STANDARD OPERATING PROCEDURES FOR RESPONDING TO WOMEN AND CHILDREN SURVIVORS OF SEXUAL VIOLENCE & DOMESTIC VIOLENCE

ROLE OF HOSPITALS AND HEALTH CARE PROVIDERS

INFRASTRUCTURE, EQUIPMENT, AND COMMODITIES

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

Infrastructure and equipment

- A private (survivor of violence should not be seen or heard from outside) consultation / examination room that is clean and comfortable
- Access to toilet / latrine attached to the consultation / examination room or close to the room that can be locked from the inside, with a disposal bin, and water supply;
- Access to drinking water.

Furniture and supplies

- Chairs for survivor, companion, and provider (minimum of 3 chairs in the consultation / examination room);
- One writing table / desk between the provider and the survivor;
- A door, curtain or screen for visual privacy during physical examination as and when required;
- One examination table for examination of physical injuries as and when required;
- A washable or disposable cover for the examination table;
- Adequate light source in the examination room/space;
- Angle lamp or torch / flashlight for pelvic exam;
- Access to a lockable cabinet, room or other unit for secure storage of survivor paper files / register;
- Access to a lockable medical supply cabinet or lockable room where medical supplies are kept.

Administrative Supplies

- Job aids in the language of provider and client population (LIVES and Signs and Symptoms associated with VAW);

- Printed copy of the MOHFW 2014 guidelines and protocols for medicolegal care for survivors/victims of sexual violence; and copies of proforma as per the MoHFW 2014 guidelines for documentation of findings of medicolegal examination of the survivor;

Essential drugs and commodities

- HIV test kits – an adequate number of 08-10 kits (or as adequate) to be present at all given times
- SAFE (Sexual Assault Forensic Evidence) Kits – an adequate number of 30 kits (or as adequate) to be present at all given times
- Pregnancy test kits (Nischay Kit) – an adequate number of 30 kits (or as adequate) to be present at all given times
- Emergency contraception pills (Ezy Pills) or IUCD – an adequate number of 30 units (or as adequate) to be present at all given times
- HIV post-exposure prophylactics (Nevirapine/equivalent brand) to be available in adequate quantity
- Drugs for treatment of Sexually Transmitted Infections (STIs) (Kit 1, Kit 2, Kit 3, Kit 4, Kit 5, Kit 6, Kit 7) to be always available as per caseload
- Drugs for pain relief (e.g. paracetamol, diclofenac) to be always available as per caseload
- Local anesthetic for suturing (Catgut thread) to be always available as per caseload
- Broad-spectrum antibiotics and dressing for wound care (Amoxicillin, Oxytocin, Ampicillin, Cloxacillin, Dexona, Ceptrazen) to be always available as per caseload
- Tetanus Vaccine (Tetvac) – to be always available as per caseload
- Essential drugs, injectibles, IV sets, gloves.

PRIVACY, CONSENT, AND CONFIDENTIALITY

PRIVACY implies the right of the survivor to have access to a personal space (physical privacy) for sharing her experience of violence and undergoing physical examination, as well as her right to the data she shares (informational privacy).

Privacy

- To ensure the privacy a private area should be designated as a facility room / space where the survivor cannot be seen or heard from outside; counseling and clinical services to all survivors should be provided in private; (The space / room should be large enough to allow an accompanying person especially in case of child survivors, 2 doctors and one nurse in addition to the survivor);
- History of incident and abuse should be taken in this private area/space only;
- If the survivor is accompanied by relatives / any other person, the health provider shall create an opportunity to speak to the survivor alone (ask the relative to sit outside, bring some material or fill up some form). Ensuring privacy will allow HCPs to offer best quality of care.

CONSENT implies the right of the survivor to decide for herself and to agree to receive – or refuse – medical treatment, intervention and care. The type of treatment and care, as well as the extent of it should be her choice as long as she is above the age of 12 and of sound mental status; the provider's responsibility is to share in accurate and understandable details, the range of options available to the survivor and the pros and cons of each option. The provider can facilitate the decision making but should never interfere with the survivor's autonomy.

Consent

- In cases when violence is disclosed to the provider, the provider should take the survivor's consent before proceeding with information provision and offering services for violence (after ensuring privacy as described above). This would entail registering of MLC and referral to Dilaasa department.
    - Survivors reporting assaults, accidental consumption of poisoning, burn, attempted suicides, falls to the Emergency department
    - Survivors reporting with other health complaints in any of the OPDs of the hospital (Annexure---Signs and Symptoms associated with VAW)
- Depending on the presenting symptoms, survivors must be informed about legal obligation for reporting under PoCSO, information about PWDVA and contact details of Protection Officer.
- Oral consent should be sought for those above 12 years, for those below 12 years, oral consent of the parent/guardian should be sought.

