STANDARD OPERATING PROCEDURES FOR DILAASA DEPARTMENTS FOR RESPONDING TO VIOLENCE AGAINST WOMEN AND CHILDREN

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NATIONAL HEALTH MISSION
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NATIONAL URBAN HEALTH MISSION

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PURPOSE AND SCOPE OF THE STANDARD OPERATING PROCEDURES (SOPs)

Health system has a critical role to play in responding to violence against women and children. Healthcare providers are often first and trusted point of contact for survivors of violence. There are several health systems based intervention for survivors of violence which have been tested and implemented in High Income Countries. However, there is limited evidence from Low and Middle Income countries on how to establish a health systems'' response to v violence against women and children.

Dilaasa, which is a hospital-based crisis intervention centre is one of the first health system-based initiatives in India and it got integrated into government's National Urban Health Mission (NHM, 2016) in Maharashtra; and has now scaled up in 11 public hospitals in Mumbai by the Municipal Corporation of Greater Mumbai (MCGM).

Dilaasa was set up jointly by CEHAT and Municipal Corporation of Greater Mumbai (MCGM) in 2000 at K. B. Bhabha Municipal Hospital in Mumbai. It functions as any other department of the hospital through rigorous training of hospital staff to provide services, formulating procedures and protocols, and establishing a core group headed by the Medical Superintendent to monitor its functioning. Over the years, Dilaasa has received international recognition as a scalable health system model in Low- Middle Income Countries (LMICs) and was replicated in several states of India.

This Standard Operating Procedure has been based on more than two decades of implementation of Dilaasa model and ensuring quality of care for survivors of violence. It aims at:

1. Providing evidence-based guidance to healthcare administrators for implementing and overcoming challenges for a holistic systems' response to violence against women and children.

2. Building health systems' readiness to respond to survivors of violence in low resource settings.

3. Guiding providers to uphold the rights of survivors in challenging cases that pose ethical dilemmas due to legal obligations for providers.

This document is significant in Indian context where there has been a legal mandate for a health sector response under the Protection of Women from Domestic Violence Act (PWDVA), 2005; Protection of Children from Sexual Offenses Act (POCSO), 2012; the Criminal Law Amendment to Rape (CLA), 2013 and the MOHFW Guidelines of 2014. Further, India's National Health Policy (NHP), 2017 gave a clear directive to the health sector to address gender-based violence.

STANDARD OPERATING PROCEDURES FOR DILAASA DEPARTMENTS FOR RESPONDING TO VIOLENCE AGAINST WOMEN AND CHILDREN

Dilaasa departments were set up in municipal peripheral hospitals to enable health services to provide comprehensive response to survivors of violence and are an integral part of the hospitals. The key role of the Dilaasa Departments is to provide crisis intervention to survivors reaching hospitals. This includes provision of psychosocial support, and referrals to other support agencies and liaison with these resource agencies to facilitate access to services and care for the survivors.

INFRASTRUCTURE, EQUIPMENT, AND COMMODITIES

Infrastructure and equipment

- Dilaasa department must be in a location that is easily accessible for women and children. Can be next to OPDs of the hospital or near the Emergency department
- The department must have atleast two rooms to ensure adequate visual and audio privacy to survivors during sessions with counsellors, with doors that can be closed when required.
- The rooms should have a comfortable / welcoming feel to it.
- Provision of clean drinking water should be in the counseling room.
- Access to a wash basin, clean, safe toilet attached must be provided.
- The department should have a phone line connection (direct / extension from the main board).
- There should be a waiting area with adequate seating for the department.

Furniture and Supplies

- Each of the rooms should be equipped with a table / desk, chairs for the counsellor, survivor, and accompanying persons if any. A minimum of four chairs should be made available for each room of the department.
- Additional desk and chair should be provided for the data entry operator.
- At least one computer (desktop) to facilitate data entry
- Adequate secure storage facility in the form of cabinets that can be locked for storing records of counseling and other documentation related to the survivors.
- Adequate light and ventilation for the room.

