

**Protocol for
Gender-based Violence Care Centres
(Mithuru Piyasa - Natpu Nilayam)**

**2015
(Reprint)**

**Family Health Bureau
Ministry of Health & Indigenous
Medicine
Sri Lanka**

**(This document needs to be used in
concurrence with the information
booklet for health care providers)**

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Abbreviations and Acronyms

DDGMS	– Deputy Director General – Medical Services
DDGPHS	– Deputy Director General – Public Health Services
EC	– Emergency contraception
FHB	– Family Health Bureau
GBV	– Gender based violence
GP	– General Practitioner
JMO	– Judicial Medical Officer
MCH	– Maternal and Child Health
MO	– Medical Officer
MOH	– Medical Officer of Health
MoH	– Ministry of Health
MOIC	– Medical Officer In Charge
MOMCH	– Medical Officer / Maternal & Child Health
MOO	– Medical Officers
MRO	– Medical Records Officer
MS	– Medical Superintendent
NCW	– National Committee on Women
OIC	– Officer In Charge
OPD	– Out Patient Department
OSCC	– One Stop Crisis Center
OSSC	– One Stop Service Center
PHM	– Public Health Midwife
RDHS	– Regional Director of Health Services
SLMA	– Sri Lanka Medical Association
SOP	– Standard Operative Procedures
STI	– Sexually Transmitted Infections
UN	– United Nations
VAW	– Violence Against Women
WIN	– Women In Need



1. Introduction

It is well known that health sector of any country is in a unique position to support survivors of gender-based violence (GBV), particularly survivors of domestic violence. Women who are the majority among survivors are likely to visit the health care system at some point in their life for a multitude of reasons. The health system provides an excellent opportunity for them to seek help. The health care professionals being the trusted service providers, have an opportunity to penetrate in to the often invisible but deep suffering women go through on account of GBV. It is also a sad reality that, most often, the opportunity available in the health system is not fully utilized. Reasons for this apparent apathy are many. They include, pressure of numbers, which in turn, make the attention limited to essential clinical interventions, lack of infrastructure to provide privacy and confidentiality seen in many health institutions and the prevailing attitudes in the society regarding GBV, which filters to the care providers themselves.

In order to overcome some of these issues and to provide focused, dedicated and committed care in a sensitive, compassionate and empathetic way, in a private and confidential manner, in a setting conducive to provide such services, a service delivery point within the hospital was envisaged.

This center would provide comprehensive care, namely medical services, emotional supportive services and referral to other supportive services such as legal and social services. This center has been named "Mithuru

Piyasa" and this document describes the operational aspects of the service delivery of the centre.

It is also understandable that the situation in different hospitals may vary with respect to the availability of staff, space, and the attitudes of the staff as well as the community. In the event of such constraints posing difficulties in adhering to the protocol, it is suggested that closest feasible options are selected by the director of the hospital in consultation and concurrence with the Family Health Bureau (FHB), in order to ensure sustainability of the services.

2. The name of the service point Mithuru Piyasa (Natpu Nilayam)

The service point serves as a One Stop Service Center (OSSC) or a One Stop Crisis Center (OSCC) mentioned in the literature, with essential services for GBV survivors provided at the same location with arrangement for follow up visits established at the same center. The term Mithuru Piyasa in Sinhala meaning friendly shelter/sanctuary, and was selected after much thought and discussion. It will be used to identify such centers that will be established in government hospitals throughout the island. The Tamil word selected to convey the same meaning was "Natpu Nilayam".

3. Policies of the Ministry of Health related to Gender-based violence.

Many policy documents identify gender-based violence as a health issue that needs to be addressed within the state health system.

