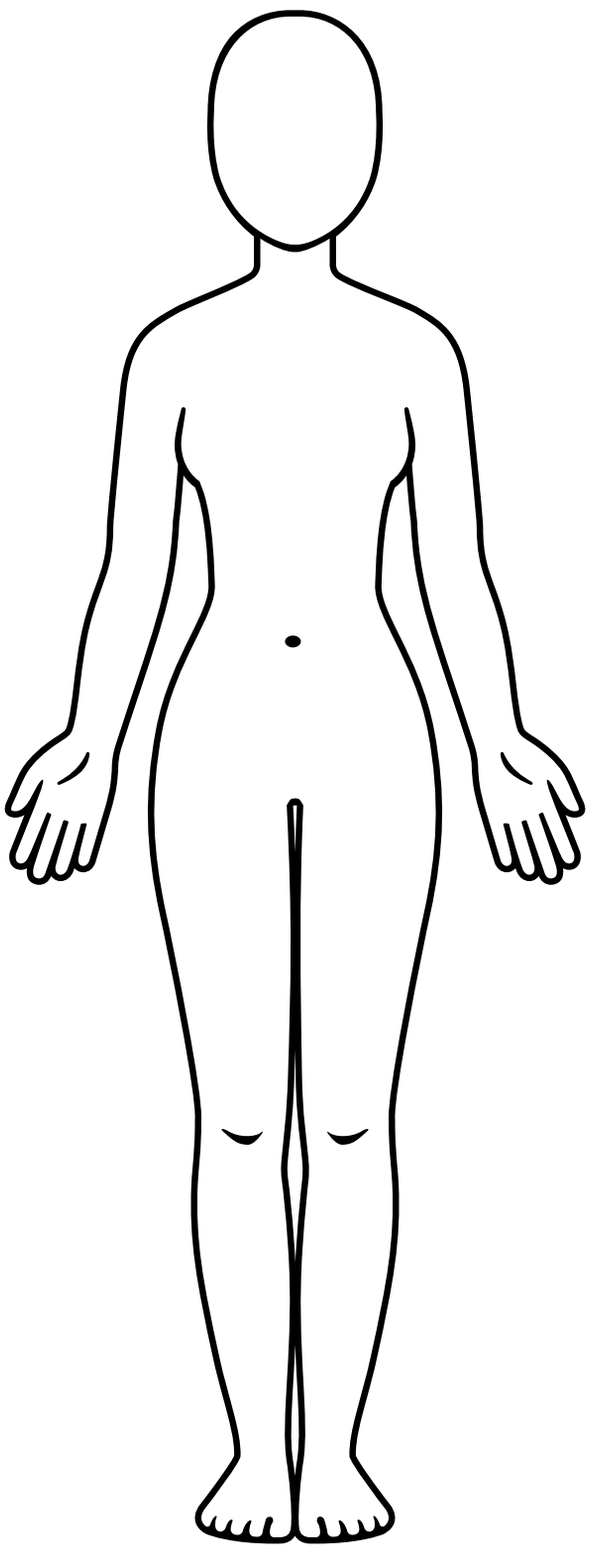
The pattern of injuries sustained during an incident of sexual violence may show considerable variation. This may range from complete absence of injuries (more frequently) to grievous injuries (very rare).

(Look for bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks) Note the Injury type, site, size, shape, colour, swelling signs of healing simple/grievous, dimensions.)

Scalp examination for areas of tenderness (if hair pulled out/dragged by hair)	
Facial bone injury: orbital blackening, tenderness	
Petechial haemorrage in eyes and other places	
Lips and Buccal Mucosa / Gums	
Behind the ears	
Ear drum	
Neck, Shoulders and Breast	
Upper limb	
Inner aspect of upper arms	
Inner aspect of thighs	
Lower limb	
Buttocks	
Other, please specify	

