MODULE FOR TRAINERS

TOWARDS ADDRESSING GENDER INEQUITY AND GENDER BASED VIOLENCE

BUILDING CAPACITIES OF NURSES

DEVELOPED BY
SAMA - RESOURCE GROUP
FOR WOMEN AND HEALTH

Sama

WITH
SUPPORT
FROM

UNFPA

Contents

Abbreviations

ANC	Antenatal Care
ASHA	Accredited Social Health Activist
CEDAW	Convention on Elimination of all Forms of Discrimination Against Women
CHC	Community Health Centre
CLA	Criminal Law Amendment Act, 2013
CWC	Child Welfare Committees
DIR	Domestic Incident Report
GBV	Gender-Based Violence
ICPD	International Conference on Population and Development
IPC	Indian Penal Code, 1860
LGBTQI	Lesbian, Gay, Bisexual, Trans, Queer, Intersex
LIVES	Listen, Enquire, Validate, Enhance Safety, Support
MLC	Medico Legal Case
MO	Medical officer
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NHRC	National Human Rights Commission
OSC	One Stop Centre
PHC	Primary Health Centre
PO	Protection officer
POCSO Act	The Protection of Children from Sexual Offences Act
RMP	Registered Medical Practitioner
SOPs	Standard Operating Procedures
WHO	World Health Organization
PWDVA	Protection of Women from Domestic Violence Act, 2005

Foreword

Gender-based violence (GBV) has been recognized and endorsed by member states in the 67th World Health Assembly as a public health issue, necessitating healthcare and other interventions. The UN-Women termed GBV as a 'shadow pandemic' following the surge in demands from women's rights activists across the world. A "shadow" perhaps because of the equally grave context and consequences of GBV during the Covid 19 pandemic, despite which it has not drawn adequate attention and response by governments.

The role of the health sector in addressing GBV is well established, but most healthcare providers fail to identify and address GBV, not only due to socio-cultural and traditional barriers, lack of time, resources and inadequate physical facilities. Even more so due to lack of awareness, knowledge and poor clinical practices and failure to monitor the quality of care. This is true pre-pandemic and despite years of advocacy, health systems across the globe have failed to adequately recognize GBV as a public health issue and respond to it.

The aggravation of GBV in the current COVID 19 pandemic has been reported globally. A health system response as part of a multisectoral response to GBV is urgent. Health systems have a major role to play in supporting women and other survivors in prevention and response to GBV through provision of health services, counseling, medico legal care, documentation, etc.

The module is for the trainers of nurses and contains concepts, definitions, information with interactive pedagogies to strengthen perspectives and knowledge on gender and gender-based violence. This module provides step by step guidance to conduct the training for nurses in any healthcare setting. The module is a first step towards building the capacities of nursing staff to address GBV effectively.

I hope that this module will become part of a comprehensive health system response to GBV.

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Acknowledgements

This module for Nurses has emerged from the experiences and initiatives by Sama Resource Group for Women and Health in building the capacities of diverse healthcare providers to address gender-based violence. This module has also been motivated by the increased recognition of gender-based violence (GBV) as a public health issue and seeks to strengthen commitment and capacities of health systems in prevention and response to GBV.

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Any errors are inadvertent.

Preface

Gender equality and freedom from violence are critical determinants of health. The intersectional structural inequalities and power on the basis of race, caste, class, sexuality, disability, age, etc. create vulnerabilities to violence and marginalize access to healthcare and justice.

Gender-Based Violence is associated with innumerable physical and psychological health consequences in the short and long term despite which it is not adequately recognized as a major public health issue. Healthcare providers are often perceived as the safer and first point of contact for survivors of violence as they are more accessible. Their role can facilitate identification of situations of violence, minimize the impact of violence on survivors through treatment and care, follow-ups and referrals. Healthcare providers can bridge the gaps in information and awareness about GBV, and create enabling environments for survivors to report violence and seek care and support, including for healthcare providers who experience gender-based violence.

The need to build the capacities of healthcare providers at different levels of the health system is urgent towards provision of healthcare, psychosocial support to survivors, and coordination of a comprehensive multisectoral response.

Leadership and interest amongst healthcare providers, especially frontline workers, young doctors, nurses and other healthcare providers, as well as civil society organizations to address GBV has been extremely encouraging. Mobilizing and expanding this to foster change and accountability in the health system is critical.

Who is this module for?

This is one of three modules for healthcare providers. This module is primarily designed for training of nurses across all states of India. Parts of it may also be useful to train other providers, including psychologists, social workers, and counsellors. The two other training modules similarly aim to build the capacities of Medical Officers and ASHA workers, respectively.

Aim of the module

The module conceptualized for trainers of nurses aims to build an understanding on:

- Gender construction, gender norms, and GBV
- GBV as a public health issue
- Key laws and legal mandates for the health system/ health care providers.
- Principles, attitudes for a gender-responsive, supportive health system in GBV prevention and response

- Skills and preparedness to respond to physical, psychological, and medico-legal needs of GBV survivors

This module enables development of capacities - knowledge and skills to provide comprehensive, high-quality care for GBV survivors. Some of the sessions in the module raise issues that may call into question the participants' deeply held convictions and beliefs, towards stimulating change.

Structure of each theme

Each theme is sub-divided into sessions with focus on diverse aspects under the theme. Each theme broadly comprises the following:

- Overview of the thematic session, objectives and duration.
- Detailed step by step instructions that can be followed for facilitation of the training based on the module.
- Reference material to be followed and presented by the trainer using available tools such as power point presentation (PPT), flipchart, whiteboard, etc.
- Handouts for participants to be disseminated by the trainer, i.e., participants to read, analyze, refer to, as part of the training.
- An interactive methodology that includes quizzes, case studies, frequently asked questions (FAQs), etc. wherever relevant and possible.

Time / duration of the training

The overall duration of the training is envisaged as about 14 hours and includes 6 themes to address the above-mentioned objectives. The module has been developed primarily for an offline format but can also be adapted as an online training.

The module is designed for flexible implementation. The 6 sessions requiring a total of 14 hours, can be planned over 2-3 days as an offline training. Alternatively, the content can be covered in half-day sessions scheduled at regular intervals over several weeks. Learning is a continuous process. Refresher sessions at regular intervals (for example, annually) will help participants to consolidate and update their knowledge and skills.

Other aspects

The training is designed for a group setting, to facilitate collective critical reflection. Adapting the training content in specific contexts as per the level of participants, the structure of the health institutions/facilities that participants are affiliated to, would be most useful. Participatory training is more effective with small groups of participants. Ideally, 30-35 participants at a time allows adequate space for interaction and discussion. However, the same content can also be facilitated in a larger group.

Notes for Trainers

Who could be a trainer?

The trainers would benefit from the following:

- A nursing background or involvement in provision of healthcare; experience or knowledge of health systems', health facilities' functioning.
- Experience of providing healthcare to survivors of GBV.
- Experience in training on gender, GBV, etc.

Trainers are expected to:

- Read the module completely before initiating the training.
- Familiarize themselves with the activities, handouts, and other resources provided.
- Have a prior understanding of the themes / issues that are being covered to be able to facilitate the training.
- Be prepared with relevant examples to contextualize the themes, practices and experiences, to respond to clarifications raised by the nurses / participants.
- Contact a few experts and mentors and brief them about the training. Request their support for clarifications before and during the training.
- Let the participants know if the answer to any question is not known. Communicate that the answer would be shared in the following session after checking. Be prepared with the response in the following session after consulting with mentors / experts.
- Clarify and provide the accurate answer to participants if a point made previously was incorrect or wrongly represented.
- Use the reference material to provide inputs, present information and facilitate discussions.
- Ensure sufficient copies of handouts for participants.
- Ensure that all the necessary training materials such as chart paper, PPT, flipchart, pens, paper, white board markers, audio visual equipment such as laptop, projector and speakers are available to run the session smoothly. When these are unavailable, plan the training using alternative methods and materials.
- Ensure that the sessions are interactive and allow for the exchange of information and experiences.
- Facilitate a safe space for the discussions and reflections.

Best wishes!

Theme 1: Welcome and Introductions
Duration: 1 Hour

Session	Title	Objective/s	Duration
Session 1.1	Introductions and Expectations	To make participants feel welcome, to present what the training aims to do and to assess the expectations of the participants	20 minutes
Session 1.2	Ground Rules for The Training and Terms Clarification	To ensure that all the participants agree to the ground rules necessary for an enabling training environment	10 minutes
Session 1.3	Have You Ever …	To assess the diversity of work experience and understanding of gender, GBV among participants	15 minutes
Session 1.4	Pre-assessment	To assess the knowledge, perspectives on GBV and skills for responding to GBV	15 minutes

Session 1.1: Introductions and Expectations  20 Minutes

Step 1: Welcome all participants to the session and introduce yourself, other trainers and resource persons.

Step 2: Explain that the session will begin with participants' introductions and a brief discussion on the expectations from the training as well as its objectives.

Step 3: Request participants to form a pair with another participant, ideally someone they are not acquainted with. Ask each of the pairs of participants to introduce themselves to their partners. They could share their names, their clinical role, institution affiliation, one hobby or interest, for example. Request pairs of participants to briefly introduce their partners to the rest of the group.

Note: Even if participants know each other well, this allows the trainer the opportunity to become acquainted with the participants. In the case of a large number of participants, request participants to introduce themselves. Other ways to facilitate participants' introductions as appropriate in the training context, can be explored.

Step 4: Ask participants to write two expectations from the training. Provide participants post-its / cards for writing their expectations. Use the following prompts:

i. Why are we here?
ii. What are the issues / skills / information that you expect to discuss or learn?
iii. Any other expectations?

Step 5: Request a few participants to take turns to share their expectations with the group.

Step 6: Stick the post-its / cards on a flipchart / board and organize them under broad themes so that they are visible through the training. For example, expectations can be organized under themes such as "laws", "protocols for health providers", "roles and responsibilities of healthcare providers", etc.

Step 7: Based on responses, explain what expectations will be addressed by the training and if any relevant expectations fall beyond the scope of the training, share information with participants to address these expectations. Present the training objectives. These can be prepared as a PPT slide or shared orally if PPT is not possible.

Reference Material for Step 7: Objectives

The training will build amongst participants an understanding on:

- Gender construction, norms, and GBV
- GBV as a public health issue
- Key laws and legal mandates for the health system/ health care providers.
- Principles, attitudes for a gender responsive, supportive health system in GBV prevention and response
- Skills and preparedness to respond to physical, psychosocial, and medico-legal needs of GBV survivors

Step 8: Present a schedule of the entire training.

Reference Material for Step 8: Schedule for the Training

Theme #	Theme	Duration of Session
Theme 1	**Welcome and Introductions**	**1 hour**
Session 1.1	Introductions and Expectations	20 minutes
Session 1.2	Ground Rules for the Training and Terms Clarification	10 minutes
Session 1.3	Have You Ever …	15 minutes
Session 1.4	Pre-Assessment	15 minutes
Theme 2	**Understanding Gender and Health**	**2 hours**
Session 2.1	Stepping Stones: Understanding Gender and Its Construction	45 minutes
Session 2.2	Gender Socialization* *Process by which persons develop and learn to 'perform' gender through internalizing gender norms and roles	30 minutes
Session 2.3	Gender as a Determinant of Health, Barrier to Accessing Healthcare	45 minutes
Theme 3	**Gender-based Violence (GBV) - A Public Health Issue**	**2 hours 50 minutes**
Session 3.1	Understanding Gender-based Violence (GBV)	20 minutes
Session 3.2	Forms of GBV	20 minutes
Session 3.3	Health Consequences of GBV	20 minutes
Session 3.4	GBV as a Public Health Issue	60 minutes

Session 3.5	Addressing Concerns in Carrying Out Roles as Healthcare Providers in Responding To GBV	30 minutes
Session 3.6	Key Principles for Survivor-Centred Care	20 minutes
Theme 4	**Laws Pertaining to Health Facility and Providers' Roles and Responsibilities**	**2 hours 30 minutes**
Session 4.1	Legal Mandate for Healthcare Facilities and Providers in Addressing GBV in India	45 minutes
Session 4.2	Key Legal Procedures Healthcare Facilities and Providers Must Follow	1 hour
Session 4.3	Documentation by Healthcare Facilities and Providers in cases of GBV and its Evidentiary Value	45 minutes
Theme 5	**Comprehensive Healthcare Response to Address GBV**	**3 hours 40 minutes**
Session 5.1	Components of a Comprehensive Health System Response to Address GBV	20 minutes
Session 5.2	Enabling Survivors to Disclose, Talk About the Violence	40 minutes
Session 5.3	Strengthening First Line Support and Care	40 minutes
Session 5.4	Towards Comprehensive Health System Response	30 minutes
Session 5.5	Comprehensive Healthcare Response to Survivors of Sexual Violence	1 hour 30 minutes
Theme 6	**Health Providers and Health Facility Preparedness and Planning**	**2 hours**
Session 6.1	Current Preparedness to Respond to GBV	20 minutes

Session 6.2	Discussion on Elements of SOPs for Comprehensive Care	40 minutes
Session 6.3	Referral Linkages and Support	40 minutes
Session 6.4	Post Assessment of the Training	20 minutes

Step 9: Inform that the training would be a mix of presentations and participatory activities. Explain the language that will be used in the training; check if there are any concerns. Plan where possible for a mix of languages to be used.

Step 10: Make announcements about the training timing, space, breaks, toilets, photography, recording, use of phones, etc. Also, check if there are any participants with disabilities or if anyone needs additional support.

Session 1.2: Ground Rules for Training and Terms Clarification

 **10 Minutes**

Step 1: Explain that it is important to establish ground rules for the training.

Step 2: Explain each ground rule briefly as you read it out. Ask participants if there are any other rules they would like to suggest. Discuss and if agreeable to everyone, add to the list.

Reference Material for Step 2: Ground Rules for the Training

- **Keep to time** - be punctual and keep to time for all sessions; return to the training space on time after breaks and for the start of the training.
- **Learn and work together** - participate in all activities, exchange/ share and learn from each other's realities, experiences, and innovations.
- **Respect each other -** there may be different experiences, differences of opinions and perspectives during discussions. It is important to allow space for everyone to share their perspectives. Respond respectfully if in disagreement or if individual experiences are different.
    - Listen other people with acceptance
    - Let everyone participate.
    - Express disagreements respectfully and politely.

- Raise your hand to speak to avoid interrupting when others are talking.
- Avoid side conversations during the training as everyone may gain from your experience.

- **Ensure a safe space** –The training space commits to zero tolerance to sexual harassment. Any complaints and concerns may be raised with the support group set up for this purpose.

Note: Ensure that a group of 2-3 persons are identified and confirmed for this purpose. Their email ids and phone numbers should be shared with participants. If the training is taking place in a particular health facility, then the Internal Committee (IC) members under The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act 2013 could also be contacted for their consent to play this role.

- **Be sensitive**- to survivors amongst participants.

- **Maintain confidentiality –** respect confidentiality, personal information should stay within the training space. In case of any reference to survivors, participants should avoid using actual names while describing the situation.

- **Be present** – participate in discussions; listen with focus and attention; keep cell phones aside along with other distracting items. If there is an urgent call participants must use the designated space outside the training space where they can take the call so that it does not disturb the session.

Note: Identify and share about the designated space with participants.

- **Suggestions to improve** are welcome!

Note: Add any other relevant ground rules that have been agreed to by the participants.

Step 3: Paste the final ground rules list on a chart so that it is visible throughout the training.

Session 1.3: Have You Ever…  15 Minutes

Step 1: Introduce the session to participants. Explain that this is to help participants and trainers to learn about each other's experiences pertaining to the themes that are to be covered in the training. This will help the trainer to facilitate the themes drawing on these relevant experiences.

Step 2: Ask participants to raise their hand if their response is “yes” to each of the questions being asked and to keep their hands down if they want to say “no”.

Step 3: Read out and allow some time after each question for the participants to respond.

Reference Material for Step 3: Questions

- Have you attended a training on gender before?
- Are you providing healthcare or medico-legal care for survivors currently?
- Have you ever interacted with an adult or child survivor of GBV?
- Do you know someone personally who has experienced violence?
- Have you conducted any training on gender or GBV before?

Step 4: Based on the participants’ responses, conclude with a summary of the experiences in the room. For example, “most participants have attended gender training before, or about half have attended training on gender or GBV”. Explain that participants come from different experiences and understanding and everyone’s perspective matters in the training.

Step 5: Clarify terms to be used during the sessions, for example, the terms “survivor”, “victim”.

Reference Material for Step 5: Clarification of Terms

The term ‘survivor’ of GBV is increasingly used instead of ‘victim’; it will also be used in the training.

- ‘Survivor’ is an empowering word that recognizes that persons experiencing GBV are not helpless and with the requisite information and an enabling environment, are capable of making informed decisions despite being victimized, humiliated, and traumatized due to GBV.
- The term ‘victim’ literally means a person suffering harm, including those who are experiencing GBV. The term ‘victim’ is usually understood as a person who does not possess agency and is not fully capable of comprehending the situation at hand and making decisions.
- While certain circumstances may not allow survivors to immediately make an informed decision, it is necessary to facilitate an enabling process through counseling, information sharing, validation, etc., to seek their informed decisions - consent or refusal - as well as to respect the decisions.

Session 1.4: Pre-assessment

 **15 Minutes**

Step 1: Distribute the pre-assessment format and explain that the participants need to complete it. Explain that the assessment is useful to collate existing perceptions and knowledge to be compared with a post training assessment to understand any shifts or changes.
Request participants to complete the format without discussion with others. State that they can clarify doubts with the trainer.

Step 2: Distribute the pre-assessment format provided in the Annexure 1. Allow 10 minutes to fill out the form.

Step 3: Collect the completed formats and conclude the session.

Theme 2: Understanding Gender and Health
Duration: 2 Hours

Theme 2	Title	Objective/s	Time
Session 2.1	Stepping Stones: Understanding Gender and Its Construction	To build a basic understanding of gender, gender roles and norms	45 minutes
Session 2.2	Gender Socialization	To build an understanding of how gender, gender roles and norms are learned, internalized	30 minutes
Session 2.3	Gender as a Determinant of Health, Barrier to Accessing Healthcare	To reflect on various ways in which gender determines health and access to	45 minutes

Session 2.1: Stepping Stones: Understanding Gender and Its Construction

 **45 Minutes**

Step 1: Introduce the overall theme and the sessions and their respective objectives.
Explain that the objective of the first session is to build a basic understanding on gender, gender roles and norms.

Step 2: Request all the participants to stand in a circle, or in inner and outer circles with some space in between the two circles to move back and front, as per the available space in the training area.

Step 3: Explain that a few statements will be read by the trainer. After each statement, the participants have to take a step forward if they think that the roles, characteristics, or attributes in the statements are because of social/gender norms, i.e., rules that are made by society. If they think the statement relates to biology, that it is “natural”, then participants should take a step back from the circle.

Reference Material for Step 3: Statements (can also be displayed one by one on PPT or Flipchart)

- Women are emotional and men are rational
- Men are responsible for taking care of their family
- Men cannot do housework
- Men are violent and aggressive
- Women rarely own property and assets
- Men are better decision makers
- Women menstruate
- Men's names are passed on to children
- Caring and nurturing of children and others is the responsibility of women
- Women cannot carry heavy loads
- Women are scared of working outside their homes at night

Step 4: At the end of all the statements, ask participants to reflect on their position – whether they have moved, are closer to the centre of the circle or have moved away from it.

Explain that participants who have agreed with the statements and stepped forward, are closer to the centre of the circle. A position closer to the centre of the circle means the higher number of accurate responses.

Step 5: Explain that each of the statements and the correct responses to them will be discussed. Request participants to return to their seats. Use reference material to explain all the statements.

Reference Material for Step 6: Explanation (can also be displayed one by one on PPT or Flipchart)

Statement	Explanation
Women are emotional and men are rational	Women have been associated with being 'very emotional,' whereas men have been associated with being 'more practical in their approaches. Women are expected to be gentler and more emotional than men by society according to the gender norms. There is nothing biological or natural about it; social norms / rules play a significant role in constructing this perception. Men experience the same emotions as women, but they are not expected to express them.

	When a man cries, he is mocked as a 'sissy' or not being "manly" or "masculine".
Men are responsible for taking care of their family	Men are expected to be solely responsible for earning and supporting families and women are supposed to be responsible for work within homes, in families and communities; most of this care and other work is not recognized as work and does not receive payment. Gender / social norms dictate this. Any person can be responsible for earning and supporting the family. A family can also have more than one wage earner. This norm puts undue pressure on men to shoulder all of the responsibility and makes it difficult for women to pursue their education and enter the workforce, or access work or receive adequate remuneration. There are a substantial number of women who are sole earners in families but are not recognized as such.
Men cannot do housework	Men are not expected to, or are ridiculed for performing domestic / household work such as cleaning or cooking and other tasks that are considered feminine or "women's work". However, men often perform this work outside for which they are paid, whereas when women who do the work at home, are not paid.
Men are violent and aggressive	This is a social construction. Men are not naturally violent or aggressive but masculine cultures expect men and teach them to be assertive, aggressive, ambitious, and violent in order to maintain power and control. Men can be gentle and nonviolent too.
Women rarely own property and assets	The majority of property and other productive resources are owned by men and passed down from father to son. This is justified, for example, in some contexts where the father pays the dowry and finances the daughter's wedding, that only sons should inherit the family property. Even in societies where women have legal rights to inherit property, there are cultural norms, social sanctions, and emotional pressures that prevent them from acquiring control over them. Despite these discouraging developments, gender neutral inheritance laws are urgently needed and need to be fairly implemented.

Men are better decision makers	Women are not at all or less involved in decision making at all levels. The share of women in community decision-making structures is very low. Men generally take decisions on various family matters. Women are quite often not even consulted and are perceived as incapable of expressing their decisions. Men are given the social sanction to provide direction to their families. This primarily serves to elevate men's position in the gender hierarchy as superior.
Women menstruate	When it comes to menstruation, people, almost always, refer to the experience of cis-gender women i.e., those who are assigned female at birth. Moreover, not all those who identify as women, menstruate. In some cases, transmen, genderqueer, intersex or non-binary people also experience menstruation. The idea that gender is binary, (i.e., there are only two genders), is socially constructed, just as the idea that menstruation is experienced merely by women and is a symbol of 'womanhood'.
Men's names are passed on to children	Most cultures in India are patrilineal (with the exception of a few matrilineal societies) because society believes that the male child carries forward the lineage. In such cultures, men's names are passed on to their children. Family, cultural lineages are perceived as being passed on only by men / male members and is closely linked to ownership of resources, etc.
Caring and nurturing of children and others is the responsibility of women	As per gender norms, women are seen as naturally caring and recognized therefore as caregivers. They are expected to have "maternal and caring instincts" while men are not expected to. However, all persons are capable of caring and feeling and expressing care.
Women cannot carry heavy loads	Women are stereotyped as incapable of carrying out heavy work although the reality indicates otherwise. In so many parts of the country and the world, women carry heavy loads such as wood, grass, water, across difficult terrains in their daily life.
Women are scared of working outside their homes at night	Gender norms dictate the unacceptability of work outside the home at night for women and justify violence against them, as well as create and sustain the fear of violence. Women are raised to fear the external, prevented by going out on their own especially at night. At the same time, violence against women is pervasive and real at any time through the day or night and is as or more prevalent within

	homes and families. Women who defy these norms and take on work at night are criticized frequently for “calling for trouble”.