- Population and Reproductive Health Policy of Sri Lanka of 1998 identified 'achieving gender equality' as an important goal. The policy reasons out that "the position of women in family and community, their reproductive health and their participation in public life is being increasingly threatened by the alarming increase in gender-based violence and intimidation and harassment of women in the community".⁽¹⁾
- The National Health Development Plan of Sri Lanka 2013-2018 identifies VAW and intimate partner violence as important issues that need to be addressed. It recognizes that the expected output as "recognition of various forms of violence against women as a major health issue by the health system and improvement of the capacity to address the issue".⁽²⁾
- The formation of the National Committee on Violence of the Ministry of Health under the leadership of a high-level health administrator indicates the commitment of the state to address violence. The mandate of the committee includes addressing gender-based violence. It has been successful in publishing the National Report on Violence with two chapters dedicated to GBV issues.⁽³⁾

- The designation of Family Health Bureau as the directorate responsible for women's health inclusive of GBV issues in the MoH was an important policy decision. The appointment of a consultant community physician for this post showed the importance of GBV in the agenda of the MoH.
- The Maternal and Child Health Policy recognizes the role of the health sector in addressing GBV and recommends the establishment of service points dedicated for providing care for the survivors of gender-based violence.
- The National HIV/AIDS Strategic Plan 2012 – 2017 under the section on guiding principles for the National HIV/AIDS response recognizes the important relationship between violence against women and HIV/AIDS and recommends that "all planning, service delivery, and research should be done with gender equality in mind".⁽⁴⁾



4. Guiding principles in caring for Gender-based violence survivors

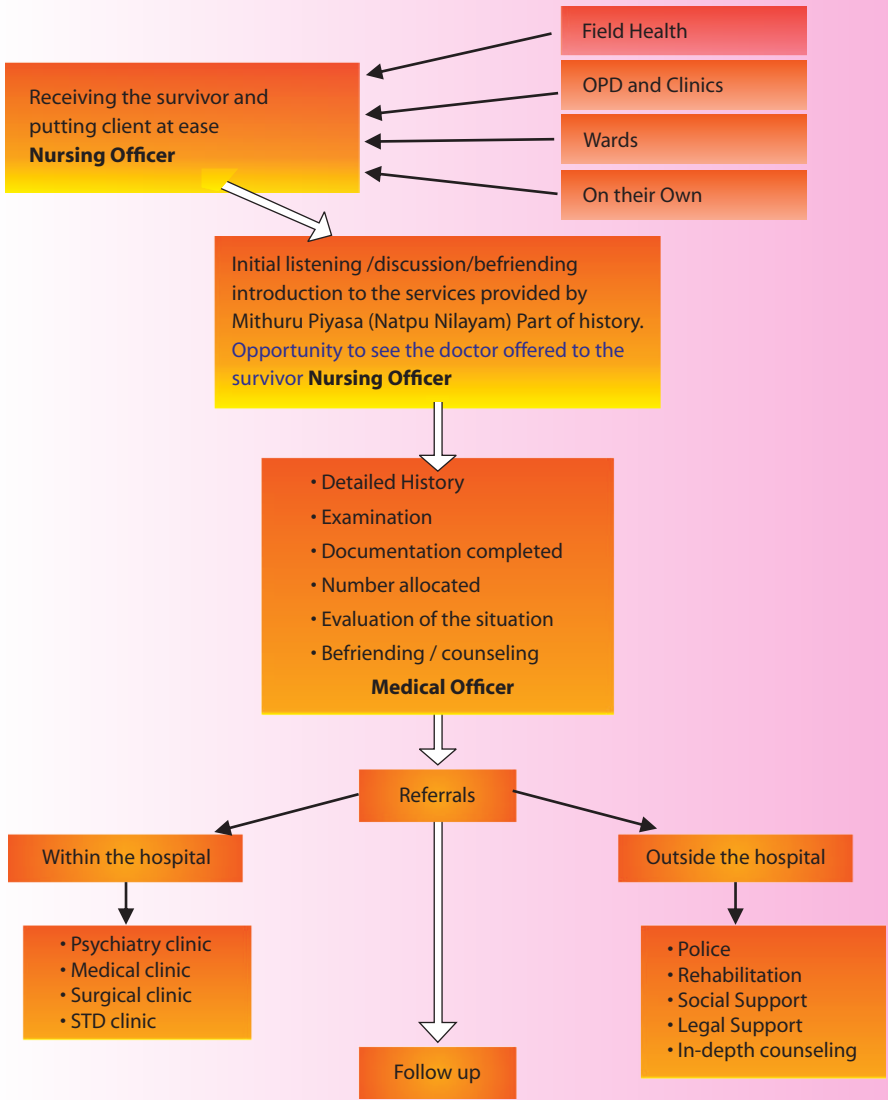
The goals of providing care to a gender-based violence survivor may be considered primarily as increasing survivor safety and supporting survivors in protecting themselves and their children. The care providers are expected to understand the unique demands of the survivors and are expected to provide high quality, non-judgmental, respectful, sensitive, private, safe and friendly services to the care seekers