Administrative supplies

- Printed copies of intake forms for documenting first contact with Dilaasa counsellor
- Printed copies of follow up forms and Dilaasa rubber stamp.

- Other registers as introduced (e.g. register for documenting suspected / cases of violence seen at casualty, register for documenting contacts with women admitted to the hospital during active case finding by the counsellors / ANMs register for documenting new cases registered, register for documenting names of survivors who follow up, etc.)
- Other items of stationery (e.g., Dilaasa letter head, inward and outward registers, printed referral forms for referring survivors to other support agencies including the protection officer, child welfare committee, shelter homes, police stations, legal aid services, NGOs that help with skill building or livelihood training or other forms of assistance, etc.)
- Health education / information material for survivor in the form of posters, pamphlets, AV materials, contact details of the department in the form of printed cards with contact details of Dilaasa and the number for helpline, etc.
- Resource directory for meaningful referrals to other support agencies (this should include names, addresses, contact numbers, specific nature of support extended, eligibility for seeking help, limiting conditions if any such as limits on duration of stay at shelter home, etc.), details of all services within the hospital, informative material on legal aspects relevant for survivors of sexual violence, etc.

PRIVACY, CONSENT, AND CONFIDENTIALITY

PRIVACY implies the right of the survivor to have access to a personal space (physical privacy) for sharing her narrative and undergoing physical examination.

Privacy

- Visual and audio privacy must be maintained during counselling.
- If the survivor is accompanied by relatives / other persons, the counsellors should create an opportunity to speak to the survivor alone (ask the relative to sit outside, ask the survivor to return at another time unaccompanied if she is more comfortable with it, etc.)
- All communication about the survivor's experience of any form of violence must take place in privacy of the counselling room or if this is for some reason not possible, private space must be made available for the counsellor to speak with the survivor alone. For example, in case of admitted patients who are not allowed to step out of the wards, counselling could be done in the side room or by ensuring privacy by taking the patient to a less crowded area within the ward, placing screens etc.

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 follow:

Consent

- All survivors who approach Dilaasa / counsellors or ANMs or the ones to whom the team reach out to must be provided information about services provided through Dilaasa; Counselling and other help (e.g. referrals) should be provided only if the survivor gives consent to it. If the survivor is unwilling for counselling at the time, she should be offered an alternative of approaching Dilaasa if and when she needs it. She should be provided with contact number and information required.
- If a child (person less than 18 years of age) discloses sexual violence to the counsellor / ANM, the counsellor / ANM should explain the need for mandatory reporting as per the law to the parent / guardian of the survivor and explain the procedures. In cases where parent / guardian is not willing to report the incident of sexual violence against a minor to the authorities, the counsellor must discuss safety of the survivor. If safety has been ensured then an informed refusal should be documented. The team could also inform Child Line and/or Child Welfare Committee if there is a need for immediate intervention at home level or if the child is lost to follow up at Dilaasa.
- A minimum of three follow ups – telephonic or in person – should be attempted by counsellor to ensure safety of survivors.
- For adult survivors, telephonic follow ups should be attempted only when consent for the same is given by the survivor. If the survivor does not return for 3 months, a call on her safe number or letter on her safe address should be sent.

> 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 intake forms, follow up documentation, registers with records of communication with women during active case finding by ANMs and any other information with identifying details of the survivor should be kept securely in locked cabinets, locked rooms. Access to it should be restricted to counsellors, ANMs and persons designated by the hospital.
- Information contained in the counseling records including contact details should not be disclosed to persons other than the Dilaasa team (counsellors, ANMs, data entry operator) and persons designated by the hospital (e.g. nodal officer). While doing so, only relevant information may be given.
- Referring survivors by names or identifiable details should be avoided when providing feedback to / discussing the case with the doctors or team members. Always use the registration number as reference.
- If a survivor expresses discomfort at seeking services at any given Dilaasa because she fears being identified (her privacy being breached) because of familiarity with the staff at the hospital, she should be referred to Dilaasa at a hospital of her choice. She should not be forced to seek services from the centre where she does not feel comfortable. (This may happen in case of staff members from the hospital or their relatives who wish to seek services from Dilaasa).

