



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



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Foreword

Domestic violence is most pervasive form of violence against women. National Family Health Survey (NFHS) 5 datashows that 29.3% (Urban 24.2 Rural 31.6) ever-married women have ever experienced spousal violence. Physical violence faced by pregnant women has been seen as 3.1% (Urban 2.5, Rural 3.4) forever-married women in the ages of 18-49 years as per NFHS-5. As is known all forms of violence have an impact on physical and psychological health of women and girls enduring it. Health system has a crucial role to play in responding to violence against women and children. Health care providers are often the first point of contact for a survivor and if treated sensitively may disclose about violence to HCPs.

Dilaasa – hospital based crisis centres in 13 peripheral hospitals were set up with the perspective of providing psycho social support to women and children facing violence. The first centre was established by Brihanmumbai Municipal Corporation (BMC) in collaboration with CEHAT in 2000; it has now been replicated with financial support from NUHM in 11 additional hospitals since 2015-16.

I am happy to share that we have developed Standard Operating Procedures (SOP) for health systems to respond to VAW/girls. These SOPs will enable health administrators to monitor health system response to VAW in a methodical manner. These SOPs will also be of utmost use to public hospitals who seek to create a health systems response to VAW.

These SOP's were developed and finalised in consultation with nodal officers, senior administrators, senior medical officers and core group members of public hospitals (comprised of senior nurses, community development officers and para medical staff) implementing Dilaasa crisis centres.

I recommend all public hospitals to implement these SOP's to monitor and assess the health systems response to VAW.

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Preface

The Municipal Corporation of Greater Mumbai was the first to recognise Violence against women as a public health issue. It set up India's first hospital based crisis intervention department - Dilaasa centre at KB Bhabha Hospital to provide psycho social services to women and child survivors. The 21-year-old department responded to more than 4500 survivors. over the years a pool of trainers has also been developed across several peripheral hospitals.

Long standing advocacy with the National Health Mission has now led to Dilaasa departments being integrated in the NHM budget Since 2016, 11 such Dilaasa centres have been set up in peripheral hospitals. As a part of the scaling of Dilaasa from 1 hospital to an additional 11, it is important to have SOPs that assign specific roles and responsibilities to different Health workers at the level of public hospitals as well as assist administrators and health managers to monitor a health system response to VAW/C. The SOPs will assist Nodal officers, Core group members and Dilaasa teams to routinely monitor the response of health system to survivors

I have great pleasure in issuing these SOPs to peripheral hospitals and strongly urge administrators to ensure its implementation at their hospitals.



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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 violence against women and children.

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.

India is committed to the Global Plan Action (GPA), adopted at the 69th World Health Assembly in May 2016, to strengthen the role of the health system within a national multi-sectoral response to intimate partner violence, in particular against women, girls and children.

The Global Plan recommends action in four strategic directions:

1. Strengthening health system leadership and governance
2. Strengthening health service delivery and health workers' / providers' capacity to respond to violence, in particular against women and children
3. Strengthening programming to prevent interpersonal violence, in particular against women and girls and against children
4. Improving information and evidence

This Standard Operating Procedure has been based on GPA as well as experiences of public hospitals implementing a health system response to Violence against women (VAW)^{1, 2, 3} 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 Offences 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.

¹ Centre for Enquiry into Health and Allied Themes & K. B. Bhabha Hospital, Bandra. (2003). *Process documentation of training of Trainers*.

² World Health Organization, Centre for Enquiry into Health and Allied Themes & Human Reproduction Programme. (2021). *Scaling up the health systems response to violence against women: Lessons from hospital interventions in Maharashtra, India: Research brief*. New Delhi: WHO.

³ Bhate-Deosthali, P., Rege, S., Pal, P., Nandi, S., Bhatia, N., & Kashyap, A. (2018). *Role of the health sector in addressing intimate partner violence in India: A synthesis report*. New Delhi, International Center for Research on Women.

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 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, gloves (IV sets).

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 inmate 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 the 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 Listening, Inquiring about needs and concerns, Validate response to survivors' experience, Enhance her safety, Support connection to information, services and social support;
- Provide medical Support: Take a thorough history; assess for effects of current and past histories of violence; attend to all injuries with medical referral;
- Provide psychosocial support: Refer the 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) me 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.