This goes way beyond providing treatment for injuries. All aspects of providing care should be governed by the following guiding principles applicable across all activities:

- **Safety:** safety of the survivor and her/his children should be the prime concern of the care provider and all interventions should take their safety into consideration.
- **Confidentiality:** all medical and health status information related to survivors and their families should be kept under lock and key to maintain confidentiality. Information regarding the clinical situation may only be divulged to the immediate family members or the guardian with the permission of the survivor (if she or / he is an adult.)
- **Privacy:** every survivor has a right to privacy. Survivor's privacy should be maintained by caring for her in a separate room where she cannot be seen or overheard by those not involved in her care.

- **Respect:** GBV survivor is a person who has undergone very traumatic, degrading and humiliating treatment. Treating her with respect and dignity is very important for her recovery in addition to it being her right.
- **Non discrimination:** all survivors of GBV have a right to receive respectful and high quality health care without discrimination and judgment regardless of their race, sex, age, marital status, religion, or socio-economic status.
- **Competence:** survivors of GBV are entitled to receive high quality health services, including reproductive health care by competent providers to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. The care provider should be aware of his or her knowledge, skill and competence to provide care and if there is any doubt on these the survivor should be referred to an appropriate level of care.
- **Compassion:** it is important to treat these patients with kindness which they have been deprived of for a long time. It is important to distinguish kindness or compassion from sympathy. The violated person may not like to be sympathized. Instead the empathetic, kind and understanding attitude not only helps the survivor to open up but also builds up her/his confidence in the system.

5. Pathway of care for Mithuru Piyasa (Natpu Nilayam)



6. Dedicated clinical services to be provided

6.1. Medical care

If clinical treatment is indicated it would be provided either at the service point or at one of the wards of the hospital such as surgical or gynecological

6.2. Risk assessment

As a part of care provided to survivors, an assessment of risk to the survivor or the children and development of a safety plan needs to be done.

Examples of risk factors are given below:

Risk Factors for Danger

1	If the husband / partner is unemployed
2	If he has access to lethal weapons / guns
3	Recent threats of deadly violence such as shooting and throttling
4	Escalation of severity and frequency of violence in the recent past
5	History of inflicting severe injuries such as fractures / stab injuries
6	Severe abuse of alcohol or drugs
7	Threats or actually having battered or harmed the children
8	Recently separated or divorced

9	Recent activities of stalking or closely watching the survivor
10	Pregnancy or recent birth
11	When cultural issues are involved

6.3. Befriending services

Emotional support is an integral and vital component of care for survivors of GBV, and the staff of Mithuru Piyasa needs to be skilled in providing the basic emotional support as it serves as the first contact point. The two day training in befriending skills is only a starting point of building these skills and a continuous and effective programme is to be planned to improve these skills.

The following key points are to be adhered to when providing befriending:

- Acceptance of and respecting the survivor
- Active listening to the survivor
- Empathetic approach
- Relaxing environment in the center
- Being genuine towards what is communicated
- Maintaining eye contact with the survivor during all discussions
- Responding immediately to the questions and queries of the survivor

6.4. Emergency contraceptive services (EC)

Emergency contraceptives (eg: Postinor) should be available at the Mithuru Piyasa. Any survivor who has been sexually assaulted should be offered the EC and information regarding the efficacy and the side effects, explained in detail. Although it is desirable that EC is given as early as possible after the sexual exposure it is recommended that it is given up to 5 days of the incident after explaining the situation.