CONFIDENTIALITY is defined as the survivor's right to have personal, and identifiable information kept private by the provider / facility. Unless mandated by the court of law, the provider shall not give access to the survivor's records to anyone else. If any discussion on the case is needed, all identifying markers shall be removed and the case should be anonymised. This is vital in ensuring the safety of survivors of domestic and sexual violence.

Confidentiality

- The healthcare facility / hospital should keep survivor files, medico-legal forms, VAW register, forensic evidence register and any other documents with identifying information about the survivor securely in a locked room / cupboard or locker;
- The history of violence, survivor's and abuser's identity should not be disclosed unless for the purpose of medical or medico-legal procedures.
- The case details should not be discussed / shared with persons not involved in provision of care to the survivor (i.e., for medical or medicolegal purposes)
- Chain of custody for forensic evidence should be laid down and strictly observed
    - In medico legal cases (MLCs) the examining doctor shall be responsible for (i) collecting, and drying collected samples (ii) labelling and (iii) properly sealing the evidence;
    - The in-charge of the OBGY department / examining department shall be responsible for securing the evidence and handing over to the police in case of MLCs.
- For non-MLC files, the documentation should be kept under the responsibility of the unit head of the concerned department (medicine, ANC or Gynaec, surgery, ortho or any other)

- Copies of relevant medical record such as MLC paper, OPD, IPD, Rape proforma, Discharge card, shall be handed over to the (i) survivor, (ii) hospital, (iii) police.

Security of records

- Staff members should not leave / expose documents related to the survivor others (it can be shared with survivor if she requests to see it), those accompanying the survivor or anyone else might see them;
- When documenting information about the experience of violence of the survivors, staff members should ask for information and write this down in a designated area where privacy is ensured.
- Staff members should not write any 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 should be shredded in the presence of the Nodal Officer of the hospital.
- Documents related to survivors of violence should be kept locked up at all times; records of treatment at hospital, duplicate copies of MLC, discharge summaries, should be made available free of cost

DOCUMENTATION, HISTORY TAKING, AND MEDICAL CARE

The hospital should maintain all intake forms, casualty, inpatient papers, copies of medico legal examination, charts, and registers that collect information about a survivor's experience of violence. The hospital should put in place systems for safe and secure storage of relevant documentation that is of relevance in court cases or for provision of care to the survivor in future.

- For all survivors the MLC documentation should follow the guidelines presented in annexure
    - Record the name of the abuser (where available) and relation with the survivor (where applicable)
    - Document verbatim narrative
    - For child survivor's colloquial words used by the child should be noted down verbatim along with inferred meaning
- If survivor is brought by the police, then Letter number, the Case Register (CR) number, and Indian Penal Code (IPC) sections should be recorded by the in-taking person;
- The date and time of arrival of the survivor to the hospital shall be recorded on the relevant forms and registers by the in-taking person;
- Contact number of the survivor to be recorded at relevant places on forms and registers only with consent of the survivor.
- All cases of women or child survivors of violence should be referred to Dilaasa through formal referral noted on the case paper of the survivor. If a doctor even suspects violence he or she may refer her to Dilaasa.
- All survivors of violence, especially women and children, who express need for shelter or express fear of returning home, should be provided emergency shelter for 72 hours by admitting them to the appropriate ward at the hospital (children in paediatric ward,

women in medical or gynaecology ward, men at male medical or surgical ward and persons with other gender identities should be admitted to male or female wards based on their comfort levels).

Role of Healthcare Providers

- Identify Abuse: Look for signs and symptoms revealing abuse (table on annexure V); ensure privacy and assure confidentiality for survivor
- Acknowledge / respect the 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 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 **L**istening, **I**nquiring about needs and concerns, **V**alidate response to survivors' experience, **E**nhance her safety, **S**upport 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 survivor to Dilaasa for psycho social support; after providing LIVES / first line psychosocial support at the point of first contact with health care 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 MOHFW 'Proforma For Medicolegal Examination of Survivors / Victims of Sexual Violence' (annexure no. I, pp 62-74);
- Ensure / Advise follow-up: It is important to recognise that referring the 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 treatment / to address ongoing clinical needs (e.g., for injury, health conditions, STIs, repetition of pregnancy test, pregnancy, mental health and planning.) and advise so:
- 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 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 survivor.

Health care providers MUST NOT DO the following:

In cases of sexual violence:

- **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.

In cases of domestic violence:

- 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 MLC: 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 Dilaasa, MLC, emergency shelter at hospital 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

FOR IMPLEMENTATION OF SOPS

Preparedness

- Orientation to all medical officers including RMOs about role of health care providers in health system response to survivors of violence
- Orientation to all nursing staff about role of health care providers in health system response to 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 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 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 survivors to seek help and to sensitise the providers

Monitoring

- A system of periodic review of health system response to survivors of violence should be put in place
- The nodal officer should facilitate this meeting where doctor and nurse representatives of OBGY, general surgery, paediatric medicine departments are present. Information on number and nature of cases registered over the review period should be presented.
- Challenging cases should be discussed.