- There are limits to confidentiality in cases where the counsellor identifies / recognises suicidal thoughts in a survivor. In such situation, the counsellor may decide to inform a family member about these and involve that person in safety planning for the survivor. However, the counsellor must first explain to the survivor the need for disclosing the information to family / friend's whom survivor feels comfortable with.

PROVISION OF PSYCHOSOCIAL SUPPORT – SCOPE OF SERVICES, ASSESSMENT OF SAFETY, MULTISECTORAL REFERRALS

Provision of psychosocial support to the survivors of domestic and sexual violence involves several aspects. The counsellors should be mindful of and incorporate the values and principles of feminist counselling into their services. Survivors are often in need of multi-sectoral services and it is important for Dilaasa teams to liaison with other agencies to facilitate access for the survivors. When referring a survivor to another agency counsellor should only say that the woman is registered at Dilaasa. Other confidential information should not be shared.

The counsellor should explain the procedures including timings, that the counsellors take turns hence for subsequent visits another counsellor might work with her. The key points from the counsellors' communication with survivor are noted down in the intake form and help counsellors for follow up.

Safety assessment and safety plan needs to be done for all survivors.

Safety assessment of survivors of violence helps the counsellor understand the threat to the woman in the context of frequency and severity of violence; and in terms of impact the violence has on the woman's physical and mental health. Assessing immediate safety of the woman and providing help to make her feel safe is an important step in the crisis intervention process.

The table below provides elements of a safety plan and questions the counsellor can ask the survivor to help her make the plan. It is important to respect the survivor's decision. Safety planning can involve developing a plan for separating from an abusive spouse or taking measures to increase survivor's safety. This may be an immediate step or preparing her for such a situation in future. In any case, she should ensure access and safety of documents such as bank passbook, ornaments, Aadhar card, any other important papers.

Elements of safety plan	Questions to ask for making safety plan
Safe place to go	If you had 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 survivor has children)
Transport	How will you get to your safe address?
Items to carry	Do you need to take any documents, keys, money, clothes, phone, telephone numbers or other things with you when you leave? What are the essential items? Can you put these essential items in a safe place or leave them with someone you trust outside your home, just in case?
Financial	Do you have access to money in case you need to leave in an emergency? Where is it kept? Can you access it in an emergency?
Support of someone who lives close by	Is there a neighbor you can talk to about violence, who can help you call the police or come with assistance for you if they hear sounds of violence coming from your home?
Source: WHO Clinical Handbook (Field Testing Version) 2014	

It is important to assess the safety of the survivor by enquiring about the severity of violence and its consequences.

- Has violence increased in severity and intensity over the years?
- Are there threats to kill her, attempts to kill her?
- Are there threats to remarry?
- Has she been beaten when pregnant?
- Answers yes to “Do you believe he / any of the family members could kill you?” / “Have you thought of committing suicide?” “If yes, then have you attempted it, do you have any plan of committing suicide?”

The more questions a woman answers with 'yes', the more danger she is in.

Safety assessment in cases of attempted suicide

The counsellors should be aware of special counselling needs of women who attempt suicide or have suicidal thoughts because of domestic or sexual violence. Assessing safety of the survivor is of great importance here. In order to be able to help such a survivor, the counsellor should

- Recognise the signs of the woman being suicidal from her communication
- Ask directly if she has thoughts of ending her life or causing self-harm and if she has ever tried to do so, explore about the preparations she made etc., to get an insight into the situation
- Do not be judgmental, blame the survivor, make her feel guilty for causing pain to herself and others who love her
- Talk to the survivor about involving a close member of family / friend in safety plan
- Talk to her about not being alone when she starts getting thoughts of self harm or when she recognises precipitating factors (e.g. an episode of violence etc.)
- Talk to the support person agreed upon by the survivor about risk for the survivor and potential role s/he could play.
- Plan small doable steps for the survivor e.g., call the support person every day, visit Dilaasa each week, call a friend when such thoughts come to her mind etc.
- Refer to specialists who could help her in suicide prevention, if required