If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after abuse, taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72 hours, but it is still moderately effective within 120 hours.

6.5. STI Prophylaxis

As Sri Lanka has a (low) prevalence of HIV of less than 0.01 per 1000 population, HIV prophylaxis is not recommended for all survivors unless there are special circumstances. In such situations advice should be sought from the Consultant / Mo STI at the hospital or from the central STI clinic Colombo.

The STIs that may benefit from prophylaxis are gonorrhoea, chlamydia and syphilis although the last is relatively uncommon. It is best that the local specialist in STI is consulted about the drug regime as resistance patterns etc need to be considered. On principle shortest possible course is prescribed. For instance: 1g of cefuroxime plus 2g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and syphilis. The drugs could be started as early as possible along with the EC. In addition to giving STI prophylaxis, you may consider referring her to STI clinic for screening of syphilis / HIV.

7. Documentation, data management and submission of data to FHB

Data collection should be on the prescribed form (annexure). The name and the contact details of the client are recorded only in the master register which should be kept under lock and key. Only the senior officer has access to it. The data collection instruments/forms are identified by a serial number and kept in a cupboard under lock and key.

Where client information is stored in a computer the files should be password protected and the password be known only to the officer in charge. The data collection forms may be retrieved when the survivor visits for the second time, but should be handled by the MO or the nursing officer directly involved with care provision, and it is his or her responsibility to return it back to the cupboard, so that the confidentiality is maintained.

No information is to be given to a third party except to fulfill legal obligations, and in such a situation the decision is to be taken by the medical officer in consultation with the Director / MS of the hospital and the judicial medical officer.

Information regarding the service provision should be submitted monthly to the Gender & Women's Health Unit, FHB through the routine data management system of the hospital i.e. through the medical records officer (MRO) until such a system is established the monthly return should be sent directly to the FHB. This is to be sent by the 5th of the following month.

Suggested format is annexed (Annexure 2 & 3) It is also suggested that a summary of the services provided is circulated among the other departments of the hospital every month. (Annexure 4)



8. Referral mechanisms

8.1. Within the hospital

The protocols and established working arrangements of the hospital should be adhered to and respected at all times when referrals are done. Wherever there is a doubt, guidance from the director of the hospital should be sought.

As any survivor could access the services referral letters should not be insisted upon. Patients may be seen at the Mithuru Piyasa without any documented request on the BHT but records at the Mithuru Piyasa should be maintained. Reply to the referral notes when made should be very brief and should not have information that will endanger the safety of the survivor.

8.2. Linkages with field health services / MOMCH, MOH, PHM

Referrals from the field services should be encouraged and entertained irrespective of whether a referral document is available or not. Reply to the referral notes should be very brief, carefully worded and should not have information that will endanger the safety of the survivor. It should preferably be done by the officer in charge.

8.3. Multi-sectoral Linkages with Police, Social Services, Probation, Women's Bureau etc.

Building up of these linkages is an important prerequisite to the success of a centre such as Mithuru Piyasa although the major part of care provision is conducted within the health institution.

Maintaining linkages with such organizations is crucial to effective and complete care provision and becomes the responsibility of the service center.

It is advised that at the time of establishment of the center, an advocacy meeting with the representatives of these organizations be held under the guidance of the Director of the hospital.

This should be followed by regular meetings quarterly or twice a year, to update them of the progress, and discuss issues related to improvement of care provision.

These communications need to be done only by the officer in charge preferably after due consultation with the Director of the hospital

An inventory (list) of these organizations and their contact details should be maintained and made available at all times.

Some of such partners would be:

- Police Women's Desk/OIC
- Legal Aid Commission
- Divisional Secretariat - counseling assistant, women development officer, child rights promotion officer.
- NGOs local and international providing services such as WIN, Sumithrayo, etc.....

9. Staffing and duty arrangements

9.1. Nursing Officer

Nursing Officer will be available at all times at Mithuru Piyasa and will be the first contact point and thereby become the vital link for the survivor in the pathway of care.