Step 6: Sum up with the reference material “Key terms”.

Reference Material for Step 6: Key Terms

- Gender refers to the attitudes, feelings, behaviors, roles, relationships, appearance and other characteristics that a given society associates with a person’s biological sex.
- Behaviors, attitudes, etc. that are compatible with gender norms are referred to as gender-normative; those that are perceived as incompatible constitute gender non-conformity.(Source: https://nazariyaqfrg.wordpress.com/)
- Gender identities, however, are beyond men and women and masculinity and femininity. Not everyone identifies as a “man” or “woman” – “masculine” or “feminine” entirely
- It is important to view gender as a spectrum beyond the category of man and woman, masculine and feminine, and rigid social roles and expectations.
- Many people identify as transgender. Trans* is used an umbrella term for transgender people, gender queer people or people who do not conform to gender assigned to them at birth.*
- Gender defines the relationships between men and women – these relationships are unequal and are created and sustained through discrimination, violence, and other forms of control. This creates power hierarchy or gender inequality.
- Gender stereotypes are widely held and fixed ideas about men and women respectively and are decided by the society. For example, “women gossip”, “men are strong”, “men don’t cry”.
- Patriarchy is a social system in which men hold primary power; men predominate in roles of political leadership, moral authority, social privilege and control of property. In the domain of the family, fathers or father-figures hold authority over women and children. This, like the caste system, is the root cause of unequal power or gender inequality.
- Sex refers to the biological characteristics present at birth. These include anatomical differences such as the presence of a vagina or penis; genetic

differences as in a person's chromosomal makeup; or physiological differences such as menstruation or sperm production

Source/s: TARSHI- Basics and Beyond – A training manual, 2006. https://nazariyaqfrg.wordpress.com/

*Human bodies have many variations, and these could be at multiple levels. For example, intersex variations include differences in reproductive parts and/or secondary sexual characteristics, and/or chromosomal variations and/or hormonal differences. (https://nazariyaqfrg.wordpress.com/)

Session 2.2: Gender Socialization

 **30 Minutes**

Step 1: Explain that the session seeks to build a deeper understanding on how gender, gender roles and norms are learned.
Explain that the participants will divide into 4 groups. Request participants to begin the count from 1 till 4, followed again by 1 till 4 until everyone has counted. Ask all participants who counted 1 to form one group, those who counted 2 to form another group and so on.

Step 2: Ask each group to discuss the following questions. Each group should nominate a person to represent their responses.

- How do we learn these norms / rules?
- What do the norms / rules do?
- Do they have any impact on health, healthcare, violence?

Step 3: Following presentations by each of the groups, sum up the responses to each question. Discuss a few of the points for a deeper understanding of social norms and their impact on health, using the reference material.

Reference Material for Step 3: Gender Socialization

- ***Gender norms, behaviour and role*s** are usually different for men and women. They often place greater restrictions on the freedom of choice, expression and movement for women in comparison to men in most societies. The roles for women are perceived as inferior whereas men's roles, behaviors are viewed as superior. For example, "household or care work" by women is seen as inferior whereas "decision making by men" is seen as superior.

- It is okay for people not to follow the gender norms. Sometimes, people break these norms. For example, not identifying with the gender assigned at birth. However, there are consequences when these norms are not followed. Violence or the threat of violence is used against persons who do not adhere to the norms.

- When people adhere to gender norms, they receive affirmation and validation from the society and the opposite happens when they do not. This is the reason why breaking norms is not always appealing or easy. It results in the loss of privileges.

- Gender norms determine ownership and access to resources (money/ capital, property, assets, production, knowledge / information, technology, machines, free time / leisure, freedom, ability) and decision making (spending, buying, eating, mobility, working, resting, children, bodies, policy, law).
  - They determine health status, access to healthcare, vulnerability to GBV, and its consequences.
  - Within health systems too, these gender and other systems of caste, race, ethnicity, religion, disability, age, sexual orientation (lesbian, gay, bisexual), gender identity (cisgender, transgender), etc., perpetuate power hierarchies, and determine health status and access to healthcare.

*__Cisgender__ (often abbreviated to cis) person is the one who has a match between the gender they were assigned at birth, their bodies, and their gender identity. In other words, those who have a gender identity or perform a gender role that society considers appropriate for their sex.

__Transgender__ is a person who identifies with or expresses a gender identity that differs from the one which corresponds to the person's gender identity assigned at birth. If someone is born and considered male but when they grow up, they feel more like a woman or if someone is born with the body of a female but identifies themselves a male when they grow up, they may prefer to identify themselves as transgender.

Source:https://nazariyaqfrg.wordpress.com/2017/05/24/terminology-gender-sexuality/

Step 4: Sum up the discussion using the reference material “Key Messages”.

Reference Material for Step 4: Key Messages

- Gender-based behaviors, roles, norms are learnt and sustained by family, friends, peer groups, society, religion, culture, traditions, schools, customs, media, legal provisions, health system, etc.

- These gender roles, behaviors, and norms pose barriers in realizing the rights to health, to life, etc. Thus, understanding of gender and other social power

hierarchies are critical for nurses, and other healthcare providers, as well as health managers and administrators. This will enable policy, program to address these barriers.

- Gender norms are not fixed and can be changed. Gender inequality, for example, is not the same in all societies and communities.
- Recognizing that gender is socially constructed, and that gender-based behavior is learned helps us to understand that behavior can be changed. For example, recognizing that aggression in men is learned can help us change the way we socialize or condition boys to be aggressive. Or that women should stay at home and take care of children is based on social norms, and can be countered by encouraging and supporting women if they choose to work. These norms are constantly being negotiated, broken in many different ways throughout our lives.

Session 2.3: Gender as a Determinant of Health and Healthcare

 **45 Minutes**

Step 1: Introduce the session – explain that it will discuss how gender determines health and access to healthcare.

Step 2: Divide participants into 4 groups. Give a few copies of the Handout of case studies to each group and ask group 1 to read and analyze case study 1, group 2 to read and analyze case study 2 and so on. Present the case studies from the reference material on a PPT or flipchart.

 **Handout for Step 2 - Case Studies**

Case Study 1	24-year-old Savita is a domestic worker. She got married when she was 18 years. Her husband is a truck driver. She is extremely concerned as she has not been able to conceive a child. They have been to many private doctors

	for treatment and have incurred huge loans. They cannot afford to get treatment any longer. Her husband's family blames her and is putting pressure on him to remarry. They have asked her to return to her natal home. Her parents are not supportive of her return as her youngest sister is to get married soon. She constantly has to face comments from others in the community where she lives and her husband and other family members also blame her. Her husband did not go for his own sperm testing/infertility checkup and Savita was unable to bring this up. She is also increasingly not being invited to family functions but no such social taboo is experienced by her husband. This situation has been affecting her - she has no appetite, has constant headaches, is anxious / tense all the time, and feels she has to put an end to it.
Case Study 2	17-year-old Maryam lives in a village with her mother and 2 younger brothers. Maryam lost her hearing when she was about 8 years old. The doctor had informed her family at the time that if she did not get treatment immediately, she would experience a loss of hearing. Her family was not able to afford any regular treatment and as her mother works as a cleaner in the village school, she was unable to take leave without loss of pay. Moreover, Maryam had to also take care of her younger brothers. Maryam's father had left the family when she was younger. She has been doing some embroidery work from home to support her mother who is keen to educate the two sons. Since the past few months her periods have been irregular and very painful and she finds it difficult sometimes to sit for long hours and work. However, she does not want to add to her mother's stress and has not told her anything. She finds it difficult to communicate with others, even with the ASHA in her village. She is afraid of going anywhere without her mother's help.
Case Study 3	Arti is a 42-year-old Dalit woman and a sex worker. She is the sole earning member in her family. She lives with her mother and her younger sister on the outskirts of a city. They have had to move often as they find it difficult to find housing being single women and as a sex worker. Arti has been suffering from dizziness and nausea for over a month. She has been getting some medicines from the local chemist but she is not feeling any better. She is hesitant to go to the government hospital that is not very far from her home because she had very bad experiences in the past. She had felt humiliated when she had gone there for an abortion a year ago. She cannot afford to go

	to a private clinic as she has not had any earnings due to the pandemic and lockdown.
Case Study 4	Shamli is 38 years old and lives in an urban *basti* in a big city. She lives with her husband and two school going children. She works on a construction site in the city. For several months, she has been feeling something protruding from her vagina. She has also been wetting herself – her urine has been leaking. She has been feeling very uncomfortable. During the last visit, the doctor who checked her, told her to get some tests done and to get admitted as surgery would be required. The doctor did not explain what the problem was. However, Shamli has not been able to go to the hospital. Her husband is very particular that she cooks and serves food on time. He is unwilling to take care of the children even for a day. If at all she has to go anywhere, he insists that she should ask her mother to come and help, which is not possible as her mother has not been keeping well either. Her husband is also angry with her because she has been avoiding sex with him due to this problem.

Step 3: Ask participants to read and discuss the case study assigned to each group from the Handout.

Ask participants to discuss the following questions in each group:

i. What are the various factors - gender as well as others that determine health in the case study?
ii. What are the main barriers to access to healthcare?

Step 4: Remind the groups that they have 10 minutes to discuss the case studies and the responses to the questions and 2 minutes each for presentations in the larger group. Ask them to decide on a representative from each group to present in the larger group. Provide chart papers to each of the groups to write the key points of their responses to present later.

Step 5: Request each group to present the case study and the responses. Put up the charts as each group presents so that it is visible to all. Ask participants from the non-presenting groups if they would like to add anything after each presentation.

Step 6: Appreciate the efforts of all the groups. Sum up using reference material “Key discussion points”.

Reference Material for Step 6: Key Discussion Points

What are the various (gender as well as other) factors that determine health in the scenario? What are the main barriers to access to healthcare?

Case Study 1

- Gender norms reinforce power hierarchies through discrimination. This intersects with other discriminations based on class, caste, work, age, etc.
- Here, women's assigned gender roles as mothers are reinforced. Thus, Savita who is not able to have children is stigmatized and blamed for not being able to conceive. Savita may herself subscribe to such beliefs.
- Her husband is not getting the tests done and the reason may be that gender norms also stigmatize men who experience infertility – they may be considered as not "masculine", not a real man. Although the stigma faced by men is relatively lesser than what women experience.
- The root cause of infertility amongst women may also be because of gender discrimination in access to nutrition, healthcare, information, etc.
- The lack of access to healthcare due to poverty, non-availability of affordable healthcare, lack of control over decision making about healthcare, and stigma are also important factors that pose barriers to health and healthcare for Savita.
- GBV is also very commonly seen in situations where women are unable to conceive and bear healthy children. Many women experience violence for not having male children.

Case Study 2

- Maryam's narrative highlights the intersection between gender, poverty, and disability and the impact on her health and healthcare.
- Gender discrimination in this scenario is evident from the lack of access to education, work options, and work conditions in the context of Maryam's mother.
- With regard to Maryam, gender and disability pose serious barriers to her health and access to healthcare.
- Often, women who only have daughters, or children with disabilities are also stigmatized. .
- Disability, like gender, is largely socially constructed. This means that society is the main contributory factor in disabling people.
- Physical, sensory, intellectual, or psychological differences in people may cause limitations in their functioning. If people with such differences are not marginalized, if infrastructure, access to education, healthcare, etc. are also inclusive, they do not have to experience disability, or the severity of the disability is reduced. In the absence of enabling conditions, accessible education, employment, health information, healthcare, the disability is aggravated.

- Maryam's experience of discrimination due to gender and disability is severe.
- Maryam's inability to communicate with a healthcare provider, or to access health information and care are because of barriers imposed by the health system, which does not address her different needs.

Case Study 3

- Arti's narrative highlights caste and gender discrimination. As a Dalit woman, in all likelihood, she faced serious barriers to education, employment opportunities, access to resources, etc.
- As a sex worker, she faces stigma, discrimination, and barriers in access to resources such as housing.
- Discrimination against sex work stems from gender and sexuality norms that prescribe sex as acceptable in certain contexts only, such as within marriage, for procreation, etc. Sex is often stigmatized outside of marital relationships and especially as work for money, for pleasure (of the woman), etc.
- All of these determine the status of health and access to healthcare.
- Arti's experience of discrimination and abuse by the health system are serious barriers to healthcare in addition to the other factors.

Case Study 4

- Shamli's narrative highlights how gender roles, norms of women's role / responsibility of the household work, care for children, the lack of decision-making power can impact health and access to healthcare.
- Perhaps, the medical problem (likely prolapse) has been precipitated by the multiple work load she does in construction.
- Gender roles, power hierarchy is also reinforced by the husband demanding that Shamli's mother replace her when she has to go out.
- This is also apparent in his refusal to take care of the children and household even temporarily, while Shamli is unable to refuse or resist performing her gender roles.
- The husband's perception and control over Shamli's body is reflected in his anxiety and anger about Shamli's refusal to have sex with him, which is perceived by him as a breaking out of her gender role.
- Not following gender roles / norms, as mentioned earlier, is often met with violence, abuse, and control. All these pose barriers to Shamli's health and access to healthcare.

Step 7: Reiterate that as nurses committed to providing care, it is necessary to reflect on what they can do to ease barriers posed to healthcare by gender and other intersecting discriminations.

Step 8: Provide post-its to participants to note the response and post them on a chart / board. Request participants to share “one bias or practice” that they will / can change to ensure healthcare that is not biased or discriminatory. Ask a few participants to share responses to #1 and #2.

1. Reflect on gender biases that exist in your personal and workspaces.
2. Reflect on gender discriminatory practices in your workspaces.
3. Think of one such bias or practice that you can/will change.

Step 9: Sum up using the reference material “Key points”.

Reference Material for Step 9: Key Sum Up Points

- Gender and other forms of discriminations based on caste, disability, sexual orientation, age, etc. have a deep impact on health, including access to healthcare.
- Gender shapes every single aspect of our lives – what work we are allowed to do, how much we get paid, if what we do is recognized as work, access to technology, to education, food, property, etc.
- As a result of these discriminations women have lesser access to information resources, and access to healthcare and other services.
- Moreover, health, gender discrimination, and violence are closely connected to each other. For example, in Shamli’s and Savita’s situation, their health concerns are a consequence of gender and other forms of discrimination. These can also become the context for GBV.

Theme 3: Gender-based Violence (GBV)- A Public Health Issue

Duration: 2 Hours 50 Minutes

Theme3	Title	Objective/s	Duration
Session 3.1	Understanding Gender-based Violence (GBV)	To understand GBV	20 minutes
Session 3.2	Forms of GBV	To understand the forms of GBV	20 minutes
Session 3.3	Health Consequences of GBV	To understand the health consequences of GBV	20 minutes
Session 3.4	GBV as a Public Health Issue	To understand the key role of healthcare providers and the health system in responding to GBV	60 minutes
Session 3.5	Addressing Concerns in Carrying Out Roles as Healthcare Providers in Responding To GBV	To flag and address concerns in carrying out roles as healthcare providers in responding to GBV	30 minutes
Session 3.6	Key Principles for Survivor-Centred Care	To discuss the key principles for survivor-centred care	20 minutes

Session 3.1: Understanding Gender-based Violence  20 Minutes

Step 1: Introduce the theme to the participants. Explain that the sessions will enable an understanding of GBV, GBV as a public health and human rights issue. The sessions will discuss the forms of GBV and their health and other consequences.

Step 2: Write **"Gender-based Violence"** on a flipchart or whiteboard. Ask participants what they understand by it. Explain that they could also think about it as **"violence on the basis of gender"** to respond to the question. Allow a few responses from the participants.

Step 3: Note the responses on a flipchart or whiteboard. Discuss and clarify if some of the examples or responses are not GBV and the reasons for the same.

Note: The responses may include forms of GBV such as "rape", "hitting", "beating", "preventing girls from accessing education", "abuse of women during childbirth", etc. Clarify that these are forms of

violence that will be discussed in more detail in following sessions. Clarify if some of the examples or responses are not GBV and the reasons for the same.

Step 4: Sum up the discussion using the reference material "Understanding GBV" on a PPT or Flipchart.

Reference Material for Step 4: Understanding GBV

- GBV involves the abuse of power due to gender and other social inequalities. The abuse or violence is perpetrated by those who have more power.
- Along with gender, other factors such as poverty, caste, ethnicity (for example, from a tribal community), religion, age, disability, sexual orientation, gender identity, etc. also determine who has more or less power and therefore are more vulnerable to violence.
- GBV is a system of threat, control, oppression directed against girls, women, transgender persons and others.
- GBV impacts everyone as it is a system that creates and maintains the fear of violence.
- GBV is one of the most prevalent human rights violations within all societies.
- The following are some of the rights of survivors that are violated due to GBV:
    - Right to Life
    - Right to Health
    - Right to Equality and Non discrimination
    - Right to Free Expression and Speech
    - Right to Education, Work, Earn
    - Right to Shelter and an Adequate Standard of Living
    - Right to Social Security
    - Right to Mobility
    - Right to Participate in Social and Political Activities

- GBV is a significant determinant of health and wellbeing - i.e., freedom from violence is necessary to be healthy. It adversely impacts health and well-being directly and indirectly, throughout life.
- Majority of those who experience GBV are women and girls.
- Globally 1 in 3 (35%) of women experience violence in their lifetime.*
- In India 29.3 % of ever married women have experienced intimate partner physical and/or sexual violence; 3.1 % of ever-married women have experienced violence during pregnancy. **

Aggravated vulnerability to GBV

Although women and girls are primary targets of GBV, gender intersects with other factors to aggravate vulnerability to GBV. This includes:

- Sexual orientation (lesbian, gay)
- Gender identity (transgender, gender non-binary persons)

• Persons with physical, psycho-social and/or intellectual disabilities • Children • Caste / Race / Ethnicity/Religion – e.g., Dalit, Tribal, Muslim women and girls • Others: those in war/conflict situations, those in occupations such as sex work, homeless, single women, abandoned/deserted women • Women during pregnancy, experiencing infertility, chronic / long term illness
Sources: *Key Facts:https://www.who.int/news-room/fact-sheets/detail/violence-against-women **Fifth Round of the National Family Health Survey (NFHS-5), 2019-21; http://rchiips.org/nfhs/NFHS-FCTS/Final%20Compendium%20of%20fact%20sheets_India%20and%2014%20States_UTs%20(Phase-II).pdf

Session 3.2: Forms of Gender-based Violence (GBV)  20 Minutes

Step 1: Introduce the session on forms of GBV. Distribute small cards (2 per participant) and pens. Ask participants to write one form of GBV on each card.

Step 2: Divide the flipchart or board where the cards are to be pinned / stuck into 4 boxes with the following headings:

- Physical
- Sexual
- Psychological
- Economic

Step 3: Ask participants to stick the cards on the board within the appropriate box. Explain that there are many forms of violence, which are organized here under four broad categories. Ask participants if they think anything is missing and if they want to add any more examples.

Step 4: Sum up adding to the responses from the examples in reference material "Forms of GBV" for each category and explain terms that are unclear to participants.

Reference Material for Step 4: Forms of GBV

Physical	Sexual
• Hitting, slapping, punching, strangling, pushing • Preventing a partner from leaving, locking in or imprisoning	• Sexual assault / Rape • Sexual abuse of children (including incest) • Sexual harassment (at the workplace)

• Burning, for example, using a cigarette or boiling water • Depriving of sleep • Threaten by throwing or hitting other objects • Stabbing, shooting	• Forced exposure to pornography • Online sexual abuse / harassment
Psychological	**Economic**
• Insult • Criticize excessively • Swear / verbally abuse • Call names • Threaten with self-harm (by perpetrator of GBV) to control survivor • Threaten harm to children and other persons dear to the survivor	• Control of money, property, assets necessary for access including to agricultural resources • Excluding from financial decision making • Control over earnings • Control over household expenditure • Denying money for any personal expenditure

Step 5: Explain that these forms of violence are merely examples. Explain that survivors often experience multiple forms of violence. The many forms of violence are experienced in various spaces – in homes, in education institutions, healthcare institutions, workspaces, public transportation, other public spaces, care institutions, prisons, etc.

Step 6: Explain that as nurses it is important to understand the forms of GBV. Use the reference material "Importance of understanding the forms of GBV" for this.

Reference Material for Step 6: Importance of Understanding the Forms Of GBV

This understanding is necessary to:

- Provide appropriate healthcare and psychosocial support for survivors in the health facility and through referrals.
- Enable survivors to talk / seek care for GBV.
- Establish health system preparedness, optimal health care, referrals within and outside the health facility.
- Document accurately the history of GBV, conduct relevant and appropriate examination, collection of evidence.
- Assist as necessary in forming and recording relevant medical opinion.

Session 3.3: Health Consequences of GBV — 20 Minutes

Step 1: Introduce the session on health consequences of GBV, stating that GBV is linked with poor health outcomes.

Explain that prevention and response to GBV is critical as it can improve the overall quality of physical and mental health.

Step 2: Present the health consequences of GBV using the reference material. If time permits share some examples of other consequences of GBV that also have serious implications for health and well-being.