Referrals and liaison with other resource agencies

Survivors of violence often need support from several resource agencies / support structures including the police, judiciary, shelter homes, child welfare committees, protection officers, various NGOs providing specific help such as vocational training, help for education of children, support for children or persons with special needs etc. The survivors may need information, guidance and assistance for availing support from these resources. The Dilaasa teams need to be prepared to extend support in this context.

- The counsellors should inform the survivor for the procedures involved, help her write down her account of abuse and put together relevant papers which would help her in her interactions with the PO.

CWC

- Child survivors of sexual violence need to be presented before the CWC. At times the counsellors may need to seek support from the CWC for arranging shelter or MTP for the survivor.
- The counsellors need to be aware of the zonal CWC their hospital / police station where the complaint is registered falls under
- Contact numbers of CWC should be available with Dilaasa.

DOCUMENTATION, HISTORY TAKING

The Dilaasa department should maintain / have all intake forms, casualty, inpatient papers, copies of medicolegal examination, charts, and registers that collect information about a survivor's experience of violence. The hospital should put in place systems for careful storage of relevant documentation that is of relevance for provision of care to the survivor in future.

- The counsellor should start the procedure of counseling after informed consent from the survivor. Details of the survivor (identifying information, contact information, narratives about the incident, safety plan including address and contact number of safe places, details of FIR, MLC etc., should be clearly noted in the intake form by the counsellor on the first visit by the survivor. The intake forms should be filled as soon after the counselling session as possible to ensure loss of information from poor / limited recall.
- Details of subsequent visits should be recorded into follow up forms by the counsellor.
- Details of telephonic follow up with survivor should be recorded into the follow up forms by the counsellor.
- Casualty register should include account of women who presented as cases of assault, fall, poison consumption, attempted suicide, bleeding per vaginum that presented to the casualty in the past 24 hours. Details such as name, age, nature of complaint, time of reaching the hospital, whether treated on outpatient basis, referral to Dilaasa.
- The ANM must record details of their communication with women during active case finding in wards or OPD waiting areas. The documentation should be completed on the same day after the rounds to identify survivors of violence.
- Cases identified during rounds and referred to the counsellor for counselling too should be noted in the case identification register if they choose not to seek services from Dilaasa (denied DV) and an intake should be filled if they agree to share history and choose to avail services from Dilaasa.
- Counsellors must complete all documentation pertaining to new cases of women on the same day. This is important as the next day if there is another colleague on counselling duty and survivors comes back; lead counsellor must have all documented information.

Police: Registration of complaint with the police is an important step in women's struggle for escaping violence and Dilaasa teams should be prepared to help women in this regard.

Preparedness in this context would include -

- Familiarising self with police procedures, including commonly used terminologies, whether NC/FIR needs to be filed, and details of procedures involved with these.
- Knowledge of drafting a complaint – presentation of contents.
- Information about police stations in the catchment area of the hospital where Dilaasa is located – the contact numbers.
- Information about steps to be taken to address any challenges faced in registering a complaint (e.g. if the survivor reports that the police did not accept her letter or did not register an NC or refused to take an FIR etc.)

Courts and Public Prosecutors: Often the survivors need information and guidance regarding the legal processes. Counsellors should be prepared to provide this.

- The counsellors (and the team) at Dilaasa should be well informed about the laws related to domestic violence – the PWDVA, POCSO, CLA, IPC 498A, etc. And they should be able to explain the relevant aspects to the survivor in simple language.
- The counsellors must have updated information about legal provisions regarding divorce, maintenance, protection, child custody, residence etc.
- Dilaasa teams should have information about provision of free legal aid cell and procedures related to these.
- A list of contact numbers for lawyers who can extend support to survivors should be compiled and kept ready at the OPD. This should be provided to the survivors in need.