- Nursing Officer will receive the survivor with warmth and kindness guided by the principles discussed in section 6.
- Nursing Officer will provide empathic listening, and making the survivor comfortable by means such as offering a cup of tea.
- Nursing Officer will gather the information in order to fill the collection form.
- Provide befriending level emotional support.
- Inform the medical officer and assist him/her to examine the survivor.
- Ensure that the guiding principles discussed earlier are adhered to.
- Assist the officer in charge in documentation, data management and in building up a good image of Mithuru Piyasa. (Natpu Nilayam)
- Maintain an inventory of the equipment and furniture.
- Maintain the registers and other relevant documents.

9.2. Medical Officer

Wherever feasible a dedicated medical officer will be sited in the Mithuru Piyasa. When this is not available, the MO who will be scheduled on a daily or a shift basis, will be called to see the patient as and when needed.

She / He will be responsible for

- Completing the history taking, and information gathering on the data collection format.
- Completing examination and documentation. (Except areas that has been attended by the Forensic Pathologist or the JMO)
- Providing befriending services and information regarding other services available along with the rights of the survivor.
- Ensure that the guiding principles discussed earlier are adhered to.
- Assist the officer in charge in documentation and data management and in building up a good image of the Mithuru Piyasa. (Natpu Nilayam)

9.3. Officer-in-charge for operational aspects of the centre

- She / he will be the person in charge of running the service point Mithuru Piyasa.
- She / he will be in charge of the master register of survivors.
- She / he will be responsible for communicating and coordinating with the director/MS of the hospital, other relevant departments and the organizations with which linkages are maintained.
- She / he will be responsible for ensuring the confidentiality of the data and the management of data including the submission of data to the MRO and the FHB.

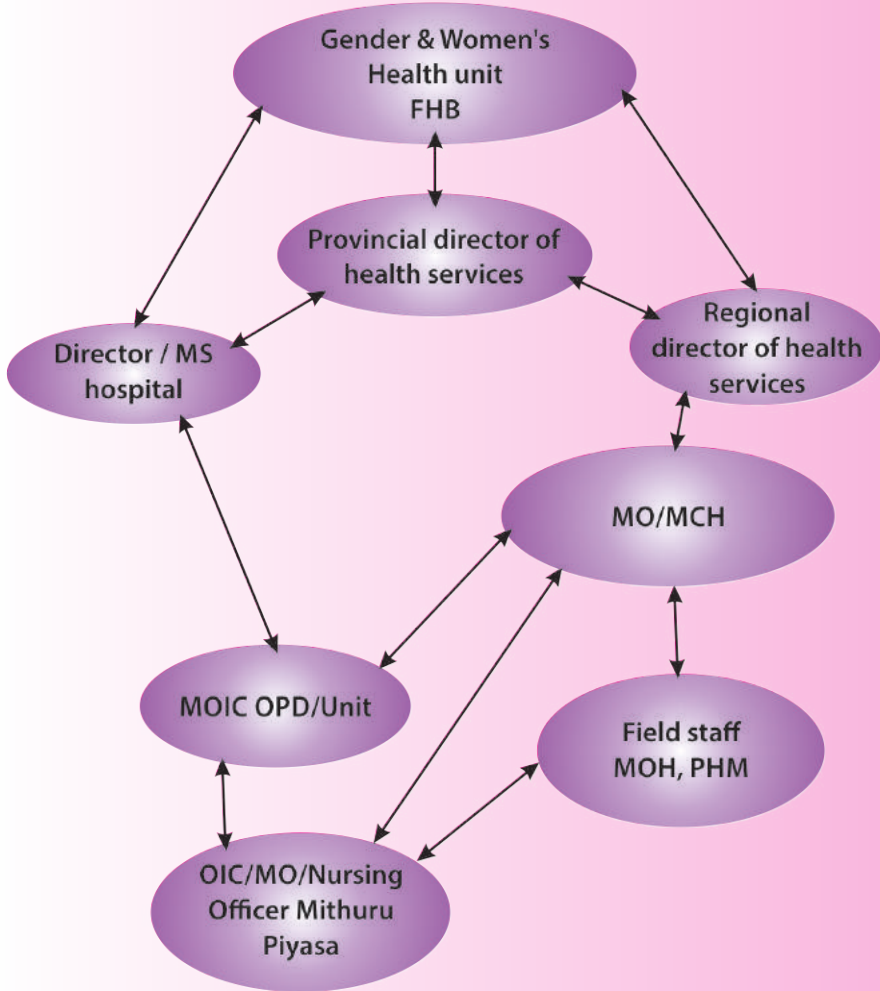
9.4. Medical Officer-in-charge of OPD / Unit to which Mithuru Piyasa (Natpu Nilayam) is attached

