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The impact of COVID-19 on services for people affected by sexual and gender-based violence

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Abstract

Sexual and gender-based violence (SGBV), and particularly intimate partner violence (IPV), has spiked dramatically during the COVID-19 pandemic. At the same time, the pandemic is impacting and interrupting SGBV and IPV services of all kinds. This paper focuses on the impact of the COVID-19 pandemic on clinical care and forensic medical documentation for SGBV survivors, including an analysis of the response in the UK and Kenya, and provides recommendations for safe implementation of these services during the pandemic.

KEYWORDS:
Clinical care; COVID-19; Domestic violence; Forensic examination; Intimate partner violence (IPV); Sexual and gender-based violence; Sexual violence

Sexual and gender-based violence (SGBV), and particularly intimate partner violence (IPV), has spiked dramatically during the coronavirus disease 2019 (COVID-19) pandemic and has been labeled by global leaders as a "pandemic within a pandemic".[1] The UN Population Fund (UNFPA) estimates that "6 months of lockdowns could result in an additional 31 million cases of gender-based violence".[2]

Even outside the context of a pandemic, there are often significant barriers for survivors to access SGBV services. COVID-19 has exacerbated these barriers. SGBV services are not deemed a priority, resources are being diverted to the COVID response, and health workers are overwhelmed and not able to give attention to forensic examinations or to performing them given restrictions on in-person medical care. In addition, survivors may forgo visiting hospitals and clinics due to fears of contracting coronavirus or lack clear guidance on how to safely access care and support.[3,4]

The pandemic is impacting and interrupting SGBV and IPV services of all kinds, including medical care, psychosocial support or counseling, and access to shelters. Legal processes are also affected, with some survivors reporting that court closures make it impossible for them to seek legal redress and that health professionals are unable or unwilling to attend court to provide expert testimony for fear of spreading coronavirus.[5]

Restrictions and stigma related to COVID-19 are impeding access to clinical care and forensic medical documentation for SGBV and IPV survivors. This article highlights the impact that this double pandemic is having on survivors of sexual violence and recommends measures to improve the provision of services for SGBV/IPV survivors, especially during the COVID-19 pandemic. Given our work, we are focusing our analysis on the response in the UK and Kenya.

1 | UNITED KINGDOM

There are 47 sexual assault referral centers (SARCs) in the UK, which provide forensic medical examinations and ensure medical and psychosocial follow-up for sexual assault patients. In the first 6 weeks of the UK's lockdown, SARCs saw a 50% decrease in the number of referrals for forensic examinations, according to internal communications. To respond to the pandemic, SARCs altered their practice to reduce face-to-face contact and changed their protocols based on feedback from staff and the evolving situation.

Before COVID-19, a determining criterion for offering a forensic medical examination (FME) was the DNA retrieval timeframe; examinations were offered for all types of assault and police and nonpolice referrals for FME were accepted. Coronavirus has changed the criteria for offering FMEs. For police referrals in London, when the complainant is 18 years of age and over, an FME is offered in cases of stranger assault and intrafamilial assault. For acquaintance and partner assault, decisions to offer an FME are taken on a case-by-case basis.

For example, police will make a referral for an FME if they determine it is crucial for the case to prove that sex occurred, to identify the suspect, or to document injuries.

In the case of nonpolice referrals, where the patient has not reported the assault to the police yet wishes to have a forensic examination for collection and preservation of evidence, FMEs are now only considered for cases deemed of public interest, where samples will not be stored but given anonymously to police for analysis by the forensic lab. This is because of potential infection control concerns when storing samples in forensic freezers at SARCs, as freezing does not destroy the coronavirus. FMEs are still offered for all types of assault for those under 18 years old, as was standard before COVID-19.

When patients are given a face-to-face FME, the patient attends alone with the police officer, unless there is a clear need for a parent or responsible adult to attend. All the necessary information is obtained, and immediate medical needs are discussed through an internal video consultation system. Face-to-face interaction is limited to the physical examination and taking swabs and the forensic team wears personal protective equipment (PPE).[6]

All requests for face-to-face FMEs are first subject to a telephone screening for COVID-19, including both the patient and the police officers. For patients with confirmed or suspected COVID-19, the clinician will propose a telephone/video consultation and forensic self-swabbing (of the oral cavity, anus, or vagina) at home as the default option, bearing in mind the patient's age and ability to perform self-swabbing.

The swabs and evidence bags are labelled by the SARC team and brought to the patient by the police officer. The forensic physician is available for support when the patient receives the swabs.[6–8] Self-swabbing has been recognized as an acceptable method of evidence collection by the courts in England and Wales in COVID-19 suspected or confirmed cases. If self-swabbing is not suitable or possible and the patient needs to come to the SARC, they are given a surgical mask to wear and the time spent documenting injuries, including colposcopy and medical photography, is limited.

For all other cases where a face-to-face appointment is not offered, a telephone/video consultation is also proposed, which includes a discussion regarding emergency contraception, HIV postexposure prophylaxis, a risk assessment of self-harm and suicide, and a discussion about any safeguarding concern. If necessary, delivery of medication to the patient will be arranged by the SARC.