Reference Material for Step 2: Health Consequences of GBV

• ***Physical consequences*** ○ Injuries ○ Functional impairments ○ Permanent disabilities	• ***Psycho-somatic Consequences*** ○ Chronic pain syndrome ○ Irritable bowel syndrome ○ Gastrointestinal disorders ○ Urinary tract infections ○ Respiratory disorders	***Fatal consequences*** ▪ Homicide ▪ Killing** ▪ Suicide
• ***Psychological / Mental Health Consequences*** ○ Post-Traumatic Stress Disorder ○ Depression, Fears ○ Sleeping disorders ○ Panic disorders ○ Eating disorders ○ Low self-esteem	• ***Others*** ○ Self-injurious behavior	

- Suicidal tendencies

- ***Consequences for Reproductive Health***
  - Pelvic inflammatory diseases
  - Sexually transmitted diseases/ HIV
  - Unwanted pregnancy
  - Pregnancy complications
  - Low birth weight

**"GBV can result in women's deaths. Fatal outcomes may be the immediate result of a woman being killed by the perpetrator, or in the long-term, as consequence of other adverse health outcomes. For example, mental health problems resulting from trauma can lead to suicidality, or to conditions such as alcohol abuse or cardiovascular diseases that can in turn result in death. HIV infection as a result of sexual violence can cause AIDS and ultimately lead to death (Heise et al 1999, WHO 2013)."

Source: "Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia - A Resource Package" developed jointly by WAVE and UNFPA Regional Office for Eastern Europe and Central Asia. Accessible at https://eeca.unfpa.org/sites/default/files/pub-pdf/WAVE-UNFPA-Report-EN.pdf.

Other Consequences of GBV (if time permits)

Social	Economic	Effects on Children
• Isolation • Ostracization • Punishment • Loss of relationships, social networks • Loss of children, consequences for children • Loss of productivity • Loss of job • Impact on education	• Loss of jobs • Economic participation curtailed • Poverty • Assets, property ownership curtailed • Inability to fend for children and other dependents	• Higher rates of infant mortality • Behavior problems • Anxiety, depression, attempted suicide • Poor school performance • Experiencing or perpetuating violence as adults • Physical injuries and health complaints • Loss of productivity in adult life

Step 3: Sum up using the reference material.

Reference Material for Step 3: Key Points

- The health consequences of GBV are well established and emphasize the urgent need to recognize GBV as a public health issue.
- As nurses who are committed to prevention of ill-health, enabling health and well-being, addressing GBV and responding to its health consequences, is critical.
- Strengthened understanding of GBV, its forms and consequences will facilitate timely, adequate and quality response to survivors.

Session 3.4: GBV as a Public Health Issue

60 Minutes

Step 1: Explain that this session takes forward the previous discussion and demonstrates that GBV is a serious public health issue. It draws attention to national and international recognition, mandates and commitments to address GBV as a public health issue.

Step 2: Ask participants to recall the previous session on health consequences of GBV. Recalling that, ask participants to respond to the following:

- Is GBV a public health issue? What are the reasons for this?
- What role/s can / should nurses and the health system play to address GBV?

Step 3: Allow about 5 minutes for reflection and then request participants to respond. List the responses on a flip chart or board.

Step 4: Sum up the responses to “Is GBV a public health issue? What are the reasons for this? Following this, screen the short film on why GBV is a public health and human rights concern by the World Health Organization (WHO), using reference material – video link.

Reference Material for Step 4: Video Link

WHO film on health consequences of GBV -
https://www.youtube.com/watch?v=Qc_GHITvTmI

Step 5: Ask participants if they have any comments or questions. Clarify any doubts that participants may have, following the screening of the film.

Step 6: Request responses to "What role/s can / should nurses and the health system play to address GBV?" Sum up the participants' responses using the reference material "Significant role of health system / health providers in prevention and response to GBV" on a PPT or flipchart.

Reference Material for Step 6: Significant Role of Health System / Health Providers/Nurses in Prevention and Response To GBV

- GBV is linked with poor health outcomes; prevention of GBV and comprehensive response is critical for health and wellbeing.
- Healthcare settings can be a place to provide support and information in a context of confidentiality and privacy.
- Healthcare providers can help identify survivors experiencing violence, facilitate access to comprehensive care. Nurses and nurse-midwives constitute a large component of the health workforce and are critical contacts in the health facilities for survivors.
- Comprehensive care implies appropriate medical care and treatment, emotional support, and in cases of sexual violence, collection and documentation of evidence and deposition in court.
- Nurses along with other healthcare providers can support survivors and establish critical referral linkages as necessary. For example, with the police, legal services, care and protection service providers like the District Child Protection Units (DCPU) and Child Welfare Committees (CWC) and the Protection Officer under Protection of Women from Domestic Violence Act, 2005.
- Nurses are in a position to integrate messages about violence, in health education and outreach programs at all levels ; information about GBV in the form of posters, brochures, or flyers may encourage survivors to talk about the violence and seek information and care.
- Nurses' expressions of concern and support can validate survivors' experiences, help them recognize abuse and feel motivated to seek support, care and justice. It can enable them to feel motivated to leave situations of violence – to safe spaces.
- Nurses can assist doctors in documenting the magnitude and causes/consequences of violence to guide future programming. Thus, they can help prevent violence as well as respond to survivors of violence.

- The healthcare system must create opportunities for development of capacities of nurses to respond to GBV through inclusion in nursing curriculum, and through continuing medical education. This should be done alongside strengthening health facility and referral preparedness.

Step 7: Explain that GBV as a public health issue based on health consequences and the critical roles and responsibilities of the health system and healthcare providers at all levels has been recognized by national and international mandates, protocols, and laws.

Step 8: Display the reference material "Key mandates that recognize GBV as a health issue and the role of healthcare providers" on PPT or flipchart. Explain that these are some key mandates. Request a volunteer from the participants to read the displayed content. Ask participants to add to this if they are aware of others.

Reference Material for Step 8: Key Mandates That Recognize GBV As a Health Issue and Role of Healthcare Providers

National Human Rights Commission (NHRC) India (2020)	Human Rights Advisory on the Rights of Women in the Context of COVID 19 Source:https://nhrc.nic.in/document/human-rights-advisory-rights-women-context-covid-19
National Health Policy (2017) India	**Gender-based Violence-** Women's access to needs to be strengthened by making public hospitals more women friendly and ensuring that the staff have orientation to gender – sensitivity issues. This policy notes with concern the serious and wide-ranging consequences of GBV and recommends that the health care to the survivors/ victims need to be provided free and with dignity in the public and private sector.
World Health Assembly Declaration A67/22 (2014)	**Role of the Health Sector-** The health sector has a leading role to play in giving care providers evidence-based guidance on appropriate responses to violence, and in particular to violence against women and girls, including clinical interventions and provision of mental health services and emotional support, as well as referral to other services such as legal or social services or those related to physical protection. Because a healthcare provider is likely to be the first professional contact for women and girls who experience violence, the health sector should increase

	awareness at different levels of its system and develop the capacity of the health workforce. Care for women and girls who experience intimate partner violence and sexual assault should be women-centred and integrated into existing health services. The special needs of children (both boys and girls) should be considered and appropriate services provided.
Sustainable Development Goals (SDGs)	**Goal 5.** Achieve gender equality and empower all women and girls. **Target 5.2:** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.
Nairobi Statement on ICPD 25 (International Conference on Population and Development) [2020]	**Zero sexual and gender-based violence** and harmful practices, including zero child, early and forced marriage, as well as zero female genital mutilation. Elimination of all forms of discrimination against all women and girls, in order to realize all individuals' full socio-economic potential.
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Recommendation No. 35 (2017) on gender-based violence against women, updating General Recommendation No. 19	**General Recommendation No. 35**: • It expands the understanding of violence to include violations of sexual and reproductive health rights. • It stresses the need to change social norms and stereotypes that support violence, including threats to gender equality in the name of culture, tradition or religion. • It clearly defines different levels of liability of the State for acts and omissions committed by its agents or those acting under its authority - in the territory of the State or abroad- and ensure access to remedies for survivors. • It unequivocally calls for the repeal of all laws and policies that directly and indirectly excuse, condone and facilitate violence. • It emphasizes the need for approaches that promote and respect women's autonomy and decision-making in all spheres of life.

Step 9: Conclude that the displayed content indicates that: There is an increasing global and national recognition of GBV as a public health issue. GBV must be prevented and its health impact reduced.

Session 3.5: Addressing Concerns amongst Healthcare Providers in Responding To GBV

30 Minutes

Step 1: Explain that it is important for participants to reflect and address concerns that may pose barriers to implementing their roles as healthcare providers. Ask participants in turn to raise any concerns that they may have. Write the concern raised on the board. Follow this till a few concerns are raised.

Step 2: Distribute the Handout "Reflect and Address Concerns That May Pose Barriers to Implementing Your Roles as amongst Healthcare Providers in Responding to Survivors" " to all participants.

Handout For Participants for Step 2: Reflect and Address Concerns amongst Healthcare Providers in Responding to Survivors

Concern: I do not have the adequate time to assess and respond to GBV

Reflection: Assessing and responding to GBV can be done efficiently. Strengthening your capacities and skills to do so must be prioritized. GBV is a physical and mental health issue and must be responded to as you would to any other health issue, providing the necessary time and priority. Understanding experiences and the consequences of violence can provide important insight into a patient's/survivor's health. It may reveal the underlying cause of the presenting health issue and facilitate diagnosis and treatment.

Concern: If I speak to patients/survivors regarding violence in their lives, they might feel offended

Reflection: Survivors who have been affected by violence are often waiting for an opportunity to speak about some aspect of what they are going through. Evidence shows that survivors do not mind being asked about abuse when it is done sensitively and without judgment, and that they mostly appreciate the provider's expression of care. Your patients

may actually gain more trust towards you by knowing that you care about their health and safety.

Concern: It is uncertain if survivors will take action against the violence, so why should I waste my time

Reflection: You can never be certain of survivors' behavior after they leave. You do not control what they do or do not do with the information you provide. For survivors experiencing abuse, it may take multiple interventions and discussions to achieve safety and well-being. You can at least listen, inquire, validate experiences, and contribute towards enhancing safety, and providing support to the survivor.

Concern: I feel discomfort and do not have any practice in discussing violence
Reflection: Speaking with your patients about GBV will become easier with training, time, and practice.

Concern: I think my role as a healthcare provider is primarily focused on physical health
Reflection: Evidence has shown that abuse has a direct and measurable effect on multiple aspects of women's physical, mental, sexual, and reproductive health. Healthcare providers have a role to play in protecting both the physical and mental health of patients/survivors.

Concern: If I inquire about violence, it may lead to other responsibilities for which I am unprepared

Reflection: Know the legal mandates of what healthcare providers must do to respond to GBV and support survivors. Look for opportunities and resources to enhance your skills and preparedness. Find out the responsibilities of the health facility that you are associated with, its preparedness and protocols to respond to GBV that you have to follow. Consult with peers, seniors, administrators to understand your responsibilities and to seek support in implementing them. Partner with community organizations, if needed, to find this information.

Concern: I have a personal history of violence which I have experienced for many years. I think this will make it uncomfortable to talk about violence with the patient/ survivor
Reflection: Healthcare providers may also experience GBV. Seek support to address your psychosocial needs. Reach out to organizations or experts who can aid you; this can also help you to be a more empathetic and effective healthcare provider.

Source: Adapted from - World Health Organization; *Caring for women subjected to violence: A WHO curriculum for training healthcare providers.*

Step 3: Compare the concerns that were raised by participants with those in the Handout. Ask participants to volunteer to read aloud the responses to the concerns that have been listed on the board.

Step 4: Ask participants if they would like to respond to any concerns that do not feature in the Handout. Respond to these concerns based on your understanding and experience. If unsure, let the participants know that those specific concerns can be discussed in the following session as there is need for reflection and inputs from the training support group.

Step 5: Thank participants for sharing their concerns and for their collective efforts at addressing them. Clarify that concerns may be raised by them at any point throughout the training.

Session 3.6: Key Principles for Survivor-Centred Care

20 Minutes

Step 1: Explain that in carrying out their roles in responding to survivors, an understanding and implementation of key principles is essential. These principles enable healthcare providers to place survivors at the centre of the response and to navigate clarifications and concerns that they may be faced with. Disseminate the handout and facilitate a brief discussion.

Handout for Step 1: Key Principles for Providing Survivor-Centred Care

As healthcare providers, be aware that GBV is driven by unequal power relations, which shows up in many ways. Survivors may, for example:

- have less access to and control over resources
- be blamed or shamed for violence; feel low self-esteem, blame themselves, lack confidence to take action
- be subjected to norms that prevent them from leaving relationships or seeking care, or exercising their autonomy or making decisions

Therefore, as healthcare providers, **ensure that the following principles are followed**:

- **Empathy:** Expressing understanding of how the survivor feels; feeling what the survivor is experiencing through understanding their context.
- **Non-judgmental:** Do not judge or blame survivors for the violence.
- **Respect:** Respect the survivors' autonomy to make informed decisions; provide information and counseling that can help survivors' make them.

- Provide age-appropriate information to enable informed consent as well as assent in keeping with the capacities of the survivors.
- Recognize the evolving capacities of adolescents and children. Do not assume that they do not understand anything or that decisions can be made only by the parent/guardian.
- Respect and validate survivors' narratives and decisions even if not always in agreement with them.
- Respect informed consent or refusal by survivors.

- **Non-discrimination:** Do not discriminate against any survivor.
- **Do no harm:** Avoid causing survivors further harm, avoid doing anything that may compromise their safety or expose them to further violence.
- **Privacy:** Ensure visual and auditory privacy; having a separate, private space for consultation, examination. Presence of others should be allowed only with the survivors' consent. Privacy if compromised, can put survivors at risk, especially if accompanied by perpetrators.
- **Confidentiality:** This implies: (i) obtaining the survivor's consent to share information with those who need to know in the healthcare system, other referral points and in the family; (ii) Safely and securely storing records.

Theme 4: Laws Pertaining to Health Facility and Healthcare Providers' Roles and Responsibilities

Duration: 2 Hours 30 Minutes

Theme 4	Title	Objective/s	Duration
Session 4.1	Legal Mandate for Healthcare Facilities and Providers in Addressing GBV	To introduce participants to the law as a tool that is shaping and guiding the roles and responsibilities of the Health System in addressing GBV and aiding process of social justice.	45 minutes
Session 4.2	Key Legal Procedures Healthcare Facilities and Providers Must Follow	To deepen the understanding of GBV and related response procedures for Healthcare Providers, as defined by the law • Indian Penal Code, 1860 (IPC) and Criminal Procedure Code, 1973 (CrPC) • The Protection of Women against Domestic Violence Act, 2005 (PWDVA) • Protection of Children from Sexual Offences Act, 2012 (POCSO)	1 hour
Session 4.3	Documentation by Healthcare Facilities and Providers in cases of GBV and its Evidentiary Value	To discuss the value and expectations from documentation done by Healthcare Providers in course of their intervention in GBV cases. Understand it in light of medical record and its evidentiary value.	45 minutes

Session 4.1: Legal Mandate for Healthcare Facilities and Providers In Addressing GBV

45 Minutes

Step 1: Introduce the session by stating that as nurses, they must be acquainted with the spirit and objective of the law. This is important to execute their professional and legal responsibilities in addressing GBV in an effective manner.
State that the Constitution of India recognizes GBV as a violation of rights and justice, through key legislations. Prescribing procedures for redressal is important to ensure that the right to life with dignity and health is equally protected for all without discrimination.
Legal compliance enables nurses, and other healthcare providers in responding comprehensively and appropriately to patients/survivors. It strengthens the role of the health system in restoring public health and social justice.

Step 2: State that the session will begin with briefly addressing Frequently Asked Questions (FAQs) to clarify doubts about why and what we must know about the law. Use reference material "FAQs on Legal Mandate of Healthcare Facilities and Providers Toward Addressing Gender-Based Violence in India" to explain each of the questions.

Reference Material for Session 4.1: FAQ on Legal Mandate of Healthcare Facilities and Providers Toward Addressing GBV in India

Question 1: Why are we discussing the legal system while discussing GBV as a public health concern? Shouldn't the police and courts have to deal with the legal aspects?

Answer: India is built on the principle of the Rule of Law as opposed to any divine right of kings, dictatorships, or mob rule. This means that no person or profession is above or outside the purview of the law, which will be transparent, enforceable, and follows due process. The source of all laws in our country is the Constitution of India. It places people, their meaningful participation, and welfare at the centre by upholding a socialist, secular, democratic republic that promises the protection of the fundamental human rights of all people. To ensure this, the Constitution has placed legal accountability on the very purpose and structure of the State and its actors. They are to make and implement laws that provide affirmative action and protect rights. This includes providing effective and survivor-centric redressal mechanisms from wrongdoing to restore social justice.

One can think of the legal system as the blood that runs through our bodies. Blood carries nutrients and oxygen to keep the body healthy, growing and active. And if any disease or

infection attacks it, the defence mechanism comes into action. Similarly, the legal system provides rules and regulations that protect the rights of every individual for a healthy and prosperous life. If rights are violated, there are fair procedures to give punishment and remedy for wrongdoing.

GBV is a human rights violation with broad and profound effects on the individual and society, along with being a public health concern. Therefore, it is considered legal wrongdoing that requires a multi-sectoral response to address its far-reaching impacts and restore rights and justice. To fulfil its Constitutional duty, the State has enacted several laws, procedures and protocols to address the issue. These prescribe a vital role for the health system, along with the role of police, courts, One Stop Centres (OSC), Protection Officers (PO), Child Welfare Committees (CWC), and other stakeholders, making it imperative to consider the legal system.

Question 2: Non-literate and rural people should be taught these laws as they are vulnerable and prone to GBV-related crime and wrongdoing. What is the purpose of the Healthcare Providers to know the laws addressing GBV?

Answer: Women from all walks of life can be subject to GBV, and along with affecting their physical and mental health, GBV also impacts their social, economic and political engagement. Hence a multi-sectoral response is critical to effectively address the issues at all stages of prevention, intervention and redressal. As part of the Health System, there is a professional and legal obligation to be part of this coordinated response to address GBV.

The Supreme Court has held that Article 21 of the Constitution of India (fundamental right to protection of life and personal liberty) obligates the State to preserve life. The patient can be an innocent person or a criminal liable to punishment under the laws; maintaining life is the obligation of those in charge of the community's health. Every healthcare provider, whether at a Government hospital or otherwise, has the professional responsibility to extend services with due expertise for protecting life. (Parmanand Katara vs. Union of India, 1989). It has also repeatedly highlighted that the expression "life" in Article 21 means a life with human dignity and not mere survival or animal existence (Francis Coralie Mullin vs. The Administrator, Union Territory of Delhi, 1981).

Healthcare Providers must know these mandates to understand the extent of their role better and perform it in a legally robust manner to aid justice and avoid any legal action against them. Hence, it is critical and unavoidable for the Health System to know and act according to the law. Also, ignorance of the law is not an acceptable excuse or defence. Better knowledge and understanding of law as a tool can also facilitate how individuals, including the participants, seek support if they or someone they know faces GBV.

Question 3: There are so many laws in India; what does the Health System need to know to perform its professional and legal duty to address GBV?

Answer: The highest reported forms of GBV, per the National Crime Records Bureau (NCRB), can be clubbed into these 3 broad categories:

- cruelty from family
- sexual violence - including rape, other forms of sexual assault, and child sexual abuse
- kidnapping and abduction

Hence, the State has made specific laws and procedures to address the same through a multi-sectoral, coordinated response, which includes the Health System. You need to know relevant provisions from the following legislations to perform your roles and responsibilities and aid the process of justice:

- Indian Penal Code, 1860 and Criminal Procedure Code, 1973
- Protection of Women from Domestic Violence Act, 2005
- Protection of Children Sexual Offences Act, 2012

The responsibility set for healthcare facilities and providers in the procedures of these laws and related guidelines covers their role in intervention in cases of GBV against women, trans* persons and children of any intersectional identity. Other laws like the Dowry Prohibition Act, 1961, the SC/ST (Prevention of Atrocities) Act, 1989, the Child Marriage Prohibition Act, 2006, the Rights of Persons with Disabilities Act, 2016, and the Transgender Persons (Protection of Rights) Act, 2019, etc., also recognize the vulnerabilities of communities and address violence through multiple forms of protection. They rely on the procedures we will discuss in these sessions for response to GBV-related MLCs.

Question 4: Apart from medical treatment and care, what is the role prescribed in the law for the Healthcare facilities and providers?

Answer: Healthcare facilities and providers play a dual role:

- providing therapeutic care through medical treatment and psychosocial support (including referrals).
- assisting the Court in ascertaining justice from GBV by conducting and documenting the examination and assisting law-enforcement agencies with their expert opinion.

Cases of ailment, etc., in which investigations by the law-enforcement agencies are essential to fix the responsibility regarding their causation are often referred to as Medico-Legal Cases (MLC). It is critical to identify such cases in order to extend other necessary support to the patient/survivor that can aid in accessing justice.

The healthcare provider is responsible for recording a proper history and carrying out an examination, along with providing treatment. Based on this, they must analyze the case to determine whether to classify it as an MLC. If it is, the healthcare facility should be equipped to provide the necessary care and initiate a coordinated response, like informing the OSC, PO or police, as per the circumstances.

Unfortunately, the usual impression is that MLC implies disputes, unwanted pressures, rough-speaking police officials, excessive hours in the Court, unrelenting defence counsels, etc. Because of this fear factor, these cases are not given their due importance. Instead, they are either ignored, avoided or removed as soon as possible. But it must be noted that the service and expert knowledge of healthcare facilities and providers may be the missing link for the survivor-centric administration of law and justice. Which is why every healthcare provider must remember that:

- When summoned by Court in relation to a GBV MLC, they are invited as friends of justice and not as a wrongdoer.
- In the trial process, the Court and lawyers can only inquire to the extent of their subject matter i.e., healthcare and the MLC related documentation.
- They are entitled to travel reimbursements from the Court under Section 312 CrPC, which can be processed by submitting a simple application with supporting travel documents.

A part of the preparedness to holistically address GBV also calls for Healthcare Facilities to be free from all forms of sexual harassment and gendered discrimination. Healthcare facilities are places of trust and authority for survivors and places of employment for healthcare providers, hence are legally obligated to provide and nurture a safe and inclusive work environment free from sexual harassment for all who work at and visit the facility. Especially those from marginalized and vulnerable communities. For this, all healthcare facilities with 10 or more employees (including volunteers) must have an Internal Committee (IC) as mandated under the Sexual Harassment of Women at Workplace (Prohibition, Prevention and Redressal) Act, 2013.

- The senior-most woman employee must chair the IC.
- Minimum 2 more employees who have interest or background of working on GBV must be members.
- There must be at least 1 external member with experience and insight into working on GBV.
- With a minimum of 5 total members, at least 50% of the IC members must be women.
- The contact information of this committee must be known to all employees and boldly displayed across the workplace.
- Failure to have an active IC can lead to fine and cancellation of registration of the facility. The IC is responsible for recommending disciplinary action in reported cases, assisting the survivor in police process, if they require and taking proactive measures to ensure sensitisation of all employees on concerns of gender-based discrimination and GBV at the workplace.
- Do inquire about the contact details about the IC at your workplace and the activity they have conducted so far.