She / he will oversee the running of the center, assist in scheduling the medical officers and provide necessary guidance to O.I.C.(9.3)


9.5. Matron/Sister in charge of OPD/Unit

She / he will assist in allotting nursing officers to the center and provide assistance and guidance to the nursing officer working in the center.

10. Administrative structure



**Communication protocol for matters
other than referral of survivors**



11. Advocacy, educational and image building activities

It is important to realize that ,when a service on a sensitive issue such as GBV, is introduced to a health institution it may be viewed and treated with much skepticism, doubts about the need, resistance and even aggression. Therefore it is important to conduct an advocacy campaign prior to its establishment and continue to do so over many years. This should cover staff of all levels of care provision.

In order to ensure success of Mithuru Piyasa it is necessary to conduct educational activities to cover both institutional and field staff of the district to impart the knowledge on the subject of GBV particularly the health consequences, the role of the health care providers and the value of the service provided by Mithuru Piyasa.

The leadership for this activity in the institution should be taken by the core staff of the Mithuru Piyasa with the guidance of the Director of the hospital, the focal point on GBV at FHB. Expert resource support could be considered only when essential.

It is important to build up a very positive image of Mithuru Piyasa particularly within the different departments of the institution for sustainability of the center and to enhance the care provided to survivors of GBV.

In addition to the educational activities mentioned earlier it is suggested that information regarding the services provided by Mithuru Piyasa and success stories, if any, be circulated to the other sections of the institution on a regular basis preferably monthly by way of a letter directed through the Director of the hospital.

Every opportunity should be made use of by the staff of the Mithuru Piyasa to contribute by way of free papers or other research literature to local or national level academic activities.



12. Reviewing and Monitoring Mechanisms

12.1. Monthly progress review meeting

A monthly progress review meeting needs to be held on a regular basis. A particular day of the first week of the month may be identified for this purpose. The meeting should be chaired by the Director of the hospital or the MOIC OPD in his / her absence and all members of the staff should participate. The minutes of the meeting needs to be maintained. Wherever possible MOMCH should be invited for the meeting as a representative from the field health services.

Presentation of the monthly statistics and information on other care provision and educational activities should be done by the officer in charge. Adequate time should be spent on discussing the challenges faced by the staff and finding solutions to overcome them.

12.1.2 Conducting a case conference

This may be done as an independent activity, or as a part of the progress review meeting. This is done in order to obtain guidance and/ or consensus to manage a difficult situation regarding a client or as an experience sharing exercise, to enhance the skills of the care provider team. This would include, a discussion which highlights some of the challenges and difficulties faced by the providers and to provide a platform to discuss some of the challenging decisions that had to be taken during the previous month. It is essential to take all precautions to maintain confidentiality when such exercise is done.

12.2. Reporting Mechanisms

- 12.2.1. Copy of the data transmission instrument which is sent to FHB should always be submitted to the Director / MS of the hospital and approval should be obtained prior to sending it to the FHB.
- 12.2.2. A report, on the progress of the activities and identifying the challenges experienced, has to be submitted to the director / MS of the hospital. This must be prepared by the MOIC OPD/Unit in consultation of the MOO and Nursing Officers working in the unit in accordance with the format given in the MIS. This may be circulated to other consultants with permission from MS / Director.