These adjustments to existing protocols have not been without difficulty. Some staff have shared that they face increased stress and tension between colleagues because of uncertainty, shifting protocols and guidance, and concerns regarding adequate PPE. Doctors have noted that wearing a mask or visor notably shifts the patient–doctor relationship, making building trust and rapport and expressing empathy—crucial when working with sexual assault patients—challenging.

As outlined above, technology has been an important tool for SARCs to continue services during the COVID-19 pandemic, but it is not without its challenges. Video consultation with patients has created new obstacles; developing the doctor–patient relationship is more difficult and viewing physical signs of the assault via telehealth is a barrier, especially when the injuries are on the genitalia, as doctors will not ask patients to show their genitalia via video consultation. There are also serious privacy issues with telehealth services for patients who may be reporting from their home, under the watchful eye of the perpetrator and/or other members of the household, including children, nearby.

Though these changes to patient care practices are challenging, they may in fact yield new protocols and practices that are of benefit even after the pandemic has subsided.

2 | KENYA

In Kenya, sexual violence patients are typically seen at gender-based violence recovery centers (GBVRCs) located within county and national referral hospitals. Following the outbreak of COVID-19 in Kenya, referral hospitals were the first to be designated as coronavirus treatment and isolation centers. In an effort to reduce overcrowding, some clinics ceased operations, and postponed or cancelled clinical services.

While some healthcare facilities remain open to provide non-COVID-related care, there have been limited efforts to inform survivors of sexual violence that these facilities are still receiving clients. As a result, the number of survivors presenting at health facilities within the first month decreased, compared with the same time frame before the pandemic. Similar to the situation in the UK and elsewhere, fear of infection also played a role in keeping people away initially.

Three months into the lockdown in Kenya, the number of survivors being seen at GBVRCs has "normalized," but the patterns of survivors seeking care have changed. Currently, the majority of survivors presenting are minors below the age of 16, potentially due to children being left alone, and therefore more vulnerable to SGBV, during school closures. There has also been an increase in patients seeking care for intimate partner violence, whereas before the pandemic most cases seen in these facilities were not intrafamilial.

Unlike in the UK, forensic documentation practices in Kenya have not drastically changed to comply with COVID-19 restrictions. FMEs are still being conducted and there has not been a reduction in face-to-face contact. All survivors who present to the GBVRCs receive an FME, counselling, treatment for sexually transmitted infections, contraceptives, prophylactic medication, and a filled-out forensic documentation form—if these are available. The health facilities cover the costs of these services. With increasing expenditure on protective equipment, testing kits, and training related to COVID-19, it remains to be seen how long these comprehensive services will be offered.

Patients now experience two additional screening points at the medical facility for COVID-19 before they get to the GBVRC. History taking has also been slightly altered to include additional questions and measures to screen for COVID-19 risks. Some health professionals have had to move to more spacious rooms that may have less privacy but allow for physical distancing.

The face-to-face encounter now includes a requirement to wear masks by both parties, which has presented challenges in building trust and the assessment of behavioral cues. There have also been

delays in sample collection by the police and in the transfer of samples to the national government laboratory, as the police force has been overstretched enforcing COVID-19 response measures.

Finally, as is the case in other parts of the world, clinicians are not able to go to court to provide expert testimony for cases of sexual violence. Activities at the courts have been scaled back, with only the most urgent cases being heard.

3 | RECOMMENDATIONS

Recognition that clinical services for survivors of sexual violence and IPV are essential and even lifesaving is the first step in addressing the "pandemic within the pandemic." Moreover, stakeholders must understand that the medicolegal aspects of such services—forensic evaluations for the purpose of evidence collection, should patients want to pursue legal action and redress—are as critical as medical care.

Frontline health workers should be made aware of increased risk for IPV/SGBV in the context of large-scale crises and receive training to identify and handle such cases appropriately.[9] Information campaigns should be developed for members of the public, who may be able to assist in recognizing signs of abuse within their familial and social circles, and for those affected about how to access resources.

Health systems must identify creative solutions to provide clinical care and forensic services for survivors, while also keeping them safe from exposure to coronavirus. Examples include: using technology for remote visits, implementing rigorous screening and testing protocols ahead of in-person visits, allocating sufficient supplies of PPE to clinicians interacting with survivors in person, creating opportunities for self-collection and preservation of evidence, addressing social issues (such as safe housing) in the context of follow-up care, and working closely with law enforcement to implement unified protocols.

Lastly, interprofessional and multisectoral collaboration must be enhanced and mechanisms for ongoing remote communication strengthened to ensure legal and psychosocial support.[10]

Without timely documentation of the evidence of sexual violence crimes, there will be little hope of justice for survivors, leading to continued impunity for perpetrators and devastating impacts on survivors, families, and communities. The time is now for governments and healthcare providers to ensure that survivors of sexual violence have access to and receive safe, high-quality services during the era of COVID-19, and the medicolegal support to pursue accountability and redress.

AUTHOR CONTRIBUTIONS

KJ, LG, MV, SK, TM, KN, and RM contributed to the conception of the piece. MV and SK gathered information for and drafted the case study sections. KJ, LG, TM, and RM conducted the literature review. RM and MV drafted the recommendations section. KJ led the drafting and coordination of the piece. All authors conducted critical revisions of the piece and reviewed and approved the final version to be submitted.

CONFLICTS OF INTEREST

No conflict of interest has been declared by the authors.

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