Handout for Step 2: Instances that Classify as Medico-Legal Cases

The following instances are to be treated as medico-legal cases. These overlap with instances of GBV that would approach a healthcare facility or provider for treatment:

1. All cases of injuries and burns where the circumstances suggest commission of an offence (irrespective of suspicion of foul play);
2. Cases of suspected or evident sexual assault;
3. Cases of unconsciousness where its cause is not natural or not clear;
4. All cases of suspected or evident poisoning or intoxication;
5. Cases referred from Court or otherwise for age estimation;
6. Cases brought dead with improper history creating suspicion of an offence;
7. Cases of suspected self-infliction of injuries or attempted suicide;
8. Any other case not falling under the above categories but with legal implications.

Source: Meera T. Medicolegal cases: What every doctor should know. J Med Soc 2016;30:133-4. <https://www.researchgate.net/publication/320892086_Medicolegal_cases_What_every_doctor_should_know>

Step 3: Sum up reiterating that:

- Nurses' understanding and clarity that the legal obligations of healthcare facilities and providers is rooted in the Constitution for the protection of rights and justice is very important.
- The following sessions will focus on understanding the legal definitions of GBV and procedures to be followed by the healthcare providers.
- Guidelines and protocols have also been put in place by the State to further operationalize these procedures and strengthen the Health System's role in addressing GBV.
- The MoHFW Guidelines and Protocols on Medico-legal care for survivors of sexual violence, 2014, for example, includes the legal mandates and ethical and other guidelines in the context of sexual violence faced by women and trans* persons of all ages. These, too, shall be covered in detail in a later session to address more practical aspects fulfilling legal obligations of the Healthcare Provider.

Session 4.2: Key Legal Procedures Healthcare Facilities and Providers Must Follow While Responding in Cases of GBV

1 Hour

Step 1: Explain that the session will include a presentation and discussion on three key laws – Indian Penal Code, 1860 (IPC) with Criminal Procedure Code, 1973 (CrPC), Protection of Women from Domestic Violence Act, 2005 (PWDVA) and Protection of Children from Sexual Offences Act, 2012 (POCSO). All these laws are rooted in the Constitution of India and provide for the procedure healthcare providers must undertake in response to GBV cases against any person, irrespective of age, including against trans* persons.

Step 2: Use the reference material **"Laws Addressing Prevalent forms of GBV"** on PPT or flipchart. State that the following presentations on each of the laws allow time for clarifications and discussion with particular focus on roles and responsibilities of health system / healthcare providers, including nurses.
To facilitate this discussion periodically ask participants whether they have ever intervened in or heard of cases that fit the definitions being discussed and what procedures did they follow in their line of response.

Reference Material for Step 2: Laws Addressing Prevalent forms of GBV

Key Laws:

- Indian Penal Code, 1860 (IPC) and Criminal Procedure Code, 1973 (CrPC)
- Protection of Women from Domestic Violence Act, 2005 (PWDVA)
- The Protection of Children from Sexual Offences Act, 2012 (POCSO)

These 3 laws attempt to address the most prevalent forms of GBV; Domestic Violence and Sexual Violence perpetrated by family members, intimate partners, known persons, and strangers.

The presentation will discuss the critical details of definitions and procedures addressing physical and sexual forms of violence. To facilitate an appropriate response from healthcare providers by identifying GBV-related MLCs through history, analyzing health consequences, and documenting details using relevant formats.
You can refer to the handout for in-depth information on the various sections in the laws that cover different forms of GBV and response.

The Indian Penal Code, 1860 (IPC) and the Criminal Procedure Code, 1973 (CrPC)

Only a court of law can decide on guilt, innocence or punishment in criminal cases. The police must carry out an investigation and submit all relevant evidence for the court to adjudicate. No other person or authority can decide on guilt or innocence or punishment other than the courts, no matter how well-intentioned.

- **Suicide and other Unnatural Death (Sections 302, 304B, etc. IPC)**

Includes offences like murder (Section 302), attempt to murder (Section 307), and abetment to suicide (Section 306). These offences address several aggravated forms of GBV, like instances of 'witch-hunting' practices and 'honor'-related murders and suicides, etc. Since these sections are gender neutral, both women and trans* persons can claim redressal from GBV using these provisions.
We must also highlight the crime of dowry death (Section 304B), defined as the death of a married woman due to burns, bodily injury, or other unnatural circumstances, where soon before her death, she was subjected to dowry-related cruelty or harassment by her husband or his relatives.

- **Grievous Hurt including Acid Attack (Sections 323, 326, 326A, etc.)**

This category covers physical forms of GBV like beating, kicking, punching, pulling hair, pushing into hard objects or down from a height, hitting with a weapon or household objects, acid attack (Sections 326A and 326B), etc., by a known person or stranger. These again are gender-neutral provisions hence extend protection to all women and trans* persons facing this nature of GBV.
Hurt can be understood as inflicting any injury to the body that does not result in death but causes bodily pain, disease, or infirmity. Done using the strength of own body, blunt or sharp objects, any dangerous weapon, poison, flammable substances, acid, etc. Hurt becomes grievous if it:

- permanently deprives the use of either eye or ear;
- destroys, permanently or otherwise deprives use of any body part or joint;
- permanent disfiguration of the head or face;
- fracture or dislocation of a bone or tooth, or
- endangers life or causes the sufferer to be in severe bodily pain for 20 days or more or unable to follow ordinary pursuits.
- It is irrespective of whether this damage is irreversible or not.

Acid is any substance with an acidic or corrosive character or burning nature, capable of causing bodily injury and leading to scars, disfigurement, or temporary or permanent disability.

- **Domestic Violence with Married Women (Sections 498A IPC)**

If the husband or his relative willingly subject the wife to any conduct, which is -

- likely to drive her to commit suicide or to cause grave injury or danger to her life, limb, or health (whether mental or physical),
- with intention to harass or coerce her, or any person related to her, to meet any unlawful demand for property or valuables
- harassing her on account of failure to meet such demand.

It is important to note that a more comprehensive definition of domestic violence that extends protections to married as well as single women and children is given in the PWDVA, which we shall discuss further.

- **Non-Penetrative Sexual Assault (Sections 354, 354A to 354D IPC)**

This category was elaborated through the Criminal Law Amendment Act, 2013 (CLA)[1] to include a range of sexual violence committed by men over women aged 18 years and above;

1. Sexual harassment (Section 354A); When a man intentionally and without consent commits any of the following acts—
    - physical contact and advances involving unwelcome and explicit sexual overtures; or
    - a demand or request for sexual favours; or
    - showing pornography against the will of a woman; or
    - making sexually coloured remarks.

For example, groping private parts, kissing without consent, abusing position of authority to ask for sexual favours, demanding sexual acts in return of favours, passing comments with sexual innuendos to make the woman uncomfortable, etc.

2. Criminal intent to disrobe a woman (Section 354B); When any man uses force or is party to act of forceful disrobing of any woman or compelling her to be naked.

For example, stripping a woman publicly or naked-parading to humiliate her.

- **Penetrative Sexual Assault (Sections 375 and 376 IPC)**

Penetrative sexual assault is termed as rape[2] under the IPC and it specifically extends protections to women aged 18 years and above.

We must note that the Transgender Persons (Protection of Rights) Act, 2019 recognizes that trans* persons are also subject to various forms of sexual assault. The Act provides some protections, albeit limited, and it follows the procedures of the CrPC to this extent. The protections for persons below 18 years of age are given under POCSO.

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[1] **The Criminal Law (Amendment) Act, 2013 (CLA)** provides for amendments in the Indian Penal Code, 1860, Indian Evidence Act, 1872 and Criminal Procedure Code, 1973 on laws related to sexual offences including acid attacks and self-defense. It was passed in the aftermath of the 2012 gangrape and murder of a young medical professional in New Delhi which lead to nationwide demands for greater protections against all forms of sexual assault.

[2] Thorough details were added to the definition for rape (Section 375 IPC) through **The Criminal Law (Amendment) Act, 2013 (CLA)** and the minimum punishment (Section 376 IPC) was increased from 7 years to 10 years through **The Criminal Law (Amendment) Act, 2018**

Section 375 defines penetrative sexual assault (rape) as when a man does the following acts to a woman, or makes her do such action to him or any other person:

- penetrates penis, to any extent, into the vagina, mouth, urethra or anus; or
- inserts, to any extent, any object or any other body part into the vagina, the urethra or anus; or
- manipulates any body part of the survivor to cause penetration into the vagina, urethra, anus or any part of the body; or
- applies mouth to the penis, vagina, anus, and urethra.

Under the following circumstances:

- Against her will,
- Without her consent,
- With her consent that
  - Was obtained through coercion, by putting her or any person in whom she is interested in fear of death or of hurt.
  - Was given because of unsoundness of mind or under intoxication.
  - Was given under the influence of stupefying substances (administered by man personally or through someone else) due to which she cannot understand the nature and consequences of her consent.
- When she is unable to communicate consent.

The law also lists several circumstances when rape is considered more aggravated. Like when committed in a gang, by someone in a position of authority over the survivor like staff of jail or shelter home or hospital under who's custody she is, when the offence causes death or a vegetative state, etc.

Consent means an unequivocal voluntary agreement when the woman, by words, gestures, or any form of verbal or non-verbal communication, communicates a willingness to participate in the specific sexual Act. A woman who does not physically resist the action of penetration, cannot be said to have consented to the sexual activity, based only on that fact.

Some Exceptions

- A medical procedure or intervention conducted by taking due informed consent shall not constitute rape.
- Non-consensual sexual intercourse or sexual acts by a man with his wife who is 18 years or above is not covered under this law.

It is important to note that there is a legal remedy for sexual abuse by a husband under the PWDVA, 2005, which we will discuss later. Irrespective of where the remedy lies, the therapeutic role of the healthcare facility and provider is the same.

- **<u>Treatment at Healthcare Facilities of survivors of acid attack and penetrative sexual assault (357C CrPC)</u>**

All hospitals, public or private, shall provide immediate first-aid or medical treatment to the survivors of acid attack, rape and gang rape. The treatment must be provided free of cost. They shall also immediately inform the police of such an incident.

Healthcare facilities must ensure sensitization and preparedness for such treatment and care, as denial or delay in their intervention in these cases of GBV is unlawful. An FIR can be filed under Section 166B IPC against any healthcare facility that denies or delays this first-aid and treatment or charges survivors a fee. The in charge of the facility can be punished with imprisonment of up to 1 year or fine, or both.

The Supreme Court has clarified that police requisition is not required for conducting forensic examinations and providing treatment to survivors of sexual violence. Health facilities should not turn away a survivor for not filing an FIR. (State of Karnataka vs. Manjanna, 2000)

- **Medical Examination of survivors of sexual assault (Section 164A CrPC):**

A registered medical practitioner employed in a hospital run by the Government or a local authority shall examine the survivor of sexual assault if it is proposed during the investigation. But if such a practitioner is unavailable, any other registered medical practitioner may examine with the consent of the survivor or a person competent to give such consent on their behalf.

Without delay, the registered medical practitioner shall examine the survivor upon taking their consent. Any action without due consent will be considered unlawful. The report of examination must have the following particulars:

- the name and address of the survivor and of the person who brought them;
- the age of the survivor;
- specifically record that they have obtained consent for such examination from the survivor or any person competent to give such consent on their behalf;
- the description of material taken from them for DNA profiling;
- marks of injury on the survivor, if any;
- the general mental condition of the survivor;
- other material particulars in reasonable detail;
- state precisely the reasons for each conclusion arrived at;
- exact time of commencement and completion of the examination.

Without delay, they shall forward this report to the investigating officer, which shall become part of the trial evidence.

The Supreme Court in several instances, as well as the 2014 guidelines by the Ministry of Health and Family Welfare, has reinforced the following points that all healthcare facilities and providers must take into account:

- The importance of documentation of the narration of the history of sexual violence by the survivor in several cases. An inference must be drawn in the opinion recorded by the healthcare provider - correlating the history and clinical findings.
- The 'finger test' or commenting on the status of hymen, the elasticity of the introitus, or sexual history of survivor is not to be conducted during examination and evidence collection. It has no bearing on a case of sexual violence and is also unlawful.
- <u>The absence of medical evidence cannot be seen as the absence of sexual violence. There are several reasons for the medical evidence not being available, which the healthcare providers should be mindful of.</u>
- It should be always kept in mind that normal examination finding neither refute nor confirm non-consensual sexual intercourse or act.

"Examination" includes the examination of blood, blood stains, semen, swabs in case of sexual offences, sputum and sweat, urine, hair samples and fingernail clippings by the use of modern and scientific techniques, including DNA profiling and other tests which the registered medical practitioner thinks necessary in a particular case;

"Registered medical practitioner" means a medical practitioner with any medical qualification defined under the Indian Medical Council Act, 1956 and whose name has been entered in a State Medical Register.

- **<u>Protection of Women from Domestic Violence Act, 2005 (PWDVA)</u>**

There could be several instances where you provide healthcare to survivors of domestic violence. From the lived realities of survivors, we know that they may be hesitant to approach the police. Hence, this law becomes vital as the relief is extended through a Protection Officer (notified in every district). They fill out a Domestic Incident Report (DIR) based on the information provided by the survivor and develop a safety plan for emergency and immediate needs. The DIR is submitted in court to seek relief that includes protection from any form of abuse, safe and rightful residence, compensation and monetary support to exit the cycle of violence, etc. The survivor can also directly approach the court with the help of a lawyer. The police have limited involvement in the implementation of this Act and punishment like jail time is not a part of the relief given in here.

- **<u>A comprehensive definition of domestic violence</u>**

Any woman or child, whether married or single, can claim relief under this Act if they have been subjected to domestic violence by a family member in the shared household. Family members will include people related by blood, by adoption, by marriage or by being part of joint family. It also includes relief to women in live-in relationships.

- Any act or conduct done intentionally by member/s of the family,
- that harms or injures, or endangers the health, safety, life, limb, or wellbeing, whether mental or physical,
- of a woman or child member of that family.

The reliefs of this Act are also directed toward remedy for survivor and her vulnerable situation, rather than punishment for the perpetrator.

Examples of the 4 categories of violence listed in the Act are:

- **Physical Abuse**: any act that causes bodily injury, harm, or danger to life; e.g., beating, kicking, punching, biting, pushing, burning etc.
- **Sexual Abuse**: any non-consensual humiliating or degrading sexual act, e.g., forced sexual intercourse by the husband or any other family member, making a woman/child watch pornography against their will, etc.
- **Verbal and emotional Abuse**: insult, ridicule and threats, e.g., using derogative terms, abusive language, ostracizing, blaming a woman for not having a male child, giving threat of violence.
- **Economic Abuse**: deprivation of the necessities of life and resources that a person legally has the right to, e.g., denial of food, disposing of household assets to the detriment of the woman, disposing of her assets (such as Stridhan) against her will, demanding dowry or unlawful demand of property or valuable security etc.

- **Duties of the Medical Facility under PWDVA (section 7, PWDVA, Rule 17)**
- The healthcare facility must provide medical services if a survivor of domestic violence or, on her behalf, a Protection Officer approaches the person in-charge with requests to provide medical aid.
- The healthcare facility shall not refuse medical assistance to a survivor for her not having lodged a DIR before requesting medical assistance or examination.
- If no DIR has been made, the healthcare facility shall fill in the DIR and forward the same to the local PO.
- The healthcare facility shall provide a free-of-cost copy of the medical examination report to the survivor.
- The DIR must be substantiated by relevant documents (MLC documentation, prescription, treatment [OPD-IPD papers], doctor's certificate, etc.)

The Supreme Court has acknowledged the need for a more holistic treatment from the State authorities in the context of GBV. Emphasizing that State authorities are obliged to issue requisite guidelines and instructions to all stakeholders in multi-sectoral response to

addressing GBV cases, including the kind of treatment to be provided to the survivor. (Dilip vs. State of Madhya Pradesh, 2013)

- **The Protection of Children from Sexual Offences (POCSO) Act, 2012**

POCSO is an Act to protect children from sexual assault, sexual harassment and pornography while safeguarding their best interest and participation at every stage. It provides for child-friendly procedures during the investigation, medical examination and trial process and facilitative mechanisms at the point of reporting, recording of evidence and investigation. Special Courts of Children have also been set up under this Act for speedy trials.

The provisions of POCSO are gender neutral. It extends protections to people below 18 years of age, irrespective of gender if they have been subjected to sexual violence by a perpetrator of any age or gender.

- **Penetrative Sexual Assault (Section 3 and 5 POCSO)**

If the perpetrator does the following acts to a child or makes the child do to the perpetrator or any other person or themselves:

  - penetrates penis, to any extent, into the vagina, mouth, urethra or anus; or
  - inserts, to any extent, any object or any other body part into the vagina, the urethra or anus; or
  - manipulates any body part of the child to cause penetration into the vagina, urethra, anus or any part of the body; or
  - applies mouth to the penis, vagina, anus, and urethra.

The above acts are considered aggravated assault if conducted on a child under 12 years or by any person of trust and authority over the child or have severe and/or long-term impacts on the child's health. E.g., by a police officer, armed forces personnel or any public servant, or a person on the management or staff of a place of custody or care for a child like a school, hospital, coaching centre, shelter home etc. This category also includes penetrative sexual assault perpetrated in a gang or where it leads to grievous hurt or bodily injury, unwanted pregnancy or STI. It is aggravated even where the survivor is a child with any mental or physical disability or below 12 years of age.

- **Sexual Assault (Section 7 and 9)**

The act of touching the vagina, penis, anus or breast of a child or making the child touch themselves or these parts on any other person's body, with a sexual intent. This offence includes any other act done with sexual intent involving physical contact without penetration.

Explanation: Sexual intent is necessary for this offence. For example, a mother bathing her child does not fall under this definition.
The above acts are considered aggravated if conducted on a child under 12 years or by any person of trust and authority over the child or have severe and/or long-term impacts on the child's health.

- **Healthcare and Medical examination (Section 27 with Rule 6 POCSO)**
  - It is compulsory for healthcare providers and facilities to treat all child survivors of sexual violence. First aid and treatments for injuries, HIV, STIs, unwanted pregnancy and emergency contraceptives, a referral or consultation for mental or psychological health or other counselling are to be provided without delay and free of cost (Rule 5 of POCSO).
  - The child's privacy must be protected during emergency healthcare in the presence of their guardian or any person of trust.
  - The medical examination and collection of any forensic evidence shall be done with the same considerations under Section 164A CrPC. The only additional considerations are that:
    - The examination is to be conducted in the presence of the guardian or any person the child trusts. Where such a person cannot be present for any reason, the healthcare provider must carry it out in the presence of a woman nominated by the in-charge of the facility.
    - A lady medical officer should examine a girl child wherever possible.
- There is no pre-requisition of FIR or other documentation for such services.

Before POCSO, the age of consent for sexual activity was 16 years. The direction for mandatory reporting, even in cases of adolescents, regardless of whether the activity was consensual or abusive, severely impacts their sexual and reproductive health rights and wellbeing. As the evidence indicates, adolescents are forced to keep their sexual and reproductive health needs like medical termination of pregnancy, treatment for STIs etc. out of the formal systems for fear of being compelled to register FIRs against their partners.

- **Other relevant mandates**
  - Minimum age of survivor for giving valid consent for medical examination is 12 years (Sections 89 and 90, IPC).
  - If the guardians of a child below 12 years of age are not available to consent for examination, then informed consent must be obtained from a panel of senior healthcare providers in administrative positions at the healthcare facility. These doctors must act in the best interest of the child.
  - A doctor can conduct any emergency lifesaving procedure without any person's consent, also applicable to child survivors of sexual violence (Section 92 of IPC).
  - Mandatory reporting: When a healthcare provider has reason to suspect that a child has been or is being sexually assaulted, they are required to report this to the appropriate authorities (i.e., the police or the relevant person within their organization, who will then have to report it to the police). Failure to do so is a

punishable offence under Section 21 POCSO. It can lead to imprisonment of up to 1 year with or without a fine.

Handout For Step 2:
Other Offences and Procedures in Key Laws Addressing GBV

- **Non-Penetrative Sexual Assault**

    - Voyeurism(Section 354C); When any man watches, captures the image, or disseminates such image of a woman engaging in a private act, where she would usually expect not to be observed by anyone. "Private act" includes an act carried out in a place reasonably expected to be private and where the woman's genitals, posterior, or breasts are exposed or covered only in underwear. It is also voyeurism when a consensually captured image or video is disseminated to a third party.

For example, photos/videos taken while she is using a lavatory or bathing, changing her clothes, or doing a sexual act not ordinarily done in public. It also includes revenge porn, MMS or video leaks, etc.

    - Stalking (Section 354D IPC); When any man follows a woman and contacts or attempts to contact her repeatedly to foster personal interaction, despite a clear indication of disinterest by such woman. It is also stalking when a man monitors the use of the internet, email, or any other form of electronic communication by a woman.

For example, keeping track of a woman's movement in person or by phone, social media or tracking apps, etc.

- **Kidnapping, Abduction and Human Trafficking (Section 359 to 374 IPC)**

These provide a wide range of GBV-related definitions and punishment, like kidnapping (section 363) and abduction for marriage (section 366). Kidnapping is defined as taking or enticing any minor (below 18 years of age) away from their lawful guardianship without the consent of the guardian. The use of force to compel, or by any deceitful means induce a woman, to go from any place to force into marriage is known as abduction for marriage.
These cases often come to the health system for age determination. Taking history from the survivor is pertinent in such cases as well.

- **Examination of accused for evidence collection (Section 53 CrPC)**

A registered medical practitioner may be requested to examine a person accused of committing an offence, and it is reasonably believed that evidence may be found from the

body. In case the accused is female, the examination shall be made only by or under the supervision of a registered female medical practitioner.
The request for such examination can only be made by a police officer of rank sub-inspector or above or someone directed by such officer.

- **Examination of person accused of sexual assault for evidence collection (Section 53A CrPC):**

A registered medical practitioner employed in a hospital run by the Government or a local authority may be requested to examine a person accused of sexual assault, and it is reasonably believed that evidence may be found from the body. Suppose such a practitioner is unavailable within a 16km radius from where the offence was committed. In that case, any other registered medical practitioner may be requested to conduct the examination.
The request for such examination can only be made by a police officer of rank sub-inspector or above or someone directed by such officer.
The medical practitioner shall examine the accused without delay and prepare a report giving the following particulars:

- the name and address of the accused and of the person by whom he was brought,
- the age of the accused,
- marks of injury, if any, on the person of the accused,
- the description of material taken from the person of the accused for DNA profiling, and
- other material particulars in reasonable detail,
- The report shall state the reasons for each conclusion arrived at precisely,
- The exact time of commencement and completion of the examination shall also be noted in the report.