Shelter home

- Dilaasa should keep a resource directory with names and contact details for shelter homes in Mumbai. Eligibility for admission (age, pregnancy status, accompanied by children, with certain medical conditions, disabilities, etc.), duration of stay allowed, other rules and restrictions (e.g., once admitted residents cannot step out for employment, if allowed to step out must return within specified hours, etc.) for each of these should be noted clearly in this directory. The counsellors / Dilaasa team should visit the shelters personally before referring survivors to them. A telephonic follow up should be carried out to ensure the survivor's safety at the shelter.

Protection Officers

- Each Dilaasa should be aware of which zone their survivors' residence falls under and refer her to appropriate office.
- The counsellors should have contact numbers for all POs and addresses for their offices. The counsellors could facilitate access for the survivor by taking an appointment from the PO for the survivor.

Dilaasa team members should not do the following

- Disregard any account of violence against woman as unimportant / minor.
- Be judgmental about the survivor / blame her for doing or not doing something or for the violence itself (counsellors should be sensitive towards linkages between mental health conditions and domestic violence; and attempted suicides and domestic violence)
- Force her to talk about incidents of violence, attempted suicide
- Force their views and opinions on her
- Force a woman to take steps she is not comfortable with / ready for
- Berate her for repeated visits / contacts without having followed up on advice from the counsellor during previous meetings. Did not follow up a case assuming it to be not-serious
- Be insensitive towards the concerns and needs of the survivor
- Let their personal biases, relationships (with other resource agencies or persons) not hinder the process of facilitating care and services for the survivor
- Encourage or use force / violence for any reason
- Ask for abuser's view on the situation
- Organise a joint meeting without adequately preparing the survivor

Roles of Dilaasa counsellors

1. Provision of Emotional support
2. If she has any medical needs, refer her to relevant hospital department.
3. Information about registration of complaints and facilitation of registration of complaints
4. Provision of Legal alternatives and information related to laws penalizing VAW
5. Provision of social support and linking survivors to additional resources such as skill building, income generation activities, support groups and community based organisations.

Points to remember

- Reassure the survivor about Dilaasa being a safe space, where she could visit when she wants
- Provide an encouraging environment for the survivor to share her painful experiences and articulate her expectations
- Provide empowerment counselling / counselling based on feminist principles to empower the survivor as per the guideline
- Understand needs of the survivor and provide relevant information (e.g. legal recourse available to her) and refer to other support agencies

- Ensure safety of each survivor through safety planning
- Record the session in the intake form, preferably the same day
- Explain the need for further follow up
- Carry out / attempt a minimum of three follow ups with the survivor
- Record the interaction in the follow up form
- Facilitate negotiations for non-violence between the survivor and her abuser in a joint meeting (if such a meeting has to be organised)
- Where required and requested, provide assistance to the survivor in registering complaint with the police. This would include
    - o helping her draft a complaint or drafting it for her
    - o Explaining to her whether the incident warrants diary entry, NC or FIR – and explaining the difference and implications of the three
    - o Explaining a survivor of sexual violence who does not want to take any action, the procedure for the same (i.e., MLC has to be done, in case of a child the police needs to be informed but if the survivor or her parents do not wish to take any action / register / follow through a complaint then the statement to the police should be made to this effect.)
    - o Helping survivors of sexual violence prepare for statements as well as court appearances by providing them information about what they may expect on these occasions and significance of their presence and statements
    - o Empower the survivor to confront / on her behalf intervene / have dialogue with the police in case the survivor reports insensitive treatment from the police (e.g., judgmental remarks in cases of survivors of sexual violence, blaming women in cases of DV, refusing to register NC, refusal to register FIR etc.).
- Guide women survivors about legal provisions applicable to them.
- Referring women to PO, free legal aid cell or feminist lawyer
- Helping woman understand the legal procedures, preparing her for various stages of the case (e.g., explaining to the survivor that if accused in a sexual violence case is released on bail and the survivor feels threatened she can give an application for cancelling the bail, in cases of divorce where women do not want to return to the abusive husband's house explaining that she can tell the judge, etc.)