12.3. Quarterly Review Meeting of the Steering Committee

12.3.1 Steering Committee at the district level comprises the following Officers:

- Representation from FHB (as and when feasible)
- RDHS
- Directors of the hospitals where Mithuru Piyasa units are sited
- MOMCH
- Officers-in-charge of the Mithuru Piyasa centers
- Technical advisor (if available)
- Representatives from local organizations linked to the service provision

12.3.2. Steering Committee at central level

A working group or a central steering committee is desirable to support the Mithuru Piyasa initiative at national level. The secretary of the committee must be the CCP of the Gender and Women's Health Unit of FHB and it should be co-chaired by the DDG/MS and DDG/PHS ii.

The members should include

- RDHS of the districts where initiative is being implemented
- Director MCH
- Representatives of UNFPA and other UN Agencies
- Representatives of Ministry of Women's affairs / NCW
- Representatives of Professional colleges such as College of Forensic Pathologists/College of Obstetrics & Gynaecologists/College of Psychiatrists, etc.....

13. References

1. Population and Reproductive Health Policy, 1998: Ministry of Health and Indigenous Medicine
2. National Health Development Plan 2013-2018, Ministry of Health, Sri Lanka.
<http://www.health.gov.lk/pub&reports.htm>
3. De Silva, S.T.G., Somathunge, L.C., Janakan, N. and Senanayake, L., 2008, National Report on Violence and Health in Sri Lanka, a WHO and Ministry of Health Publication
4. National HIV/AIDS Strategic Plan, 2007-2011, National STD/AIDS control programme: Ministry of Health care and Nutrition Colombo, Sri Lanka, ISBN 978-955-577-674-5
5. Clinical Management of Rape Survivors. Developing protocols for use with refugees and Internally displaced persons Revised Edition WHO ISBN 92 4 159263 X

14. Annexures

14.1. Data Collection instrument

Mithuru Piyasa (Natpu Nilayam)

Name of Hospital

.....

Confidential

This document is:

- Confidential
- To be kept under lock and key by the Nursing Officer-in-charge
- To be used at each follow up visit.

It is suggested that the health care provider first allows the survivor to talk freely, express her/his feelings, listen with empathy and then complete this form with necessary clarifications. Please use blank sheets to make notes .

Serial number
(same as appearing in the client register) :

With regard to the first visit please tick the appropriate

Referral from a ward / OPD :

Referral from police :

Referral from field health staff:

Self referral:

Others:

In the case of self referral how had the client come to know of this centre:

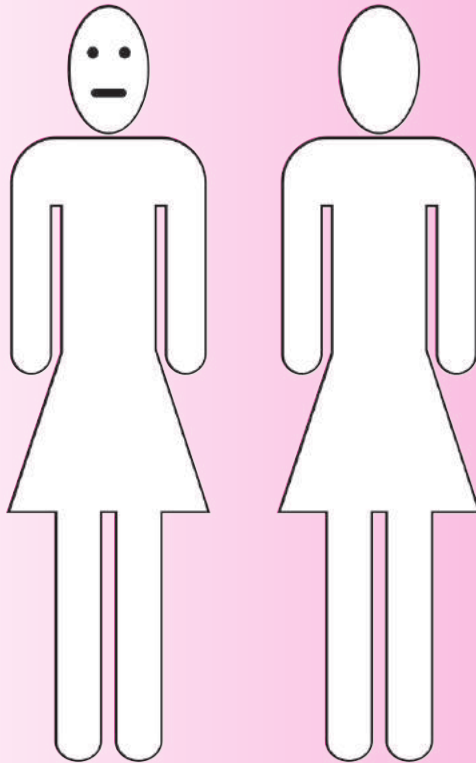
About the survivor		
Age		
Sex	female/male	
Employment status	Yes /No	
Is the client in a stable relationship	Yes /No	
If so how long		
Marital status	Yes /No	
Details of the incident that prompted the visit		
When did this incident happen	TodayDay/s agoMonths ago	
Types of violence experienced both present and past episodes (by the same perpetrator)		
Physical violence		Yes /No
• Slapped or hit		Yes /No
• Choked		Yes /No
• Beaten /Kicked		Yes /No
• Tied or blind folded		Yes /No
• Threatened with any weapon		Yes /No
• Stab or shot at		Yes /No