Without delay, the registered medical practitioner shall forward the report to the investigating officer, who shall forward it to the concerning Magistrate as part of the charge sheet.

- **Post-mortem examination of victim in case of suicide and other unnatural causes of death (Section 174 CrPC)**

The concerning police officer shall forward the body of the deceased person for examination to the nearest Civil Surgeon or other qualified medical person appointed for this by the State Government, when the case involves:

- suicide by or unnatural death of a woman within 7 years of her marriage,
- request made by a relative of the woman who's committed suicide or died under unnatural circumstances within 7 years of her marriage,
- any circumstances raising a reasonable suspicion of commission of an offence with the deceased
- any doubt regarding the cause of death
- the police officer for any other reason considers it expedient to do so

When conducting such examination, the medical practitioner must follow the guideline and proforma setup by the state.

- **Medical Benefits as part of victim compensation scheme (Section 357A CrPC)**

The State or the District Legal Services Authority, as the case may be, to alleviate the suffering of the victim of an offence, may order for an immediate first-aid facility or medical benefits to be made available free of cost on the certificate of the police officer not below the rank of the officer in charge of the police station or a Magistrate of the area concerned. Or any other interim relief as the appropriate authority deems fit.

- **Highlights of the Protection of Women from Domestic Violence Act, 2005**

Domestic violence is the pattern of abusive behaviour in any domestic relationship that is used to gain or maintain power and control over another person. The elaborate nature of relief and structure of the support system provided for through the PWDVA reflects the recognition of power dynamics in domestic relationships and GBV as a human rights violation that requires a survivor-centric response.

- The procedures of PWDVA are of a Quasi-Criminal nature, which means that only some part of the process involves the police structure. It is mainly steered by a designated public servant, the Protection Officer, in every district. They are the arms of the court on the ground. Unlike under IPC offences, where the police lodges a First Information Report (FIR) upon gaining knowledge of an offence and then starts an investigation, under PWDVA, a Domestic Incident Report (DIR) is prepared to initiate the relief process.
- The Courts can also be approached directly and call upon the support of POs. The courts provide remedies to aid in ending dependency on the respondent to end or exiting the cycle of violence, rather than giving punishment of jail time. These are all indicative of civil law cases. But the semi-criminal nature of the law comes in for summoning to court dates and implementing court orders for remedies, which is to be done with the assistance of the police. In case of breach or violation of any court order under this Act, the police shall take cognizance and necessary action (Sections 31 and 32 PWDVA).
- This act further reiterates the right to reside in a shared household of every woman in a domestic relationship, whether or not she has any right, title, or beneficial interest in the same.
- The PWDVA has laid down procedures for Emergency Aid and call upon multistakeholder support like shelter homes, healthcare facilities, legal services authorities and other specialized support agencies that intervene in cases of GBV.

- The relief provided under the PWDVA can run parallel to any other redressal from the criminal justice system or civil suits related to the dissolution of marriage, custody of children, succession of property, etc.

- **Who can seek relief under the PWDVA, from whom, and in what circumstances?**

An "**Aggrieved person"** can seek relief - Any woman or child who is or has been in a domestic relationship with the respondent and alleges to have been subjected to domestic violence.
From the "**Respondent"** - Any person who is or has been in a domestic relationship with the aggrieved person and against whom the aggrieved person has sought relief under this Act.
"**Domestic relationship"** - When people related to each other through some family ties live or have lived together in a shared household. These family ties could be by blood or members of a joint family living together, adoption, marriage, or a live-in relationship. E.g., grandmother, mother, aunt, sister, wife, daughter, foster child, stepchild, etc.

- **Key Remedies**

- Protection orders from domestic violence and violation of any other order under the act. E.g. protection from coming to the place of residence or work or to children's school and creating a scene, from creating hindrance in benefiting from any other relief related to the case, etc.
- Residence order to secure the right to the residence. E.g. a habitable alternate housing if it is not feasible to stay in the shared household or possible to stay there safely and with dignity, etc. Under this order, the court can ask the male respondent to leave the shared household.
- Monetary reliefs for loss of earnings, for medical expenses, for loss caused due to the destruction, damage, or removal of any property from the control of the aggrieved person, the maintenance of the aggrieved person, and her children. This could be sought in lumpsum or periodic payments, and the court decides the amount after considering the capacity to earn, the standard of living, etc.
- Child/Children's custody order for the custody of dependent children for the period of the case being heard and decided under PWDVA.
- Compensation orders: In addition to other reliefs as may be granted under this Act, the Magistrate may, on an application being made by the aggrieved person, pass an order directing the respondent to pay compensation and damages for the injuries, including mental torture and emotional distress, caused by the acts of domestic violence committed by that respondent.

- **Mechanisms for reporting violence under PWDVA**

- Any person with reason to believe that an act of domestic violence has been, or is being, or is likely to be committed, may provide information about it to the concerned Protection Officer.
- The complaint can be filed by the woman/ experiencing violence or on behalf of a child and by any person who has reason to believe that an act of domestic violence is being/likely to be committed –neighbours, social workers, service providers, relatives, etc.
- The Domestic Incident Report (DIR) can be filled up by (i) the Protection Officer (PO), (ii) the Service Provider (SP), or (iii) the notified medical facility.
- Domestic Incident Report (DIR) – FORM 1 in the Act, which briefly records the violence faced by women and the reliefs sought. DIR includes:
    - the particulars of the aggrieved woman and the respondent
    - the incidents of domestic violence
    - the orders that she needs from the court
    - Any assistance that she needs

Step 3: Conclude the session by reiterating that:

- Legal mandates for healthcare providers and facilities reflect the seriousness of the issue of GBV and recognize the critical role of the health system in this regard.
- They are binding on all facilities regardless of whether they are public or private.
- Ask the participants to reflect upon whether their role and intervention in the cases discussed so far is in line with the procedures highlighted in this session. OR
- Ask them to think about what steps can they take to align their work with what the law is mandating so that survivors of GBV are able to access healthcare, support and medico legal care without delay and with dignity.

Session 4.3: Documentation by Healthcare Facilities and Providers in cases of GBV and its Evidentiary Value

45 Minutes

Step 1: Introduce the session stating that as nurses, the participants should know how to document the medical treatment and examination in a legally robust manner as it is crucial for maintaining medical record and also has evidentiary value in court.

Giving the example of the MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014, explain that updated proformas and protocols have evolved to include these legal mandates as well as ethical and other guidelines. Mention that the guidelines on sexual violence will be covered in a separate session.

Step 2: Use the reference material "**Documentation by Healthcare Facilities and Providers in cases of GBV and its Evidentiary Value**" on a PPT or Flipchart to facilitate a discussion.

Reference Material for Step 2: Documentation by Healthcare Facilities and Providers in cases of GBV and its Evidentiary Value

As we have understood from the previous sessions, the prevalent forms of GBV related offences affect the health of the survivor and overlap with what is termed as Medico-Legal Cases (MLC). Because of the location of healthcare facilities and providers in such cases, they play a critical role in supplementing police and court with their findings to aid the trial process.

Meticulous documentation can help the healthcare provider in keeping a detailed record of the medical history of the survivor of GBV or nay nature and in displaying that they have followed the necessary steps in keeping with the direction and spirit of law. This documentation, along with opinion of the healthcare provider acts as evidence used by courts.

Some key points to keep in mind while carrying out documentation in GBV MLC are:

- Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor. The provisional opinion must, in brief, mention relevant aspects of the history of sexual violence, clinical findings and samples which are sent for analysis to FSL.
- In case of lack of medical evidence like injury, the reasoning must be mentioned while formulating the opinion.
    - Delay in reporting for examination.
    - Inability of survivor to offer resistance to the assailant because of intoxication or threats.
    - Additional for Sexual Violence - Activities such as urinating, washing, bathing, changing clothes or douching, use of condom/vasectomy or diseases of vas, penetration using object, etc. which may lead to loss or lack of evidence.
- Reports must have clear mention of age, sex, father's name, complete address, date and time of reporting, time of incident, brought by whom. Along with Identification marks and finger impressions.
- Reports must be prepared in duplicate on proper pro-forma giving all necessary details

- Avoid abbreviations, over writings. Correction if any, should be initialled with date and time.
- A free of cost copy must be provided to the survivor of any form of GBV.
- Reports must be submitted to the authorities promptly.
- MLC documents should be stored under safe custody for 10 years.

Important Documentation Tools for Medico-Legal Cases

A "medico-legal register" should be maintained in the emergency department of every healthcare facility, and details of all MLCs should be entered in this register. This should include:

- the time, date, and place of examination and
- the name of the examining healthcare provider

The Ministry of Health and Family Welfare, Government of India, has issued "guidelines and protocols for medico-legal care for survivors/victims of sexual violence." This is discussed in detail in Theme 5.

Besides this, healthcare providers must also be aware of Chapter 4 of the Model Guidelines under Section 39 of "The Protection of Children from Sexual Offences (POCSO) Act, 2012".
Protocols and proformas have also been put in place for post-mortem examination, burns and acid related injuries, etc.

Other relevant points:

- A case may be registered as an MLC even if brought several days after the incident.
- All MLCs to be informed to the police for taking further action.
- Police should also be informed upon the discharge or death of such a case in the healthcare facility.
- All women patients should be examined in the presence of a woman attendant, and consultation with colleagues is always encouraged.
- If the situation of the survivor is critical, the recording of a 'dying declaration' must be facilitated in the presence of a magistrate.
- In suspected poisoning cases, medical practitioners must assist in finding out the manner of poisoning. Any suspected materials, food articles, excreta, gastric lavage samples, etc., should be preserved and handed to the investigating agencies.

The testimony of a medical practitioner in a GBV case is that of an Expert Opinion (Sections 291 of the CrPC and Section 45 of the Indian Evidence Act, 1872)

Duty of the expert:
An expert is not a witness of fact. They depose and do not decide.
Their evidence is of an advisory character.

An expert witness is to furnish the Court necessary scientific criteria for testing the accuracy of the conclusion so as to enable the Court to form their independent judgment by application of the criteria to the facts proved by the evidence.

An Expert Medical Opinion has to be provided on the following aspects:

- Physical condition of a person.
- Age of a person.
- Cause of death of a person.
- Nature and effect of the disease or injuries on body or mind.
- Manner or instrument by which such injuries were caused.
- Time at which the injury or wounds have been caused.
- Whether the injury or wounds are fatal in nature.
- Cause, symptoms and peculiarities of the disease and whether it is likely to cause death.
- Probable future consequences of an injury etc.

The character of the survivor or their previous sexual experience is not relevant to the issue of consent or the quality of consent in any offence related to penetrative or other forms of sexual assault. (Section 53A and 146 IEA, 1872)

Key points on Medical Examination Report:

- When made as per procedure, an examination report can be a legally robust record of healthcare intervention prepared in the regular course of business by the healthcare providers. The Courts can safely rely on such a report, even when the healthcare provider is not examined. Instead, it is proved by any other representative from the healthcare facility.
- Proving of MLC documentation by a colleague, any administrative staff of the healthcare facility, or any record keeper who identifies the signatures of the healthcare provider on MLC documentation is valid and suitable proof.
- The report is prepared and documented as a medical record. No healthcare provider can be expected to remember the history, injuries and opinions derived in a case after a few days.
- The registered medical practitioner who prepares the report is typically called to prove the report in Court during evidence. This may be after a year or more of their examining the survivor of GBV. A healthcare provider is not expected to depose from memory and speaks from documents related to the MLC.
- When a medical practitioner is examined to prove the MLC of a colleague, all questions regarding medical jurisprudence can be asked to him. When a clerk is examined, but the accused wants to ask about medical aspects of injuries, their nature, and their impact on the body, the Court can summon a doctor.

[As laid down by Delhi High Court in Rajesh Kumar @ Raju vs The State (Delhi Admin), 2007].

Step 4: Sum up the sessions by using the reference material “Key points”.

Reference Material for Step 4: Key Points

- The source of all protection of rights of the people, the duty of State, policy and legislation is the Constitution of India. Healthcare providers are duty-bound ethically and legally to provide healthcare to ALL survivors of GBV irrespective of their age or identity.
- An understanding of the laws prepares healthcare providers to carry out their roles in compliance with the laws and to support survivors who report to them.
- Laws related to GBV clearly emphasize the critical responsibilities that healthcare providers and facilities have in providing care and linkage and also as experts in deposing in a Court of law towards facilitating justice for survivors.
- Until the enactment of the POCSO and the rape law amendments in the IPC and CrPC, it was observed that healthcare providers emphasized only the collection of medico-legal evidence. There has increasingly been a shift from evidence collection to a therapeutic / treatment approach to be followed by all healthcare providers and facilities. Healthcare providers are duty-bound ethically and legally to provide health care to ALL. They are not required to “judge” the veracity of the situation.
- Refusal to provide medical care to survivors has legal implications for healthcare providers and facilities under these laws. It amounts to an offence under Section 166B IPC read with Section 357C CrPC.

Theme 5: Comprehensive Health System Response to Address GBV

Duration: 3 Hours 40 Minutes

Theme 5	Title	Objective/s	Duration
Session 5.1	Components Of a Comprehensive Health System Response to Address GBV	To introduce the components of a comprehensive health system response to address GBV	20 minutes
Session 5.2	Enabling Survivors to Disclose, Talk About the Violence	To strengthen skills of healthcare providers to - ask about GBV using direct and indirect questions - identify signs of violence	40 minutes
Session 5.3	Strengthening First Line Support and Care	- To understand and implement first line support and care - To implement the LIVES approach	40 minutes
Session 5.4	Towards Comprehensive Health System Response: Mental Health, Safety Planning, and Documentation	To build understanding and skills on: (i) Mental health assessment, care and counselling; (ii) Medico legal Documentation, (iii) Safety and Support	30 minutes
Session 5.5	Comprehensive Healthcare Response to Survivors of Sexual Violence	To enhance knowledge and skills towards responding to sexual violence survivors To build capacities towards - informed consent - history taking - examination, evidence collection, health care and psychosocial first aid	1 hour 30 minutes

Session 5.1: Components of a Comprehensive Health System Response to Address GBV

 **20 Minutes**

Step 1: Introduce the theme and explain that the following sessions will enable understanding and demonstrate skills to implement the components of a comprehensive health system response to address GBV.

Step 2: Using reference material "Components of a comprehensive healthcare response to GBV" on a PPT or flipchart, provide a brief overview.

Reference Material for Step 2: Components of A Comprehensive Health System Response To GBV

A health system response to GBV includes measures to prevent as well as to respond to GBV. These measures may frequently overlap given the long cycles of GBV that may require repeated steps for prevention and response.

Prevention of GBV entails:

- Changing of perceptions and attitudes to GBV and through shifts in gender and other social norms to prevent occurrence of GBV.
- Early detection of violence to prevent its recurrence.
- Focus on long term support to prevent health and other consequences, to reduce trauma and empower the survivor.

Response to GBV includes:

- Asking about / identifying signs of violence by healthcare providers to enable survivors to talk about / disclose the violence.
- First line of support and care: immediate health care, mental health assessment, care and counseling.
- Assessment of safety, safety planning and support.
- Medico legal examination, evidence collection and documentation.
- Linkages and referrals to other service providers and agencies.

Session 5.2: Enabling Survivors to Disclose, Talk About the Violence

 **40 Minutes**

Step 1: Explain that as healthcare providers, enabling survivors to disclose violence and building self-awareness and skills to be able to ask about and identify violence is critical.

Step 2: Use resource material "Enabling survivors to disclose violence" to draw attention to key points.

Reference Material for Step 2: Enabling Survivors to Disclose Violence

- Early disclosure of violence and providing appropriate interventions can prevent and address health consequences of violence.
- Ask / inquire about the violence if there are any signs that suggest that the person is experiencing violence or if the person is seeking treatment for a medical condition that may be a consequence of violence.
- Universal screening is not recommended. Universal screening refers to asking all persons every time they visit the health facility about violence.
- Show commitment to respond to GBV. Commit to not perpetuating or tolerating GBV in your health facility.
- Some immediate steps could include: Display of messages, information and contact numbers for services in the health facility and outside. For example, "zero tolerance to GBV", "GBV is a public health issue", "Contact us for any information or support if you or anyone you know is experiencing violence".
- Disseminate information about GBV, services, in health facilities, as well as through public health programs in communities, schools, adolescent health clinics, etc.
- Strengthen skills of nurses and other healthcare providers to identify and ask about GBV.

Step 3: Explain that measures in the health facility, enhanced capacities of nurses is important to identify survivors and enable them to disclose or speak about the violence. State that certain indications/ signs may alert the healthcare provider to ask about the violence.

Step 4: Use resource material "Indicative signs of GBV" on PPT/ flipchart to discuss this further.

Reference Material for Step 8: Indicative Signs Of GBV

The signs listed below are merely indicative. They can alert the healthcare provider to ask in a manner that is enabling for the survivor to talk about the violence:

Survivors may present themselves in varied situations in this regard.

- Anxious and reluctant to provide information about a particular injury.
- History of repeated accidents.
- Survivor who comes to the facility repeatedly with multiple injuries that usually covered by clothing, or is hesitant to disclose.
- Accompanied by partner and/ or relatives accompany and stay close at hand in order to monitor what is being said.
- Injuries during pregnancy/observed during antenatal check-ups.
- Delay between injury and seeking treatment.
- Survivor who is reluctant to disclose details about the health concern, injury for which treatment is sought.
- Repeated visits to the health facility with complaints that have no defined / underlying medical issue.
- Unexplained chronic pain or health conditions such as headaches, gastrointestinal problems, sexual problems, etc.

<u>Signs across departments in a health facility that may be indicative of violence</u>

Casualty	**Gynecology/ Obstetrics**	**Psychiatry**	**Medicine**
• Rape/Sexual assault • Assault • Poisoning/Attempted suicide • Burns • Fractures • Falls • Pregnancy with history of fall/assault • Unexplained bruises, lacerations and/or abrasions	• History of assault • History of fall during pregnancy • Repeated pregnancy • Spontaneous abortion • Repeated birth of girl child	• Depression • Insomnia • Attempted suicide • Anxiety/tension • Self-harm • Obsessive compulsive disorder • Eating disorders	• History of consumption of poison • Breathlessness • Fainting spells • Swelling • Tenderness • Chronic Anemia • Aches and pains

• Repeated health complaints despite normal reports • Old scars or fractures in different stages of healing	• MTP • Reversal of tubal ligation • RTI • HIV • Chronic leucorrhea • Postpartum psychosis • Injury marks on labia, breast and/or other sexual organs • Pelvic inflammatory disease • Infertility	• Substance abuse • Repeated health complaints	• Sudden weight loss • Tuberculosis • Repeated health complaints despite normal reports • Pyrexia of unknown origin • Convulsions • Irritable bowel syndrome • Loss of appetite
Orthopedic	**Surgery**	**ENT**	**Skin**
• Fractures • Falls at home • Minor sprains • Ligament injury • Contusions • Chronic ache in back, shoulder, neck	• History of assault • Abdominal trauma • Burns • Contusions, lacerations and/or bruises	• Perforated ear drum • Injuries and fractures • Locked jaw • History of reduced hearing • Chronic discharge from ears • Sudden loss of voice • Difficulty in swallowing	• Repeated allergies • Eczema • Eczematous Change • Allergic reactions around the neck, thighs, waist, shoulders • Fungal infection

Source: Contractor Sana, Deosthali Padma, Et.al, Guidelines for health professional in responding to women facing violence, Dilaasa crisis intervention department for women, CEHAT, 2011, reprinted 2015.

Step 5: Ask participants to add any other signs that they may have come across that are indicative of violence. State that the first step should be to respond to the immediate health needs of the person.

Step 6: Clarify that if the indicative signs seem to be a consequence of GBV or if the survivor discloses violence, they should ask the survivor questions to understand the situation better and assess the gravity of the violence and its impact.

Step 7: Use reference material "Asking About Violence"" to demonstrate examples of how questions can be posed indirectly or directly.

Reference Material for Step 7: Asking About Violence

- Ask about the violence only when the survivor is alone and not accompanied by others even if these are known persons or even her own children; not amidst other patients.
- Ask when it is safe, in a space that provides privacy; designate a room in the healthcare facility that can be used without their safety being jeopardized.
- Ask about the violence with empathy, without being judgmental, using language and terms that are appropriate, not intimidating that the survivor may relate to.
- Assure confidentiality (except where the healthcare provider is bound by law to report, as discussed earlier).
- Initiate the conversation by asking about things that will put the survivor at ease, will not be uncomfortable.
- Do NOT - insist, be authoritative, suggest that the survivor is lying if violence is denied or not disclosed.

Asking to assess if the person is experiencing violence can be through questions that are indirect or by using direct questions.

Some examples of indirect questions:

- Violence is quite common in many people's lives. We understand this and hence, we are trying to provide support and care for anyone who is experiencing violence. May I ask you some questions.
- In our health facility, we have started a program to support, provide treatment for anyone who is experiencing violence by their husbands / partners or other family members. We have more information available about this if anyone requires it. I would also like to ask you some questions, if that is okay with you. For example,

- "What do you do?"
- "Is everything okay at home?"

Possible ways of asking directly about the violence could be:

- Are things okay at home? Does your husband / partner or anyone else cause tension or problems at home for you?
- Does your husband / partner or anyone else at home threaten/ insult or beat you?
- Are you afraid of anyone at home?
- Have you been hurt by anyone at home?
- Is there a reason that you were not able to come sooner for your treatment? Does your husband / partner or anyone else at home not allow you to go out?
- You mentioned that you fell down. Your injuries may have also been caused by an accident. Did anyone hurt you? I am worried that someone may have caused the injury.

If the survivor does not disclose despite the signs of violence and despite asking:

- Do NOT insist.
- Do NOT be authoritative.
- Do NOT suggest that they are lying about the violence.
- Do inform them about available services and other relevant information such as helpline number, etc.
- Do let them know that the health facility and healthcare provider are available for care and support and are providing this to many survivors.

Step 8: Divide participants into 4 groups. Share a few copies of the handouts of the case studies in each group and assign a case study for each of the 4 groups. Allow groups 15 minutes to discuss the case study and responses to the questions in the Handout.