Assured referral: support to other services

Assured referrals will be facilitated to inform referral facility of condition and case of survivor, follow up, as well as documentation.

Multi-sectoral referral: Linkages to other VAW services will be provided to survivor (such as legal assistance, psychological services, etc.). Information shall include the following information:

- ➢ Name, address and phone number of the service / organisation
- ➢ Name and phone number of contact person

- List of services available
- Hours of operation
- Cost of services
- Direction (and a landmark if possible)

ROLES OF DIFFERENT MEMBERS REGARDING SURVIVORS OF DOMESTIC VIOLENCE

Role of MO / AMO

- Ensure adequate privacy in each OPD to enable survivors of violence to disclose it to the examining doctor.
- Ensure procedures such as asking the accompanying relative to step out to ensure privacy.
- Introduce and implement a protocol at hospital for ensuring response to survivors of domestic violence. (There should be policies regarding free services that can be provided to survivors, paid services, procedures facilitating access to services etc, along with clear assigning of responsibilities)
- Provide adequate orientation and skill building for examining doctors
- Respond to queries by examining doctors
- Facilitate interaction with other agencies such as police, CWC, PO etc. where required.
- Facilitate interaction / referrals / access to services / access to documentation with other departments in the hospital (the processes for accessing services from other departments in the hospital to be streamlined)
- Ensure admission to hospital when required including for the purpose of emergency shelter for 72 hours.
- Ensure that police record the survivors' statement while they are admitted to the hospital.

Role of CMO

- Respect woman's disclosure of domestic OR sexual violence.
- Suspect domestic violence if signs and symptoms are suggestive of it and explore with the survivor.
- Suspect sexual violence if signs and symptoms are suggestive and explore sensitively with the survivor
- Medicolegal case should be recorded. The survivor should be explained the purpose / usefulness of this document and clarify that this is not FIR.
- MLC register entries should be as clear as possible e.g., relationship between the survivor and abuser should be mentioned.
- Ensure prompt treatment and appropriate referral to other departments.
- Ensure that when appropriate, survivor gets an opportunity to communicate with doctor in privacy / absence of her family members.

- In case a survivor discloses domestic violence in an OPD, she should be first provided examination and treatment she needs and then referred for MLC. Treatment should not be delayed for MLC.
- Ensure that women disclosing violence, in need of in-patient care are admitted without delay, procedures regarding admission, hospital stay and discharge should be streamlined to protect privacy and confidentiality of the survivors

Role of examining doctor

- Provide enabling environment for disclosure of DV in OPD as well as IPD. (enabling environment would include nonjudgmental attitude of doctor, privacy during consultation, encourage woman to speak, respecting her account, not blaming her, etc)
- Suspect DV in case of clinical presentation and ask woman about / explore DV sensitively
- Suspect SV in clinical presentation is suggestive of the same and explore sensitively
- Explain the importance of MLC in case of injuries, refer for MLC, facilitate process of registering an MLC
- Document history of domestic violence on case paper / inpatient records very clearly – duration, abuser, most recent episode that brought the survivor to the hospital, woman's narration about violence and present / other health complaints, etc.)
- Provide appropriate treatment and referrals
- Refer to Dilaasa for counselling

Role of staff nurse on call

- Suspect domestic violence among women admitted to the ward and explore, bring to the notice of the doctor, refer to Dilaasa.
- Give brief information and brochure / pamphlet about Dilaasa to survivor / suspected case of domestic violence
- Inform Dilaasa counsellor about suspected / survivor of domestic violence
- Provide psychological first aide to the survivor if she discloses to the staff nurse.