Front

Right



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Back

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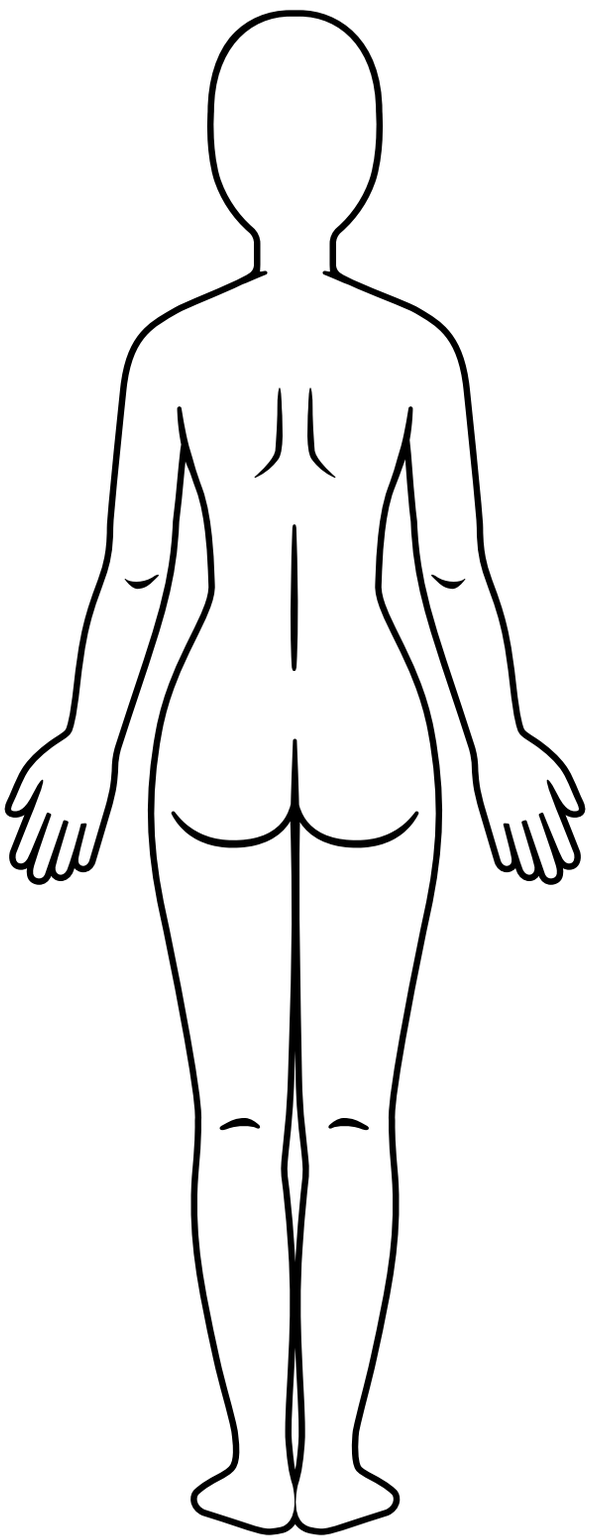

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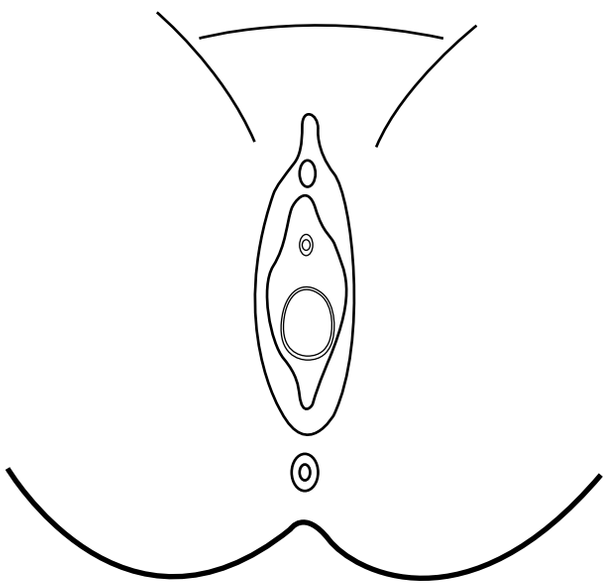

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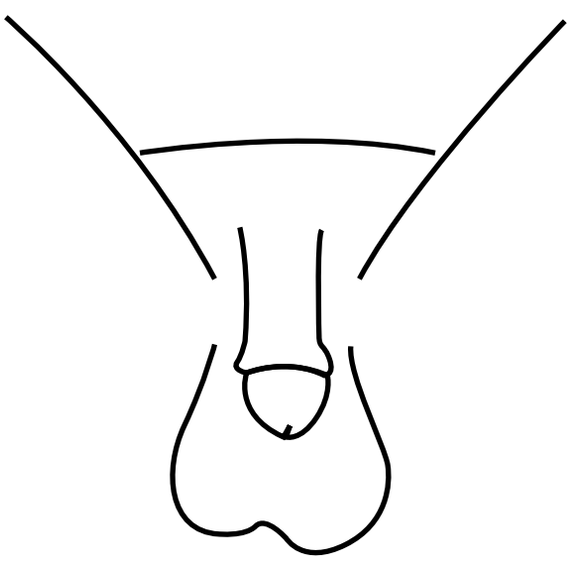

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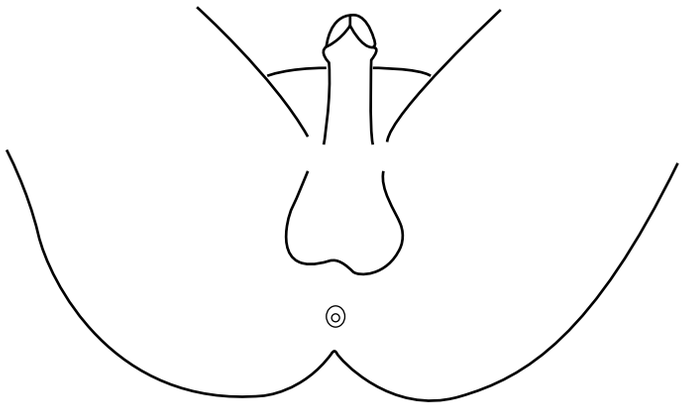