Handout for Step 8: Case studies

Case Study 1: Sakeena, aged 20 years, comes to the facility OPD. She has a 3 year-old child with her. She has come for treatment because she is unable to sleep and is suffering from frequent headaches. She complains of fatigue and lack of appetite. She asks for medicines to help her sleep and also something to make her feel stronger so that she can take care of her child and do her work. She seems very anxious.

Case Study 2: Asha, aged 30 years has come to your PHC for antenatal care. She is 5 months pregnant but has not come before for ANC. When asked the reasons for not coming, she is evasive and does not respond. She says she does not go out of the house at all. This is her first pregnancy. During examination, you observe that she keeps trying to cover her left arm and back with her saree. When you ask her if she is eating regularly and if she is feeling okay, she does not respond at all.

Case Study 3: Beenu, aged 17 years old, comes with her mother to the health facility. Her mother has taken several healthcare appointments in different facilities, but no doctor has been able to provide a clear diagnosis. Her mother says Beenu's behavior has changed a lot - she used to be an easy-going girl, but now she is easily irritated, she disappears after school, refuses to talk to anyone in the family and spends a lot of time by herself.

Case Study 4: Meena aged 62 years, has made visits to the health facility repeatedly with complaints about lack of appetite and breathlessness. This visit, Meena has come for treatment for an injury/fracture in her right arm. She explains that she fell and injured her arm while fetching water.

Questions:

- Is there any possibility that the person may be experiencing GBV?
- What are some of the red flags or signs that indicate to you that the person may be experiencing GBV?
- How will you ask about the violence?
- What steps can be taken to enable disclosure of the violence by the survivor?

Step 9: Request responses from each of the groups. Following presentation by each group, facilitate a discussion. Note the key points on a flipchart or board. Drawing on the responses of the participants, explain that all the four case studies indicate that there is a possibility of violence being experienced. Recall the signs that were covered earlier that could indicate the possibility of violence. In the 4 case studies, lack of sleep, lack of appetite, changes in behaviour, moods, injuries due to falls, repeated visits, lack of access to healthcare, etc. could be some of the signs / red flags.

Step 10: Sum up the responses using the reference materials for Step 8 and Step 10. Early identification of violence and providing appropriate care and support is critical and nurses have an important role to play in this.

Step 11: Conclude that the case studies are to facilitate the application of the information about the signs of GBV, ways of enabling survivors to talk about the violence. The case studies simulate real contexts and facilitate the demonstration of skills that are necessary for nurses in identifying and enabling survivors to talk about the violence.

Session 5.3: Strengthening First Line Support and Care  40 Minutes

Step 1: Introduce that the session in on strengthening First Line Support and Care, which is critical when the survivor talks about the violence or confirms experiencing violence on being asked by the healthcare provider.

Step 2: Ask participants what they understand by First Line Support and Care. Explain using reference material "What is First Line Support and Care".

Reference Material for Step 2: What is First Line Support and Care

First Line Support includes:

- Immediate care and support, first aid for survivors.
- Response to survivors' emotional, physical, safety and support needs.
- Enabling survivors to speak about the violence, feel more in control and to make informed decisions about safety, care-seeking and other support.
- Can be provided anywhere: at any level of the health system - at the primary or tertiary level, in private or public facilities.
- Requires minimal preparedness and skills.

Step 3: Explain that the LIVES approach is an important first line response approach recommended by the World Health Organization for healthcare providers. It is developed in the particular context of domestic violence but can be applied to respond to other forms of GBV. Explain that each element of LIVES is closely connected with the other and may be applied simultaneously. LIVES is a combination of emotional and practical support.
Use reference material "LIVES approach" to explain its elements.

Reference Material for Step 3: LIVES approach

The LIVES approach if carried out appropriately can be extremely enabling for the survivor.

LISTEN	Attentively, with empathy, and without judging
INQUIRE	In a sensitive manner about needs and concerns

VALIDATE	Show you believe and understand the survivor; assure that they are not to blame
ENHANCE SAFETY	Discuss safety plans in case of recurrence or escalation of violence; discuss how the survivor can protect herself
SUPPORT	Provide treatment, care for urgent health needs Provide information, connect the survivor to other services, social networks

Step 4: Explain that following the introduction the LIVES, it is necessary to demonstrate its application. Present reference material "Case Study for LIVES" on a PPT or flipchart. Say that the case study being displayed will be responded to through LIVES. Ask participants to use each of the elements from LIVES - one at a time in responding to the situation in the case study.

Reference Material for Step 4: Case Study for LIVES Application

Scenario:

Rita, 23 years, comes to your department / hospital with a complaint about pains in her stomach-abdominal area. She is 7 months pregnant. Rita has been married for 4 years, has 2 children. While asking her about her condition / pain, you realize she is very anxious. She begins to cry.

Rita narrates: "I care for my children. I do not work outside. My husband comes from a wealthy family, and I always felt lucky to have married such a man. I always follow his wishes. I know he also loves me but he sometimes loses his temper, breaks things, shouts at me and my children. He does not like me meeting my family or friends. I feel very alone. I cannot talk to anyone.

Two days ago, he arrived home when I had gone out to visit my mother. I had not met her for a long time. When I returned, he was very angry and pushed me against the wall. I was terrified. I am also worried as I am pregnant. I hope everything is okay with my pregnancy".

Step 5: Wrap up the discussion using the reference material "Application of LIVES in responding to a survivor" on a PPT or flipchart. In case time permits, this activity can be conducted as a role play. Use **Annexure II- Application of LIVES In Responding to a Survivor.** The points under the

column “Possible Responses to Rita” (Annexure II) can be used to discuss the case study guided by the LIVES approach explained in first column.

Reference Material for Step 5: Application of LIVES In Responding to a Survivor of Domestic Violence

As a first step:

- Provide a safe space, ensure privacy - where no one can overhear but not a place that indicates to others why you are there.
- Assure confidentiality; if you are required to inform anyone, explain to the survivor and seek consent.
- Respect the survivors’ agency, their capacity to make informed decisions.
- Provide care for the survivor’s immediate healthcare needs.

Step 6: Sum up using the reference material “Do’s and Don’ts in First Line Support” on a PPT or flipchart.

Reference Material for Step 6: DO’S and DON’TS In First Line Support

DOs	DO NOT
✓ Identify needs and concerns ✓ Respond to emotional, safety and support needs. ✓ Listen & validate experiences & concerns. ✓ Help the survivors feel connected to others, calm and hopeful. ✓ Empower the survivors to feel able to help themselves and to seek help, explore options. ✓ Respect their wishes, decisions, agency.	× Try to solve the survivors’ problems. × Try to convince them to leave a violent relationship. × Try to convince the survivor to go to the police or courts. × Ask questions that force them to relive painful events. × Ask survivors to analyze what happened or why. × Pressure survivors to tell you their feelings & reactions.

Session 5.4:Towards Comprehensive Health System Response to GBV: Mental Health, Safety Planning, and Documentation

 **40 Minutes**

Step 1: Share that the LIVES approach that was discussed previously is very enabling for survivors. It also has a positive impact on mental health if implemented well. Mental healthcare is critical given the impact of GBV on mental health, which is experienced by survivors in the immediate but also in the long term.

Mental health concerns may include Post Traumatic Stress Disorder (PTSD), depression, anxiety, substance misuse, self-harm, suicidal behavior, sleep disturbances and many more as was covered earlier. In addition, survivors may also experience stigma and blame from healthcare providers, the community and family for disclosing her violence, which aggravates their mental trauma.

Explain that the response to mental health needs of survivors remains one of the least understood and addressed by healthcare facilities and providers. This is partly because of the lack of available healthcare providers with the necessary capacities, skills. However, healthcare providers at all levels in all facilities must provide at least psychosocial first aid to the survivor and provide referrals for mental health care.

Step 2: Present using reference material "Steps to assess mental health and ensure care and counseling for survivors" on a PPT or flipchart.

Reference Material for Step 2: Steps to Assess Mental Health and Ensure Care and Counseling for Survivors

- GBV may result in long term mental health consequences.
- Healthcare providers should be able to assess mental health needs of survivors.
- Healthcare providers must provide empathetic and non-judgmental services to enable survivors to express their emotional and mental health needs and to seek help to cope in the immediate and long term.
- Healthcare providers should be cognizant that survivors cope with GBV and the consequent mental distress in different ways

- **Survivors may talk about:**
  - feeling fatigue, low energy
  - experiencing nightmares, problems in sleeping
  - stress, sadness, irritability or anxiety
  - feeling of isolation, hopelessness
  - unexplained aches and pains
  - lack of focus, inability to carry out daily work

- feeling like crying frequently or anger

Note: These are just some examples of emotions that survivors may report.

Providing psychosocial first aid:

First line psychosocial first aid by healthcare providers should include:

- Reassurance to survivors that they are likely to feel better with time. Help the survivor feel safe, calm and hopeful.
- Ask about immediate concerns and urgent needs. Discuss how the survivor can address these and what support is required.
- Help survivors strengthen positive coping methods.
- Explore ways in which anxiety, stress can be immediately reduced. Suggest and demonstrate activities/exercises to reduce stress and anxiety
- Help the survivor regain a sense of control by being able to help themselves by building on their strengths.
- Give information to assist making informed decisions and offering options.
- Recognize thoughts of self-harm or suicide and access care and support as soon as they occur.
- Emphasize the availability of support to the survivor especially in case of distress and thoughts of self- harm or suicide. Provide support services contacts.
- Help the survivor to explore support networks and connect to others.
- Coordinate access to referral resources and safety.
- Fix an appointment with the survivor to return to the facility or to come sooner if required.
- If the health facility does not have a trained healthcare provider and in case of severe mental health impact, coordinate referral to an appropriate facility / healthcare provider following psychosocial first aid.

Step 3: Sum up the discussion on mental health reiterating that regular assessment of mental health is very important. Apart from psychosocial first aid, healthcare providers should assess on a regular basis if there is improvement or any deterioration in mental health. If the available healthcare providers are not able to provide necessary care, survivors must be referred to external support services. Healthcare providers must coordinate these linkages and continue to follow up and monitor the survivor's mental health.

Step 4: Explain that safety assessment planning and support is a key element in first line support and care, in addition to all that has been covered previously.

In the case of a survivor disclosing a crisis situation, or concerns about escalation of violence, fear for their own and the lives of their children or other dependents, healthcare providers should support them in assessing safety and discuss a safety plan.

This can be done by nurses in coordination with other healthcare providers such as medical officers, counselors, social workers in the facility. In case this is not immediately possible, healthcare providers must coordinate with other support services such as one stop centres, protection officers, counselors, shelters, and other service providers with the consent of the survivor.

Step 5: Use reference material "Safety planning" to discuss some basic steps to be followed.

Reference Material for Step 5: Safety Planning

Safety assessment of the survivor should be conducted by the healthcare provider. If the assessment reveals that the survivor is unsafe and fears recurrence of violence, the healthcare provider should facilitate linkages with support services. A range of stakeholders are involved in ensuring safety and support to the survivors of violence.

Healthcare providers can support survivors to develop a safety plan. They can assist survivors to:

- Identify and connect with a friend, a neighbor, an organization who can be told about the violence and who will be able to support the survivor in a crisis situation.
- Get and keep contact numbers of such persons.
- Be prepared to leave home urgently if required. Keep important documents (identity cards, medical documents, bank related, keys, money, etc.) together in one place that can be collected immediately before leaving.
- Decide on a plan after leaving such as immediate shelter (for example, a friend's home, shelter home), transportation, etc. Be safe at all costs. If the situation is dangerous and escalates, judge and plan without putting self, children at risk. Seek support in such a situation if required to leave the site of violence.

Step 6: Explain that medico-legal documentation is another critical component of a comprehensive health system response to GBV. It also guides physical and psychological care of survivors as well as legal processes as it is evidence in a Court of Law. Healthcare providers have a legal and ethical obligation to comprehensively, accurately and in an unbiased manner document and maintain the records of the survivor.

Step 7: Use reference material "Understanding medico-legal documentation" to emphasize the responsibility of healthcare providers in carrying out this important task.

Reference Material for Step 7: Understanding Medico Legal Documentation

Doctors, assisted by nurses, must meticulously document and maintain records ensuring their safe-keeping and confidentiality.

- Healthcare providers must explain to the survivor that their narrative, the details of examination findings, analysis of samples, opinions of the healthcare provider will be documented to enable access to treatment, support and aid in legal proceedings.
- Medico-legal documentation must include accurate details of history, examination and evidence collected, medical care provided, as well as interim and final opinion of healthcare provider in the case of survivors of sexual violence.
- In case a survivor reports to the casualty department, details of findings from examination should not only be recorded on a case paper but also in the Medico Legal Case (MLC) register.
- In case a survivor has reported to any Out Patient Department (OPD), findings should be recorded on OPD papers and should be referred appropriately to have a medico-legal case recorded.
- In cases of domestic violence, Domestic Incident Report (DIR) needs to be filled by the provider and forwarded to the Protection Officer, as laid down in the PWDV Act, if a DIR has not been previously filled.
- In addition to the DIR all details of the history of the violence, medical examination, treatment, evidence of injuries, trauma, mental health assessment should be accurately documented.

  Note: Refer Annexure for DIR copy to be shared as Handout with the participants.

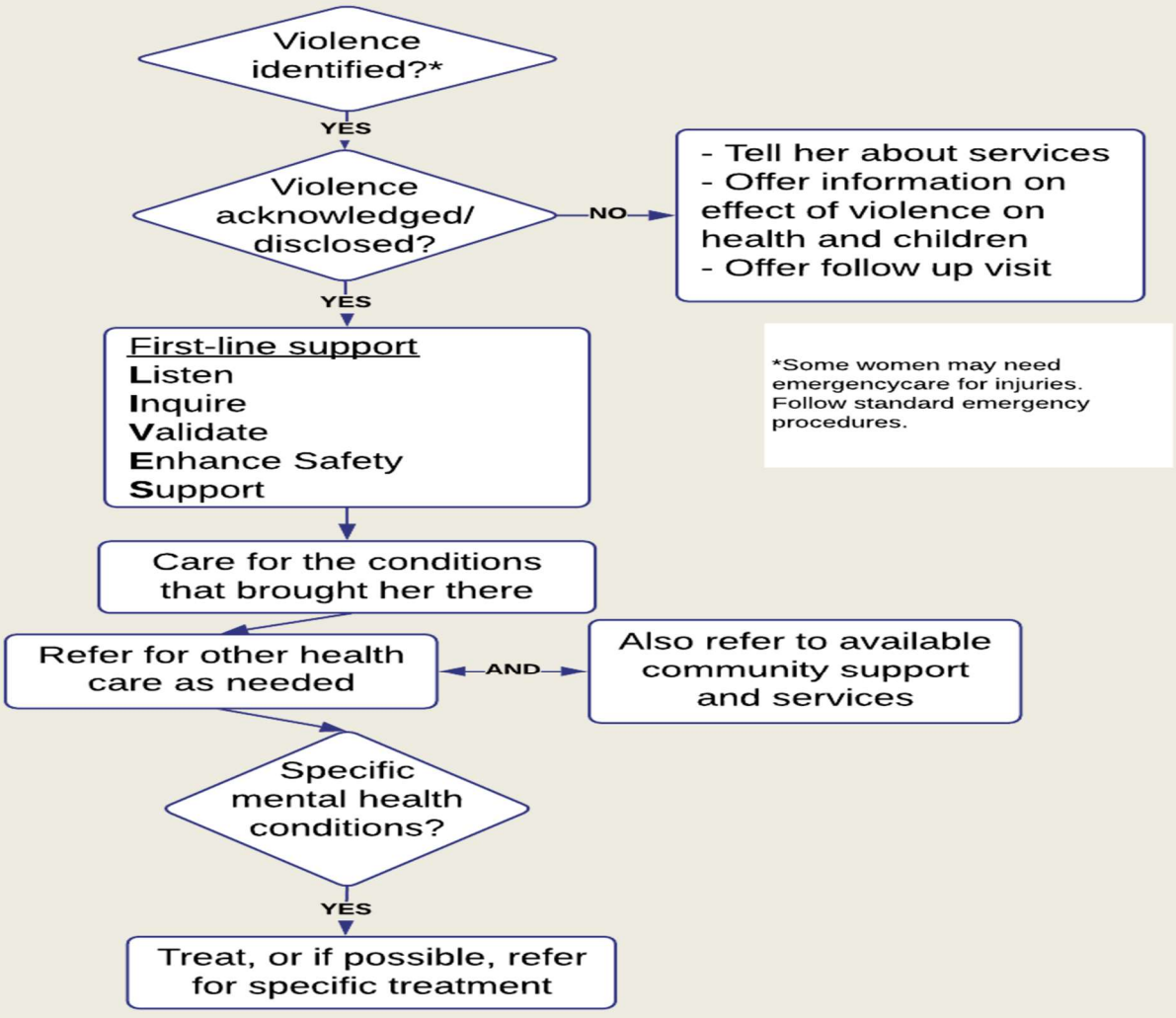
- In cases of sexual violence, the MoHFW protocols / guidelines include a detailed proforma to document various aspects of consent, examination, evidence, treatment, healthcare provider's opinion.

  Note: Refer annexure for copy of the proforma to be used for documentation in the case of sexual violence. This is part of the GUIDELINES & PROTOCOLS for Medico-legal care for survivors/victims of Sexual Violence by MoHFW (2014).

- Healthcare providers / health facilities are legally obliged to provide a copy of medico-legal documentation free of cost to the survivors.

Step 8: Conclude that as nurses, participants must ensure that they are thorough with medico-legal documentation. As was seen in the previous discussion, the implications of such documentation are key for medical but also for legal purposes. Sum up with a display of the image on "Pathway of care for GBV survivors".

Handout For Participants For Step 8: Pathway Of Care For GBV Survivors



Source: Health care for women subjected to intimate partner violence or sexual violence A clinical handbook" by WHO, UN women and UNFPA. https://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf

Session 5.5: Comprehensive Healthcare Response to Survivors of Sexual Violence

1 Hour 30 Minutes

Step 1: Introduce the session – explain that it will discuss the components of comprehensive healthcare response for survivors of sexual violence.

Reiterate that sexual violence has a range of health consequences for the survivor, impacting mental, physical, sexual and reproductive health as discussed in previous sessions. Survivors often require care and support in the immediate as well as in the long term.

Explain that the right to treatment for all survivors of sexual violence by the public and private healthcare facilities is well recognized. Failure to treat is now an offence under the law.

Step 2: Explain that the discussions in the session will primarily refer to the *Guidelines &*Protocols for Medico-legal Care of survivors/ victims of Sexual Violence by Ministry of Health and Family Welfare, Government of India, 2014 (henceforth referred to as MoHFW protocols). These guidelines / protocols are aligned with global standards as well as compliance with legal provisions in India for comprehensive response to survivors of sexual violence.

Request participants to recall the expanded definition of sexual assault / rape in the IPC and POCSO to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/fingers and non-penetrative (touching, fondling, stalking, etc.). This has been covered in a previous session on the law. Sum up the responses of the participants using the material from the session. Present reference material "Introduction to the MoHFW protocols" on a PPT or flipchart to discuss the components of comprehensive healthcare response as stated in the protocols.

Reference Material for Step 2: Introduction to the MoHFW protocols

The *Guidelines & Protocols for Medico-legal Care of survivors/ victims of Sexual Violence by Ministry of Health and Family Welfare, Government of India, 2014* does the following:

Recognizes:

A. Role of the health sector in strengthening legal frameworks, developing comprehensive and multi-sectoral national strategies for preventing and eliminating all forms of sexual violence.
B. Need to create an enabling environment for survivors/victims where they can speak out about the violence without fear of being blamed, where they can receive empathetic support in their struggle for justice.

C. Critical role of healthcare providers in their interface with the police, child welfare committees (CWCs) and the judiciary. Such inter-sectoral collaboration is essential to provide services and deliver justice.

Provides:

A. Directives to health facilities to ensure that all survivors of all forms of sexual violence, rape and incest, including people that face marginalization based on disability, sexual orientation, caste, religion, class, have immediate access to healthcare services.

Emphasizes:

A. Sensitive handling to reduce self-blame and enhance healing for survivors.
B. Gender sensitive medico legal examination and care to ensure that no gender biases, or gaps exist within medico legal aspects.

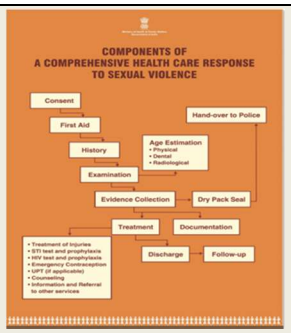
MoHFW protocols and guidelines aim to achieve the following:

- Operationalize informed consent and respect autonomy of survivors in making decisions about examination, treatment and police intimation.
- Specific guidance on dealing with persons from marginalized groups, such as persons with disabilities, sex workers, LGBT*QI+ persons, children, persons facing caste, class or religion-based discrimination.
- Ensure gender sensitivity in the entire procedure by disallowing any mention of past sexual practices through comments on size of vaginal introitus, elasticity of vagina or anus. Further, it bars comments of built/height-weight/nutrition or gait that perpetuate stereotypes about 'victims'.
- Focus on history by recognizing various forms and dynamics of sexual violence including activities that lead to loss of evidence.
- Evidence collection based on science and history, with specific guidance for taking relevant samples and preservation of evidence.
- Lay down Standard Treatment protocols for managing health consequences of sexual violence.
- Lay down Guidelines for provision of first line psychosocial support.

Step 3: Using the reference material “Comprehensive care for survivors of sexual violence” explain its components.

Reference Material for Step 3: Comprehensive Care for Survivors of Sexual Violence

Referring to the image – present the different components:



- Initial resuscitation/ First Aid
- Informed consent for examination, evidence collection, police procedures
- Detailed History taking
- Medical Examination
- Age Estimation (physical/dental/radiological) – if requested by the investigating agency
- Collection of medical evidence
- Documentation
- Packing, sealing and handing over the collected evidence to police
- Treatment of Injuries
- Testing/prophylaxis for STIs, HIV, Hepatitis B and Pregnancy
- Psychological support and counseling
- Referral to higher health facilities for further treatment if required.
- Referral for further support like legal, shelter etc. through - One Stop Centre / CHILDLINE (1098) / Women Helpline (181), etc.
- Maintenance of Medico Legal Register

Source: Guidelines and protocols for medico-legal care of survivors/victims of sexual violence, Ministry of Health and Family Welfare, Government of India, 2014

Step 4: Explain that some of these components are going to be discussed in detail in the following sessions.