• Burnt	Yes /No
• Deprived of food	Yes /No
• Physical disfigurement	Yes /No
• Others :	
Sexual violence	Yes /No
• Forced to remove clothes	Yes /No
• Beaten on sexual parts	Yes /No
• Forced oral sex	Yes /No
• Rape	Yes /No
• Forced sex with an object	Yes /No
• Forced to watch pornography	
• Forced to pose for pornography	
• Forced to watch someone being sexually assaulted	Yes /No
• Others	
Emotional Violence	Yes /No
• Scolds regularly	Yes /No
• Made to feel inferior and small	Yes /No
• Abused in public	Yes /No
• Limits movement	
• Restricted access to relations	
• Others	
Economic violence	Yes /No
• Deprived of money	Yes /No
• Others	

**Results of Violence due to present or past episodes
(observed or as told by the survivor)**

Physical Consequences	Yes /No
• Bruises	Yes /No
• Blackout	Yes /No
• Dislocations	Yes /No
• Broken bone or bones	Yes /No
• Broken teeth	Yes /No
• Cuts needing stitches	Yes /No
• Burns	
• Others	
Sexual Consequences	Yes /No
• Dysparunia	Yes /No
• Loss of libido	Yes /No
• Lack of interest in sexual relationships	Yes /No
• Pregnancy	
• Others	
Emotional Consequences	Yes /No
• Depression	Yes /No
• Suicidal tendencies	Yes /No
• Panic attacks	Yes /No
• Sleep disturbances	Yes /No
• Other	

Was the client pregnant at the time of violence ?	Yes /No
Had the client ever spoken to someone about violence?	
• Husband / partner	Yes /No
• Mother / Mother in law / Female family member	Yes /No
• Male family member	Yes /No
• Friend	Yes /No
• PHM	Yes /No
• GP	Yes /No
• MO OPD	Yes /No
• Clergy	Yes /No
• Other	
About the Perpetrator	
What is the relationship?	
husband/lover/living partner	
family member (if so state the relationship)	Yes /No
relation (if so state the relationship)	Yes /No
friend	Yes /No
Other (explain)	Yes /No
Is he living with the client	Yes /No
Was he drunk at the time	Yes /No



Other findings : x-ray and at surgery

Reason for attending Mithuru Piyasa		
Sexual abuse not within family		
Domestic violence		
Disharmony in the relationship without physical violence		
Stressful situation not related to domestic violence		
Suicidal tendencies		
Others		

Safety Assessment	
• Has the violence increased in the past one year ?	Yes /No
• Does the perpetrator use drugs or alcohol ?	Yes /No
• Has he made threats to kill the client ?	Yes /No
• Are there weapons in the house ?	Yes /No
• Is client afraid to go home ?	Yes /No
Total Score (Risk score 1 – 5 1- low risk 5 - very high risk)	
Basic steps of a safety plan discussed and agreed by the survivor:	
What does the client feel about going to police (optional)	
Is the client aware of the Domestic Violence Act ? (in cases of domestic violence) Explain if She/he does not know	
Is client willing t to be contacted by telephone to inquire about her ?	Yes/No If yes what time of the day?
If yes: contact details	

	Initial visit	Second visit	Third visit
1. Befriending / provision of emotional support			
2. Referrals for other services within the hospital <input type="checkbox"/> Medical <input type="checkbox"/> Surgical <input type="checkbox"/> Psychiatry <input type="checkbox"/> JMO <input type="checkbox"/> Others			
3. Referrals for other services outside the hospital <input type="checkbox"/> Counseling/ In-depth counseling <input type="checkbox"/> Legal aid <input type="checkbox"/> Rehabilitation <input type="checkbox"/> Social service <input type="checkbox"/> Police <input type="checkbox"/> Others			
4. Discussion with family members			
5. Discussion with the perpetrator			