Role of MRO

- Extend support for sealing, storage and handover of forensic evidence in case of sexual violence
- Store properly the documentation of medicolegal examination of survivors of sexual violence
- If a survivor needs it, provide duplicate records of medical papers after confirming her identity
- Give injury certificate to the survivor free of cost

Role of monitoring committee

- This Monitoring Committee is to be comprised of 1 Nodal Person; representatives from medical and nursing staff from key departments (emergency / casualty, obstetrics and gynecology, paediatric, medicine, general surgery); representative from Medical Records Department, Police Constable on duty at the hospital, Dilaasa counsellors and ANMs, representatives of CEHAT.
- Review the hospital's response to survivors of domestic violence including services provided through Dilaasa on monthly basis
- Provide support and guidance to examining doctors, CMOs, Dilaasa counsellors and ANMs regarding challenges they face in providing health care to survivors of domestic violence (this could include facilitating / advocating for / streamlining the procedures)
- Facilitate access to various departments within the hospital as well as other support agencies.
- Organise and conduct periodic sensitisation trainings for health care providers on domestic violence as a health issue.
- Report of meetings should be sent to CMS on quarterly basis

Role of core group

- This is a group of sensitised health care providers across the cadres who have undergone training related to health system response to survivors of violence and are committed to promoting it in their institutions
- The members will take initiative and provide trainings to staff members
- Extend support in facilitating access to care (in their professional capacities)

Role of Dilaasa Advisory Committee

- Meet once a year
- Review progress and work carried out by Dilaasa / Review response of hospitals and Dilaasa departments to survivors of domestic and sexual violence
- Recognise / identify challenges faced in ensuring efficient health system response to survivors of violence
- Advise strategies for resolution of gaps
- Facilitate administrative actions to ensure efficient functioning Dilaasa and optimum response from hospitals to survivors of violence

JOB RESPONSIBILITIES

Counsellor

1. To identify potential survivors of violence through.
   a. Casualty round
   b. Ward round
2. Counseling of sexual violence and domestic violence, and periodic follow up of cases registered with Dilaasa.
3. Suicide prevention counselling.
4. Documentation of cases (intake forms and follow ups).
5. Report writing – for submission to them monitoring committee at the hospital, to be sent to F/South ward.
6. Referring survivors for further help.
7. Visits to Police station, court, protection officers and other organisations as per case requirements.
8. Liaison with other support agencies such as the police, shelter homes, PO, CWC, NGOs etc. to facilitate the survivors' access to these.
9. Helping TOT members in organising training every month (if there are no TOT members organise trainings and meeting when required).
10. Update registers.
11. Handholding support to ANMs – for conducting health education sessions in wards, OPDs, building their skill to enable them to seek history of survivor approaching, Dilaasa in absence of counsellor.
12. Attend monthly case presentation meetings to ensure / upgrade quality of counselling and to address burn out.

ANM

1. Identifying potential survivors of violence through
   a. Casualty round with counsellor
   b. Ward round (talking to the patients about Dilaasa)
2. Accompany survivor from ward / OPD to Dilaasa department and from Dilaasa to various other departments (e.g. Casualty for MLC) if needed.
3. Screening cases for violence from among women attending OPDs and admitted to wards with history suggestive of violence
4. Delivering health talks in wards, OPDs about violence as a health issue, health impact of violence, rights of women, services provided through Dilaasa – relating to the specific audience (e.g., in ANC / PNC, OPD focus should be on violence during pregnancy and its impact on health of women, for paediatric wards focus could be on signs / symptoms among children suggestive of violence on mother and child etc.)

5. Pamphlet distribution / poster exhibition / talking to people about Dilaasa
6. Ward round in afternoon
7. First line psychosocial support
8. Taking history of women approaching Dilaasa in absence of counsellors
9. Visiting OPD Doctors for cases
10. Take circular to doctors / nurses / hospital staff for meeting and training
11. Admin work – maintaining registers ready with formats
12. Attend monthly case presentation meetings to ensure / upgrade quality of counselling and to address burn out

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.
- 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 below guidelines
  - 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; 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' ;
- 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.