Step 5: Explain that informed consent and the right to informed refusal will be discussed next. State that informed consent is a core requirement for - examination, sample collection for clinical and forensic examination, treatment and police intimation. Informed consent acknowledges the rights of survivors to bodily autonomy and integrity.

To enable survivors to give an informed consent, the healthcare providers are responsible to provide comprehensive information in a manner, format, language that is accessible and understood by the survivor. Informed refusal is also the right of the survivor.

Reference Material for Step 5: Seeking Informed Consent and Informed Refusal

- Informed consent or informed refusal should be sought from every survivor.
- Informed consent has to be sought for each of the following procedures:
  - Examination
  - Sample Collection for clinical and forensic examination
  - Treatment

- Police Intimation
- The right of the survivor to informed refusal must be respected and documented. No Court or person can force a medical examination on a survivor, when the survivor does not consent for the same.
- Both ethically and legally, a healthcare provider cannot examine any survivor / victim without seeking their informed consent.
- Informed consent should be sought in a language that the survivor understands.
  - Minimum valid age of survivor for giving consent for medical examination is 12 years as per provisions of sections 89 and 90 of IPC.
  - In case of a child below 12 years of age, whenever parents and/or guardians are not available for giving consent for the examination, then informed consent can be obtained from a panel of senior doctors in administrative positions in the hospital who will act in the best interest of the child.
- Persons with mental illness and intellectual disabilities are able to give informed consent or decide on informed refusal. Their informed consent should be sought and obtained before the medical examination.
  - They should be provided the assistance of a friend / colleague / caregiver in making the informed consent decision.
  - Where the survivor is unable to give consent either due to age, social circumstance (homeless child), trauma, mental condition or disabilities, consent can be sought from either a parent or guardian, panel of healthcare providers from the hospital, CWC or jurisdictional court, who will act in the best interest of the survivor.

Step 6: Request participants to refer to the MoHFW protocols and the format for consent / refusal in the proforma. Explain that seeking history which is to be discussed next is an extremely critical component of comprehensive healthcare for survivors. Medical history and detailed description of the sexual violence is critical to guide treatment, the medical examination process and sample collection. Explain that the documentation of the history must be done accurately and verbatim in the words of the survivor. History of the survivor is upheld as evidence in a Court of Law.

Reference Material for Step 6: Seeking history

Detailed history should be sought sensitively, without missing any relevant information. The survivor may omit or avoid describing details of the violence as it may be traumatic. The healthcare provider should facilitate with empathy, using probes and questions to document the narrative of the survivor. Particular care

should be taken prevent aggravating any trauma that the survivor may be experiencing.

The following details must be documented:

- Relevant medical and surgical history, including menstrual history.
- History of assault/ violence.
    - Complete history of the incident, must be recorded in the survivor's own words as it has evidentiary value in the court of law.
    - Note who is narrating the incident - survivor or an informant. If history is narrated by a person other than the survivor, the name and relationship to survivor should be noted.
    - For children, history seeking can be facilitated by the use of body charts, pictures, dolls, etc. Experts can also be called to assist with eliciting history.
- While collecting history, date, time and location of the assault should be recorded.
- Healthcare provider should try to understand exactly what happened without re-victimizing the survivor to assess any health risks, including STI, HIV, pregnancy, etc.
    - Details of the sexual assault like attempted or complete penetration, use of condom during assault, etc. should be collected.
    - Details of activities undertaken post assault like changing clothes, washing, bathing, douching, urinating, washing of genitals (in all cases) and rinsing mouth, drinking, eating (in cases of oral sex), etc. are critical. Also, history of sexual intercourse after the violence is important.
- Healthcare providers must enhance their skills to appropriately and sensitively ask about these details without feeling awkward.
    - This is important so that the survivor's narrative/testimony is not compromised.

Step 7: Clarify any doubts or questions that the participants may have. Distribute copies and share the online link of the MoHFW protocols and ask participants to go through the sections in the proforma for seeking and documenting medical and sexual violence history.

Step 8: Ask participants what are the other components of a comprehensive healthcare response. Validate appropriate responses. Explain that medical examination and evidence collection will be covered next.

Step 9: Use reference material “Medical examination of sexual violence survivors and evidence collection and preservation” to discuss them.

Reference Material for Step 9: Medical Examination of Sexual Violence Survivors and Evidence Collection and Preservation

Medical examination

- Medical examination requires the consent of the survivor; the survivor may refuse any part of the examination (Other details about consent have been covered previously).
- The medical examination and type/s of evidence to be collected is determined by the time of examination post sexual violence.
- Given that there could be delays in reaching the healthcare facility for medical examination due to various social issues / barriers, the decision must be founded on the details available from the survivor's history.
- Complete privacy must be ensured during medical examination, preferably a separate room must be made available for the same.
- Medical examination should be carried out without delay, when a survivor reports to a health facility.
- Survivor should be informed of the nature and purpose of the examination, including providing treatment and support and also to assist in investigation, arrest and prosecution of the perpetrator.
- Survivor should be informed that she can refuse any aspect of the examination or all of it. In such a case, informed refusal should be documented.
- Past sexual practices or history for the purpose of medico legal documentation must not be done.
- The two-finger test must not be conducted.

Other points to remember for medical examination

- Medical examination can be conducted by a registered medical practitioner and it is not mandatory for a gynecologist to examine cases of sexual violence.
- If possible, a lady medical officer should conduct examination of a woman survivor. If not available, examination can be conducted by a male doctor in the presence of a female attendant. However, a lady medical officer should examine a girl child (below 18 years of age) as per section 27 of POCSO Act. During examination of a child, a parent or any person that the child trusts should be present. In case such a person is unavailable, then the health facility should depute a person.
- In the case of a person with disability his/her parent, guardian or any other person with whom the survivor is comfortable should be present.

- Anesthesia maybe administered only in extremely rare situations to enable medical examination. This should be done in the best interest of the survivor and not otherwise.
- Medical examination should be conducted ensuring complete privacy, preferably in a separate room, respecting the individual's autonomy and after explaining the procedures involved.
- There is no need for a police requisition or a Court order to do the medical examination.

Collection and preservation of medical evidence

- Evidence should be collected based on the history of assault – whether violence was penetrative or non-penetrative; penile or non-penile penetration; which orifice was penetrated – vagina, anus, mouth, urethra; whether ejaculation occurred or not).
- Evidence should also be collected based on post assault activities that the survivor/victim may have undertaken.
- Collection of available evidence at the time of medical examination is useful; in case of heavy menstruation then a repeat medical examination may be required due to potential loss of evidence. The menstruation and non-collection of medical evidence should be documented.
- Clothes worn at the time of the violence can be collected even if there is delay in the survivor reporting and medical examination.
- Sexual Assault Forensic Evidence (SAFE) kit along with proforma is recommended by the MoHFW protocols to facilitate standard methods of examination and evidence collection. Safe kit contents are listed in the MoHFW protocols. These can be assembled in the health facility and used as per the requirement for each survivor.
- The accuracy /efficacy of some of the SAFE kit contents such as Woods lamp, Toluidine, Colposcope are increasingly being debated. Healthcare providers can inform themselves on updated information / evidence so that there is no compromise in the quality of care, examination, evidence.
- Medical examination and evidence collection should be done without any delay, when a survivor reports to a health facility.
- The type/s of evidence to be collected will depend on the actual time of medical examination post sexual violence (keeping in mind that there could be delays in reaching the healthcare facility for medical examination due to various barriers).
- When a healthcare provider is opining on matters of science, he/she are an expert witness as per law. As an expert witness, the healthcare provider may be asked questions related to injuries and medical evidence in the Court.
- The healthcare provider needs to answer these questions based on medical knowledge and on details of the episode as provided by the survivor.

Step 8: Ask participants to refer to the details on medical examination, evidence collection and preservation in the MoHFW protocols. Explain that as per the protocols all evidence needs to be packed and sealed properly in separate envelopes. The responsibility for this lies with the examining healthcare provider. The hospital has the responsibility of properly preserving samples till handed over to police.

Every facility must establish a chain of custody and designate certain staff responsible for handling evidence with access to the samples limited to them. This is necessary to prevent mishandling and tampering. If this is not maintained, the evidence can become inadmissible in the court of law. A log book to maintain the handing over of evidence from one 'custodian' to the other is important.

Step 9: Draw the participants' attention to understanding the opinion formulation, provisional and final opinion. Explain that this is a core responsibility of healthcare providers.

- As medical experts, their reasoned opinion aids the legal process and access to justice. Provisional opinion must be drafted immediately on the basis of the history / narrative of the survivor and after examination and collection of evidence.
- The final opinion is to be drafted after the reports from the Forensic Science Laboratory (FSL) are received by the hospital.
- The MoHFW protocols have detailed the drafting of provisional and final opinion. Ask participants to refer to the sections on drafting provisional and final opinions and discuss any clarifications, questions that may be flagged. Use reference material "Key points for drafting opinion."

Reference Material for Step 9: Key Points for Expert Opinion for Medico-Legal Proceedings

- As per 164 A, CrPC., an examining healthcare provider/RMP/doctor has to prepare a reasoned medical opinion without delay and is considered an "expert witness" by law and is summoned to depose in Court.
- Absence of injuries on the survivor may be explained based on:
  - Medical knowledge and details of the violence provided by survivor
  - Time lapse between the violence and reporting to the hospital
  - Lack of resistance due to fear, threats to the survivor
  - Administration of drugs/ alcohol to survivor, etc.
- Negative findings related to forensic lab analysis. Absence of negative laboratory results may be due to:
  - Delay in reaching a hospital / health centre for examination and treatment.

- Activities undertaken by the survivor after the incident of sexual violence such as urinating, washing, bathing, changing clothes or douching which leads to loss of evidence.
- Use of condom/vasectomy or diseases of vas of the perpetrator.
- Perpetrator did not emit semen if it was a penile penetrative sexual act.

- Healthcare providers must have the knowledge and clarify that such findings neither refute nor confirm whether the sexual violence took place or not.
- There must be a clarity that a medical opinion cannot be given on whether 'rape' occurred because 'rape' is a legal term. Ensure that comments on past sexual history, status of vaginal introitus must not be made as these are unscientific and the courts too have determined them as biased.
- Healthcare providers should always provide reasoned opinion.

Step 10: Sum up that the following components of comprehensive response to sexual violence survivors have been covered:

- Informed consent / refusal
- History seeking
- Medical examination, evidence collection and preservation
- Opinion drafting

Step 11: Ask participants to share 2-3 key points for each component that has been discussed. Explain that apart from these, healthcare including psychosocial first aid are core components and the primary responsibility of healthcare provider and facilities. Reiterate that:

- Survivors should receive all services free of cost, including registration, medicines, therapeutic products and aids, diagnostics, treatment, surgery, as well as a copy of medico legal examination report.
- First aid and treatment should be provided to survivors of sexual assault without any delay.
- Treatment should be provided for physical needs – including injuries, emergency contraception, prophylaxis for HIV/ STIs as well as psychosocial first aid / counseling**.**
- Healthcare providers should refer to the MoHFW protocols provide detailed guidelines for treatment.
- Psychosocial first aid should be provided to the survivor to enable immediate coping with the trauma. Itis critical part of first-line support. This has been covered previously.

Theme 6: Healthcare Providers' and Health Facility Preparedness and Planning

Duration: 2 Hours

Theme 6	Title	Objectives	Duration
Session 6.1	Current Preparedness to Respond to GBV	To assess current preparedness to respond to GBV and gaps therein	20 minutes
Session 6.2	Discussion on Elements of SOPs for Comprehensive Care	To understand the standard procedures as well as supporting them in preparing an immediate and long-term plan	40 minutes
Session 6.3	Referral Linkages and Support	To understand what kinds of referral information healthcare providers / health facilities should have	40 minutes
Session 6.4	Post Assessment of The Training	To assess shifts in understanding, knowledge at the end of the training	20 minutes

Session 6.1: Current Preparedness to Respond to GBV

20 Minutes

Step 1: Introduce the theme and the activity briefly. Explain that the theme will discuss the elements of preparedness for healthcare providers and health facilities. This will also include discussion on facility specific Standard Operating Procedures (SOPs) for responding to survivors of GBV as well as steps to build linkages and referrals. The first session will assess current preparedness.

Step 2: Ask participants to stand in a straight line in the centre of the training space.

Step 3: Explain that four points have been marked on the floor with cards:

Card 1 – We have full preparedness to respond to survivors
Card 2 – We are somewhat prepared to respond to survivors
Card 3 – We have initiated some response – have started the process
Card 4 – We do not provide any services or care for survivors

Note: Prepare the four cards prior to the session and place them at different locations in the training space at the beginning of the session.

Step 4: Participants can walk around the room and choose the point that is most appropriate for them. This will also depend on the level of the health facility that they are currently in – whether it is a primary health centre (PHC), community health centre (CHC) or a tertiary level facility.

Step 5: Ask participants to reflect on the reasons for choosing their position. Request a few participants to share and list the responses on the flipchart / board. Ask some participants to share 1-2 points that they have gained from the training that has enabled them to respond better to survivors.

Step 6: Explain that the positions on preparedness will also differ based on the level of the health facility, infrastructure, staff strength and skills, etc. However, all facilities must be prepared to commit to respond in a systematic manner through intra and inter-sectoral linkages. Use reference material "Towards health facility preparedness", to elaborate this.

Reference Material for Step 6 : Towards Health Facility Preparedness

All health facilities should ensure availability of the following to respond comprehensively to GBV survivors:

- Facility based SOPs/protocols: Screening protocols/ SOPs/proformas to identify and document violence and provide care.
- Trained healthcare providers for responding to survivors.
- Medicines, equipment and other supplies.
- Intake forms & registers including MLC registers for recording information about survivors and care provided.
- Referral systems, protocols to refer to other care.
- Referral systems, protocols with other agencies or service providers.
- Information education communication (IEC) material (available in the OPD as well as in common spaces such as the toilet, etc.) to build awareness and inform survivors how to report violence without compromising their safety.
- Designated space/safe space for private and confidential consultation and examination.
- Mechanisms to provide ongoing mentoring, supervision and support to healthcare providers. Anonymous feedback and grievance redressal mechanisms to receive feedback from survivors about services provided, or any grievances, etc.

Step 7: Conclude the discussion by explaining that preparedness for a comprehensive response to GBV must be understood and initiated at multiple levels. Using examples from the group presentations explain that this may broadly include:

- Preparedness as healthcare providers through trainings, continuing medical education (CME) to strengthen understanding and capacities to respond to GBV.
- Preparedness in a health facility which involves a range of systems, protocols to be put in place to respond comprehensively.
- Preparedness in coordinating with external agencies, experts, referrals to address the first 2 points.

Session 6.2: Discussion on Elements of SOPs for Comprehensive Care

 **40 Minutes**

Step 1: Introduce that the session will discuss implementation of the elements of comprehensive response to GBV.

Step 2: Divide participants into 3 groups. Ask each group to discuss the following:

- What are the 5 immediate steps that can be taken to ensure comprehensive response to GBV (within 3 months)?
- Identify 5 steps that can be follow up in the longer term (within 1 year).
- What support, inputs would be required for this, from where?

Step 3: Following the discussion, ask each group to present the discussion points in the larger group.

Step 4: Add if anything critical is missing. Follow a similar process for the 3 questions.

Step 5: When the groups present, note the responses on a flipchart. Encourage discussion, questions, and clarifications. Sum up the discussion, identifying any gap in discussions. Use the reference material “Ensuring Preparedness – Steps Towards Improving and Developing Comprehensive Response to GBV” on PPT or flipchart.

Reference Material for Step 5 – Ensuring Preparedness – Steps Towards Improving and Developing Comprehensive Response to GBV

All service providers at District and Sub- district hospitals, including nurses and counselors specifically dealing with survivors of violence should be trained to respond to GBV.

Important to remember that:

- Survivors may access healthcare at different levels of the health system: through a community-based healthcare provider, through a Primary Health Centre (PHC), Community Health Centre (CHC), or tertiary level healthcare facilities.
- Survivors may access healthcare at any or different department(s) of healthcare facilities / hospitals – dental, skin, casualty, obs-gynae, orthopaedics, ophthalmology, burns, psychiatry, community medicine, etc.
- Survivors can be diverse - across age groups and with special needs. For example, children, survivors with disabilities, with different language skills, etc.
- Response to GBV necessitates intra-health facility (within facility) coordination, as well as inter-facility coordination (external) with other nodal agencies, one stop centres, non-health sector service providers.
- Establishment of standard operating procedures (SOPs) for treatment / psychosocial care, MLC, referrals based on guidelines / protocols, laws at these different levels is critical. These SOPs are necessary so that the response is informed by laws, protocols in keeping with the level of the health facility.
- Appointment of dedicated staff and clarity of roles / responsibilities of to respond to survivors.

How can SOPs be developed?

- Develop Standard Operating Procedures at each facility for comprehensive and coordinated response.
- A small group of healthcare providers, including nurses, medical officers counsellors, hospital administrators, social workers, etc., in each facility can be involved in developing SOPs.
- The SOPs can be reviewed and detailed through regular meetings based on implementation – what has been effective, gaps, etc.

What should SOPs include?

The SOPs should include guidelines on the following elements that can be followed by the particular health facility:

- Information at the health facility, including signages, information desks at bigger facilities, referral directory (messages against GBV, services being provided, etc. for display as well as for sharing with survivors).
- Referral information for intra and inter health facility referral and coordination.
- Transportation for survivors for referrals to health facilities as well as other agencies such as one stop centres, shelters, etc.
- Dedicated space and staff for the first line response, and ongoing medico legal care; organising of material required for survivors such as clothes / toiletries for survivors.
- Plans to build capacities of staff to respond to GBV.
- Documentation, records management system, registers, copies of documentation to survivors. For example, replacing older MLC proformas with the MoHFW 2014, ensuring DIR (PWDVA) and other relevant formats are accessible.
- Storage, preservation of evidence; Chain of custody for evidence storage and hand over.
- Set up internal committee (IC) in the health facility as per The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act.

Note: These are merely indicative. Health facilities and healthcare providers can add to this based on their current preparedness levels.

Session 6.3: Referral Linkages and Support

 **40 Minutes**

Step 1: Explain that referral linkages and support is a core component of a comprehensive response to GBV. The lack of coordination and awareness about referral linkages and support services can challenge survivors and cause delays and denials in care and support.

Step 2: Refer to the material “Strengthening referral linkages and support” to discuss sources of the information, possible ways in which the referral information can be compiled and used.

Reference Material for Step 2: Strengthening Referral Linkages and Support

Providing for appropriate referral and linkages is a very critical aspect of a coordinated public health system response to GBV.

Referrals may be required within a facility or to higher health facilities for specialized care, as well as to other service providers to address the diverse needs of survivors. For example, police, child welfare committee, shelter homes, prosecutors, legal aid, one stop centres, protection officers, counselors, etc.

Health providers may also need to interface with other institutions such as police, child welfare committee, shelter homes, prosecutors, judiciary, etc. to ensure comprehensive care to survivors.

Referral pathways should:

- Respect self- determination
- Maintain safety and confidentiality
- Minimize points of care and be coordinated by the health facility

Establishing referral pathways

- Identify and map available service providers:
  - Police/law enforcement
  - Justice/legal services
  - Social services
  - Economic/livelihood support
  - Child protection
- Compile a referral directory of these contacts that is regularly updated.
- Establish formal and informal linkages and agreements with the service providers.
- Refer and coordinate referrals and their follow up.

Maintain accurate information to refer

- Know what services are provided by the varied service providers to counsel and refer survivors.
- Build inter-linkages and relationships with service providers, health facilities and healthcare providers through regular meetings.

Referral within health facility or to higher medical facilities

The following points must be ensured by the healthcare provider while referring survivors to higher level health facilities:

- Use referral formats with reasons for referral, care to be provided, etc.
- Inform the facility and healthcare provider for immediate response and to avoid long waiting for survivors.
- For inter facility transport of survivors, ambulance must be made available free of charge.
- Maintain a list of services, service providers. These may be compiled at the state or district level:
    - Protection Officers
    - Service Providers (organizations) under PWDVA
    - One Stop Centres
    - Child Welfare Committees
    - Shelters
    - Helplines
    - Legal Aid Organizations, District Legal Services Authority (DLSA), State Legal Services Authority (SLSA)
    - Counsellors and mental healthcare providers
    - Interpreters
    - Organizations/experts working with disabled persons, with lesbian gay bisexual trans queer intersex (LGBTQI) communities
    - Crime Against Women Cells; Special Cells for Women
    - Survivor Compensation Scheme
    - Counselors available in the district including those available within the health setup, at One Stop Crisis Centres, appointed in shelter homes, or at the District Child Protection Unit / CHILDLINE and independent volunteers with adequate expertise in providing counseling services, to refer survivors of violence.

Be aware of the available services / government departments / offices mandated by law to respond to GBV

Police, Law and Judiciary, government departments such as Health, Women and Child, Social Justice, etc. Child Welfare Committees, shelter homes, etc.

Link with / reach out to local organizations that may already have the necessary information for referrals, contact details, phone / helplines, transport support, interpreters, links with other organizations working with children, LGBTQI persons, women, women with disabilities, sex workers, girls and women from Dalit and other marginalized communities.

Session 6.4: Post-assessment

 **20 Minutes**

Step 1: Explain the post training assessment process to the participants. Request them to complete the format that is being shared. Explain that the questions are the same as was provided to them for the pre-assessment. The pre and post assessment will enable understanding of any shifts in perceptions, knowledge as a result of the training.

Request participants to complete the assessment without discussion with others. State that they can raise any clarifications.

Step 2: Distribute the post-assessment format provided in the Annexure 1. Allow a few minutes for participants to complete the format.

Step 3: Collect the completed formats. Ask participants to share any other feedback they have about the training – about the content, methodology, timing, language, space, interest in future trainings, etc. Note the feedback from participants as this is important to improve future trainings.

Step 4: Appreciate / validate the participation of the medical officers in the training and share any experiences or reflections that you have as a trainer. Thank all the participants for their time and participation.

Annexures

Annexure I: Pre and Post Assessment

Read the following statements and mark on the preferred answer - agree or disagree.

Statement 1. Survivors are to be blamed for domestic violence – they usually ask for it.

Answer-

- Agree
- Disagree

Statement 2. Anyone who is seeking health care is always treated equally, with respect, without any bias or discrimination.

Answer-

- Agree
- Disagree

Statement 3. Gender-based violence is a law-and-order issue mainly and health system / health providers do not have much of a role to address it.

Answer-

- Agree
- Disagree

Statement 4- Gender-based violence, especially domestic violence is a private matter – it should be discussed and resolved within the home or between those who are involved. It should not be made into a public issue.