Left

18. Local examination of genital parts/other orifices*:

A. External Genitalia: Record findings and state NA where not applicable.

Body parts to be examined	Findings
Urethral meatus & vestibule	
Labia majora	
Labia minora	
Fourchette &Introitus	
Hymen	
Perineum	
External Urethral Meatus	
Penis	
Scrotum	
Testes	
Clitoropenis	
Labioscrotum	
Any Other	

*** Per/Vaginum /Per Speculum examination should not be done unless required for detection of injuries or for medical treatment.**

P/S findings if performed

……

P/V findings if performed

……

Record reasons if P/V of P/S examination performed

……

C. Anus and Rectum (encircle the relevant)

Bleeding/ tear/ discharge/ oedema/ tenderness

D. Oral Cavity - (encircle the relevant)

Bleeding/ discharge/ tear/oedema/ tenderness

19. Systemic examination:

Central Nervous System:

……

Cardio Vascular System:

……

Respiratory System:

……

Chest:

……

……

Abdomen:

……

20. Sample collection/investigations for hospital laboratory/ Clinical laboratory

1) Blood for HIV, VDRL, HbsAg
2) Urine test for Pregnancy/
3) Ultrasound for pregnancy/internal injury
4) X-ray for Injury

21. Samples Collection for Central/ State Forensic Science Laboratory

(1) Debris collection paper

(2) Clothing evidence where available – (to be packed in separate paper bags after air-drying)

List and Details of clothing worn by the survivor at time of incident of sexual violence

(3) Body evidence samples as appropriate (duly labeled and packed separately)

	Collected/Not Collected	Reason for not collecting
Swabs from Stains on the body (blood, semen, foreign material, others)		
Scalp hair (10-15 strands)		
Head hair combing		
Nail scrapings (both hands separately)		
Nail clippings (both hands separately)		
Oral swab		
Blood for grouping, testing drug/alcohol intoxication (plain vial)		
Blood for alcohol levels (Sodium fluoride vial)		
Blood for DNA analysis (EDTA vial)		
Urine (drug testing)		
Any other (tampon/sanitary napkin/condom/object)		

(4) Genital and Anal evidence (Each sample to be packed, sealed, and labeled separately-to be placed in a bag)

* Swab sticks for collecting samples should be moistened with distilled water provided.

	Collected/Not	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two Vulval swabs (for semen examination and DNA testing)		
Two Vaginal swabs (for semen examination and DNA testing)		
Two Anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans of penis/clitoropenis		

**Samples to be preserved as directed till handed over to police along with duly attested sample seal.*

22. Provisional Medical Opinion

I have examined (name of survivor) _____M/F/Other_____ aged_____ reporting_ (type of sexual violence and circumstances)_____ , XYZ days/hours after the incident, after having (bathed/douched etc)_____. My findings are as follows:

- Samples collected (for FSL), awaiting reports
- Samples collected (for hospital laboratory)
- Clinical findings
- Additional observations (if any)

(4) Genital and Anal evidence (Each sample to be packed, sealed, and labeled separately-to be placed in a bag)

* Swab sticks for collecting samples should be moistened with distilled water provided.

	Collected/Not	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two Vulval swabs (for semen examination and DNA testing)		
Two Vaginal swabs (for semen examination and DNA testing)		
Two Anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans of penis/clitoropenis		

**Samples to be preserved as directed till handed over to police along with duly attested sample seal.*

22. Provisional Medical Opinion

I have examined (name of survivor) _____M/F/Other_____ aged_____ reporting_ (type of sexual violence and circumstances)_____ , XYZ days/hours after the incident, after having (bathed/douched etc)_____. My findings are as follows:

- Samples collected (for FSL), awaiting reports
- Samples collected (for hospital laboratory)
- Clinical findings
- Additional observations (if any)

23. Treatment prescribed:

Treatment	Yes	No	Type and comments
STI prevention treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post exposure prophylaxis for HIV			
Counselling			
Other			

24. Date and time of completion of examination

……

This report contains …….. number of sheets and ……..…..number of envelopes.

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

25. Final Opinion (After receiving Lab reports)

Findings in support of the above opinion, taking into account the history , clinical examination findings and Laboratory reports of …… bearing identification marks described above, ……. hours/ days after the incident of sexual violence, I am of the opinion that:

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

COPY OF THE ENTIRE MEDICAL REPORT MUST BE GIVEN TO THE SURVIVOR FREE OF COST IMMEDIATELY

Technical Acknowledgement

Name list of participants in developing the standard operating procedures for health facility response to VAW

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27. Dr. Mrs. Anoulack Chanthapadith	Technical staff, Mahoshoth hospital
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4. Mr. Sisouphanh Thongsaithala	Deputy director of justice management, MOJ
5. Mrs. Soudalack Phounsavad	Director of counseling and protection for women and children
6. Dr. Amphone Phommatha	Deputy director 103 hospital
7. Dr. Veingmala Phomemixay	Deputy director 5 April hospital
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9. Mr. Taidavan Keouthai	Deputy assistance prosecutor, people supreme court
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Technical support by:

UNFPA

Ensuring rights and choices for all since 1969

NCAWMC

Financial support by:

KOICA

Korea International Cooperation Agency