Answer-

- Agree
- Disagree

Statement 5- There are laws in India that clearly mandate the role of the health system / health providers in addressing GBV.

Answer-

- Agree
- Disagree

Statement 6- The absence of injuries on a person who comes to a health facility for medico-legal care following sexual violence implies that the violence did not take place or that it was consensual.

Answer-

- Agree
- Disagree

Statement 7- Health providers cannot provide any medical treatment / care unless the survivor is brought by the police or until after they have filed a report with the police.

Answer-

- Agree
- Disagree

Statement 8 - The Ministry of Health and Family Welfare Guidelines & Protocols for Medico-legal care for survivors/victims of sexual violence are being implemented effectively in your health facility / hospital.

Answer-

- Agree
- Disagree

Statement 9- Conduct and opining on two finger test is a necessary part of examination of sexual violence survivors.

Answer-

- Agree
- Disagree

Statement 10- Built/height-weight or gait, occupation of the survivor are important aspects to be noted in history seeking by health providers.

Answer-

- Agree
- Disagree

Statement 11- Only a female doctor can do medical examination of a survivor of sexual violence.

Answer-

- Agree
- Disagree

Statement 12- All the medical evidence must be collected in all cases even when there is delayed reporting (beyond 96 hours) following the sexual violence.

Answer-

- Agree
- Disagree

Statement 13- In providing opinion, the health professional should conclude whether rape or sexual assault has occurred or not.

Answer-

- Agree
- Disagree

Statement 14- The guidelines and protocols for medico-legal care for survivors/victims of sexual violence in India provide guidance on dealing with persons from marginalised groups such as persons with disabilities, sex workers, LGBTQI persons, children, etc.

Answer-

- Agree
- Disagree

Statement 15- Survivors generally cannot make an informed decision about their situation.

Answer-

- Agree
- Disagree

Annexure II: Application of LIVES In Responding to GBV Survivor

LIVES	Possible Responses to Rita
Listen • Listen closely, attentively, with empathy and without judging. • Demonstrate active listening through appropriate-Body language, Eye contact, Gestures / actions • Allow adequate time. Be patient. • Allow for silences / allow time to think. • Encourage expressing of feelings, emotions.	❖ I am concerned. ❖ I am here to help. ❖ I understand that you are anxious. How can I help you? ❖ Take your time to talk about how you are feeling. ❖ You can talk when you feel a little better, when you are feeling less anxious.
Do Not- • Do not be biased. • Do not try to find reasons to justify the violence. • Never say or do anything to suggest disbelief. • Don't think and act as if you must solve her problems for her.	**Do Not Say-** ❖ This is your third child. Why did you get pregnant knowing this situation? ❖ This is normal in a marriage. ❖ You said he loves you. So why would he be violent? ❖ Is there something that you did to cause this reaction from him? ❖ Did you inform him about meeting your mother? Did you come back late from your mother's place?
Inquire • Explore further about her situation. • Ask open-ended questions to encourage her to talk instead of saying yes or no.	❖ You said you had no one to talk to. Would you like to talk to me? ❖ What is making you feel anxious?
• Reflect her feelings.	❖ It seems like you are anxious about the pregnancy. ❖ It seems like you are worried about your children.

• Repeat or restate what the person says to check your understanding. • Help her to identify and express her needs and concerns.	❖ You mentioned being terrified; are you afraid of being at home? ❖ What about your children? How does your husband behave with them?
• Ask for clarification if you don't understand. • Sum up what she has expressed.	❖ You mentioned feeling alone; what do you mean by that?
• Avoid leading questions, and "why" questions that may sound like you are blaming her.	❖ I think that you are very upset with your husband, isn't it? ❖ I imagine that you want to leave him after what he did, isn't it? ❖ Why did you go to visit your mother when you know he doesn't like it?
Validate • Express belief in and understanding of the survivor's narrative of violence. • Assure that they are not to blame • Reiterate that the violence is not justified under any circumstance.	❖ Thank you for sharing about the situation at home. ❖ It is very courageous of you to come and talk about your experience. You are not alone. ❖ Unfortunately, many other women have faced this problem too. ❖ I believe you, and understand that this must be very difficult and worrying for you.
• Assure the survivor that the violence is not their fault and they should not blame themselves.	❖ This is not your fault. ❖ This should not happen to anybody. ❖ You are not to be blamed for what happened ❖ Violence is not acceptable and no one should have to experience violence. ❖ Everybody deserves to feel safe at home. ❖ You are not responsible for your husband's anger or violence.
• Empower them to feel able to help themselves and to seek help.	❖ Many women have been able to get help and support. ❖ There is support available for you. We are here to support you.

• Help them to cope emotionally and practically.	❖ Other information that may be helpful is also available and I can share that. If required, I can assist you seek those services, once you have decided.
Enhance Safety • Enhancing safety	❖ I am concerned about your safety. ❖ Your safety and that of your children is most important. ❖ Let us discuss what to do so you won't be harmed.
• Assess immediate risk of violence. (Questions to assess immediate risk of violence. "Yes" to some of these questions may indicate high and immediate risk of violence.)	❖ Has the physical violence happened more often or become worse over the past 6 months? ❖ Has your husband ever used a weapon or threatened you with a weapon? ❖ Has he ever tried to strangle you? ❖ Do you believe he could kill you?
• **Safety planning**	
• Safe place to go to	❖ Is there anyone's home you can go to and stay in for some time? ❖ What about your parent's home? ❖ Have you any friends who will be supportive?
• Planning for children	❖ What about your children? Will you be able to take them? If not let us plan for them.
• Transport	❖ How will you reach the safe place? Plan and share support options in this regard.
• Things to take with you	❖ Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you keep them with someone, or keep a bag packed in a safe place at home?
• Financial	❖ Do you have access to money? How can that be arranged?

• Support of someone close by	❖ Anyone you can reach out to for support? ❖ In the neighborhood, community, organization, healthcare worker.
• **Staying safe within home**	❖ Even if you are staying at home, you can stay safe, try to protect yourself from violence. ❖ In the case of arguments or if you fear that he is very angry and he may become very violent, try to move to a room or place in your house from where you can leave or call for help. ❖ Stay away from any room or space with weapons or things that can be used as weapons. ❖ If you have decided to leave, go to a safe place. Do not inform your husband before leaving as that might see escalation of violence.
• **Safety vis-a-vis information, documents, phone records, emails** • Avoid causing further harm or do anything that may compromise the survivor's safety or expose them to further violence. • Some survivors may prefer not to carry information pamphlets, brochures, etc. for fear that they may be discovered and violence may escalate. This may also include health records. • Explore alternative, safer ways of storing the number, contact information on their phone or in a trusted friend's or neighbour's phone	❖ I will share the information, and contacts if it is safe for you. ❖ Let me know what would be a safe format for you.
Support • Connect the survivor with other resources for her health, safety, and social support. • Help her to identify and consider her options.	❖ What would be most helpful for you immediately?

• Discuss her social support.	❖ Is your mother supportive. ❖ Do you have any family member, friends, or trusted person whom you could talk to? ❖ Do you have anyone who could help with financial support?
• Set up a follow up visit; suggest that the survivor can come sooner if she wants to.	❖ Your next checkup is due in two weeks. You should try and come then. ❖ If the situation at home is not good, you can also come sooner.
• Share referral information about what support and resources are available nearby for her. • Offer to connect / coordinate with the referral service. • Provide details such as directions, transportation possibilities, contact persons, etc	❖ You can also contact the counselor, helpline that I shared with you. ❖ If you prefer, I can call them and make an appointment as per your convenience. ❖ If you want to think about this some more, you can come and meet me during your next visit here and let me know. Or you could call at the number provided for any help.

Annexure III: Domestic Incident Report (DIR) - PWDVA

14

FORM 1

[See Rule 5(1) and (2) and 17 (3)]

DOMESTIC INCIDENT REPORT UNDER SECTIONS 9 (B) AND 37 (2) (C) OF THE PROTECTION OF WOMEN FROM DOMESTIC VIOLENCE ACT, 2005 (43 OF 2005)

1. Details of the complainant /aggrieved person

(1) Name of the complainant/aggrieved person:

(2) Age :

(3) Address of the shred household :

(4) Present Address :

(5) Phone Number, if any :

2. Details of Respondents :

Sl. No.	*Name*	*Relationship with the aggri-eved person*	*Address*	*Telephone No. if any*

3. Details of children, if any, of the aggrieved person :

(a) Number of Children:

(b) Details of children :

Name	*Age*	*Sex*	*With whom at present residing*

1. Incidents of domestic violence:

Sl. No.	*Date, place and time of violence*	*Person who caused domestic violence*	*Types of violence* / *Physical violence*	*Remarks*
			Causing hurt of any kind, please specify.	
			II SEXUAL VIOLENCE Please tick mark [√] the column applicable	
			□ Forced sexual intercourse □ Forced to watch pormo-graphy or other obscene material □ Forcibly using you to entertain others □ Any other act of sexual nature, abusing humilia-ting, degrading or otherwise violative of your dignity (please specify details in the space provided below):	
			II VERBAL AND EMOTIONAL ABUSE	
			□ Accusation/aspersion on your character or conduct, etc. □ Insult for not brining dowry, etc. □ Insult for not having a male child □ Insult for not having any child □ Demeaning, humiliating or undermining remarks/ statement □ Ridicule □ Name calling □ Forcing you to not attend school, college or any other educational institution	

			☐ Preventing you from taking up a job ☐ Preventing you from leaving the House ☐ Preventing you from meeting any particular person ☐ Forcing you to get married against your will ☐ Preventing you from marrying a person of your choice ☐ Forcing you to marry a person of his/their own choice ☐ Any other verbal or emotional abuse (please specify in the space provided below)	
	III ECONOMIC VIOLENCE			
			☐ Not providing money for maintaining you or your children ☐ Not providing food, clothes, medicine, etc., for you or your children ☐ Forcing you out of the house you live in ☐ Preventing you from accessing or using any part of the house ☐ Preventing or obstructing you from carrying on your employment ☐ Not allowing you to take up an employment	

			☐ Non-payment of rent in case of a rented accommodation ☐ Not allowing you to use clothes or articles of general household use ☐ Selling or pawing your stridhan or any other valuables without informing you and without your consent ☐ Forcibly taking away your salary, income or wages etc. ☐ Disposing your stridhan ☐ Non payment of other bills such as electricity, etc. ☐ Any other economic violence ☐ (Please specify in the space provided below)	

(iv) DOWRY RELATED HARASSMENT

:

			☐ Demands for dowry made, please specify: ☐ Any other detail with regard to dowry, please specify Whether details of dowry items, stridhan, etc. attached with the form. ☐ Yes ☐ No	

(iv) any other information regarding acts of domestic violence against you or your children.

(Signature or thumb impression of the complainant/aggrieved person)

1. List of documents attached

Name of document	*Date*	*Any other detail*
Medico legal certificate		
Doctor's certificate or any other prescription		
List of Stridhan		
Any other document		

2. Order that you need under the Protection of Women from Domestic Violence Act, 2005.

S. No.	*Orders*	*Yes/No*	*Any other*
(1)	Protection order under section 18		
(2)	Residence order under section 19		
(3)	Maintenance order under section 20		
(4)	Custody order under section 21		
(5)	Compensation order under section 22		
(6)	Any other order (specify)		

1. Assistance that you need

S. No.	*Assistance available*	*Yes/No*	*Nature of assistance*
(1)	(2)	(3)	(4)
(1)	Counsellor		
(2)	Police assistance		
(3)	Assistance for initiating criminal proceedings		
(4)	Shelter home		
(5)	Medical facilities		
(6)	Legal aid		

2. Instruction for the Police Officer assisting in registration of a Domestic Incident Report:

Wherever the Information provided in this Form discloses an offence under the Indian Penal Code or any other law, the police officer shall—

(a) inform the aggrieved person that she can also initiate criminal proceedings by lodging a First Information Report under the Code of Criminal Procedure, 1973 (2 of 1973)

(b) if the aggrieved person does not want to initiate criminal proceedings, then make daily dairy entry as per the information contained in the domestic incident report with a remark that the aggrieved person due to the intimate nature of the relationship with the accused wants to pursue the civil remedies for protection against domestic violence and has requested that on the basis of the information received by her, the matter has been kept pending for appropriate enquiry before registration of an FIR.

(a) if any physical injury or pain being reported by the aggrieved person, offer immediate medical assistance and get the aggrieved person medically examined.

Place: (Countersignature of Protection Officer/Service Provider)

Date: Name:

Address:

(Seal)

Copy forwarded to:—

1. Local Police Station
2. Service Provider/Protection Officer
3. Aggrieved person
4. Magistrate

Annexure IV: Medico-legal Examination Report of Sexual Violence

(MoHFW Guidelines and Protocols for Medico Legal Care for Survivors of Sexual Violence)

1. Name of the Hospital …… OPD No…..……. In patient No ….....…
2. Name ……..……..... D/o or S/o (where known)…….....
3. Address……..……..
4. Age (as reported) ……..…… Date of Birth (if known)……
-
5. Sex (M/F/Others) ……..……..…….....…..……..
6. Date and time of arrival in the hospital……..…..…
7. Date and time of commencement of examination……...…..……
8. Brought by..... (Name &signatures)
9. MLC No. ……..Police Station……...……
10. Whether conscious, oriented in time and place and person……...……...
11. Any physical/intellectual/psychosocial disability…….……...

(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal

I……D/o or S/o… ..... hereby give my consent for:

a) Medical examination for treatment	Yes	No
b) This medico legal examination	Yes	No
c) Sample collection for clinical & forensic examination	Yes	No

I also understand that as per law the hospital is required to inform police and this has been explained to me.

I want the information to be revealed to the police Yes ☐ No ☐

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in ..... language with the help of a special educator/interpreter/support person (circle as appropriate)…….…..

If special educator/interpreter/support person has helped, then his/her name and signature…….....

Name & signature of survivor or parent/guardian/person in whom the child reposes trust in case of child (<12 yrs.)

……

……

…… With date, time & place

Name & signature/thumb impression of Witness

……...

……...

……... With Date, time and place

13. Marks of identification (Any scar/mole)

(1) ……

(2) ……

Left Thumb impression ☐

14. Relevant Medical/Surgical history

Onset of menarche (in case of girls) Yes/ No Age of Onset…….. Menstrual history – Cycle length and duration…….. Last menstrual period……. Menstruation at the time of incident – Yes/ No Menstruation at the time of examination – Yes/ No Was the survivor pregnant at time of incident – Yes/ No If yes, duration of pregnancy…… week Contraception use – Yes/ No If yes, method used - …… Vaccination status – Tetanus (vaccinated/ not vaccinated), Hepatitis B (vaccinated/ not vaccinated)

15 A. History of Sexual Violence

(i) Date of incident/s being reported (ii) Time of incident/s (iii)Location/s
(iv) Estimated duration: 1-7 days……. 1 week to 2 months….. 2-6 months…..……. >6 months….. Episode: One……Multiple ……..…Chronic (>6 months) …….Unknown……...
(v) Number of Assailant(s) and name/s .....……..... (vi) Sex of assailant(s)…..Approx. Age of assailant(s) …….....If known to the survivor – relationship with thesurvivor.....……..... ....
(vii) Description of incident in the words of the narrator: Narrator of the incident: survivor/informant (specify name and relation to survivor) .....

If this space is insufficient, use extra page

15 B. Type of physical violence used if any (Describe)

Hit with (Hand, fist, blunt object, sharp object)	Burned with
Biting	Kicking
Pinching	Pulling Hair
Violent Shaking	Banging Head
Any Other:	

15 C.

i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing)

…….....

ii. Use of restraints if any …….....

iii. Used or threatened the use of weapon(s) or objects if any……

iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for black mailing, etc.)if any:

…….....

v. Luring (sweets, chocolates, money, job) if any:…….....

vi. Any other:…….....

15 **.** i. Any H/O drug/alcohol intoxication:

ii. Whether sleeping or unconscious at the time of the incident:…….

15 E. If survivor has left any marks of injury on assailant/s, enter details: ……

15 F. Details regarding sexual violence:

Was penetration by penis, fingers or object or other body parts (Write Y=Yes, N=No, DNK=Don't know)**Mention and describe body part/sand/or object/s used for penetration.**

	Penetration			Emission of Semen		
Orifice of Victim	By Penis	By body part of self or assailant or third party (finger, tongue or any other)	By Object	Yes	No	Don't know
Genitalia (Vagina and/or urethra)						
Anus						
Mouth						

Oral sex performed by assailant on survivor	Y	N	DNK
Forced Masturbation of self by survivor	Y	N	DNK
Masturbation of Assailant by Survivor,	Y	N	DNK
Forced Manipulation of genitals of assailant by survivor	Y	N	DNK
Exhibitionism (perpetrator displaying genitals)	Y	N	DNK
Did ejaculation occur outside body orifice (vagina/anus/mouth/urethra)?	Y	N	DNK
If yes, describe where on the body			
Kissing, licking or sucking any part of survivor's body	Y	N	If yes, Describe

Touching/Fondling	Y	N	If yes, Describe
Condom used*	Y	N	DNK
If yes status of condom	Y	N	DNK
Lubricant used*	Y	N	DNK
If yes, describe kind of lubricant used			
If object used, describe object:			
Any other forms of sexual violence			

***Explain what condom and lubricant used to the survivor**

Post incident has the survivor	**Yes/ No/ Do Not Know**	**Remarks**
Changed clothes Changed undergarments Cleaned/washed clothes Cleaned/washed undergarments Bathed Douched Passed urine Passed stools Rinsing of mouth/Brushing/Vomiting (Circle any or all as appropriate)		

Time since incident… .....H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence……

H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence……..……

H/opainfulurination/painfuldefecation/fissures/abdominalpain/painingenitalsoranyother part since the incident of sexual violence.

16. General Physical Examination-

i. Is this the first examination……...……...

ii.Pulse……..……BP……..……..……

iii. Temp……..Resp. Rate…….……..

iv. Pupils…….…….

v. Any observation in terms of general physical wellbeing of the survivor…….……

17. Examination for injuries on the body if any

The pattern of injuries sustained during an incident of sexual violence may show considerable variation. This may range from complete absence of injuries (more frequently) to grievous injuries (very rare).

(Look for bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge, especially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks) Note the Injury type, site, size, shape, color, swelling signs of healing simple/grievous, dimensions.)

Scalp examination for areas of tenderness (if hair pulled out/ dragged by hair)	
Facial bone injury: orbital blackening, tenderness	
Petechial hemorrhage in eyes and other places	
Lips and Buccal Mucosa / Gums	
Behind the ears	
Ear drum	

Neck, Shoulders and Breast	
Upper limb	
Inner aspect of upper arms	
Inner aspect of thighs	
Lower limb Buttocks	
Other, please specify	

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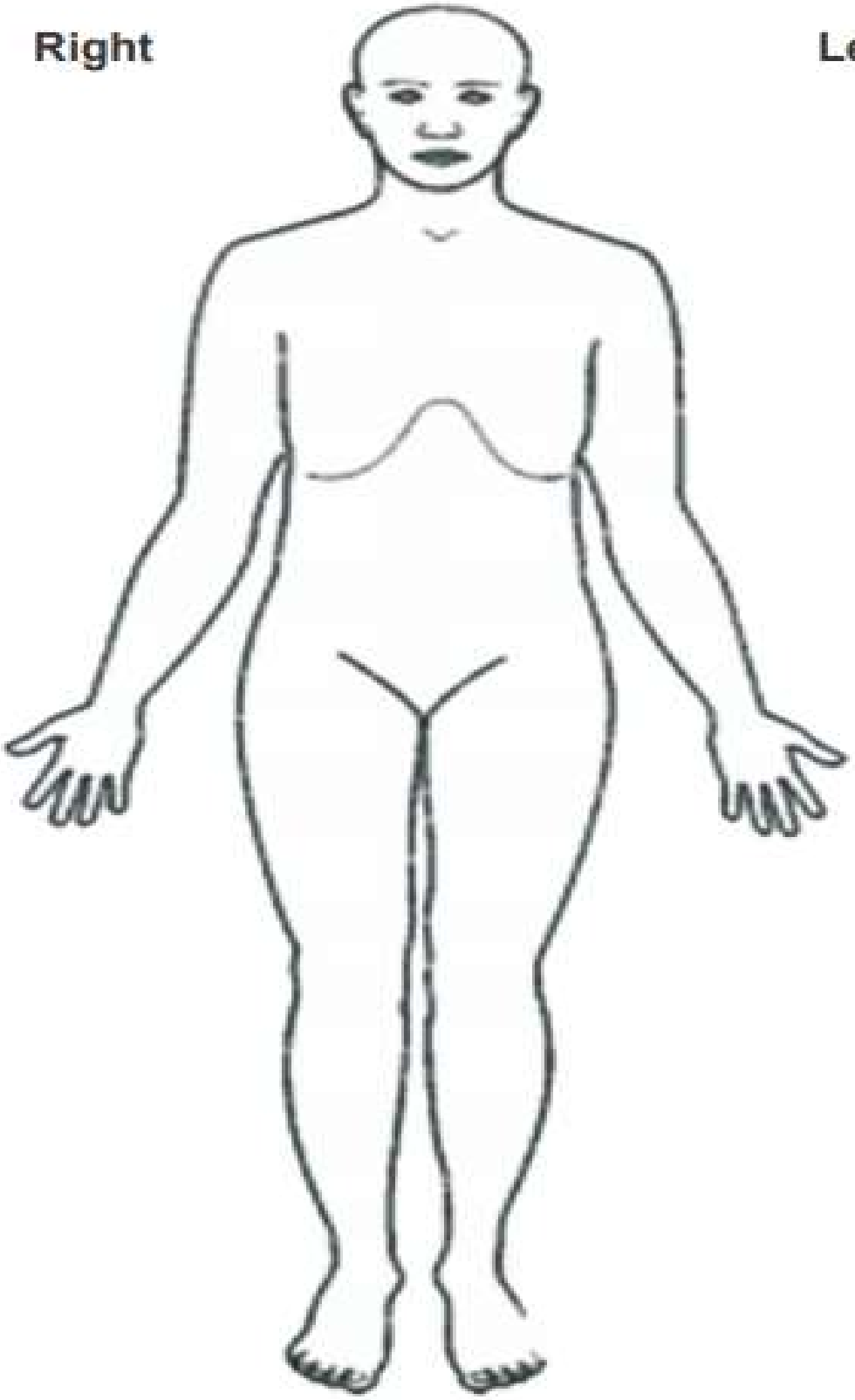

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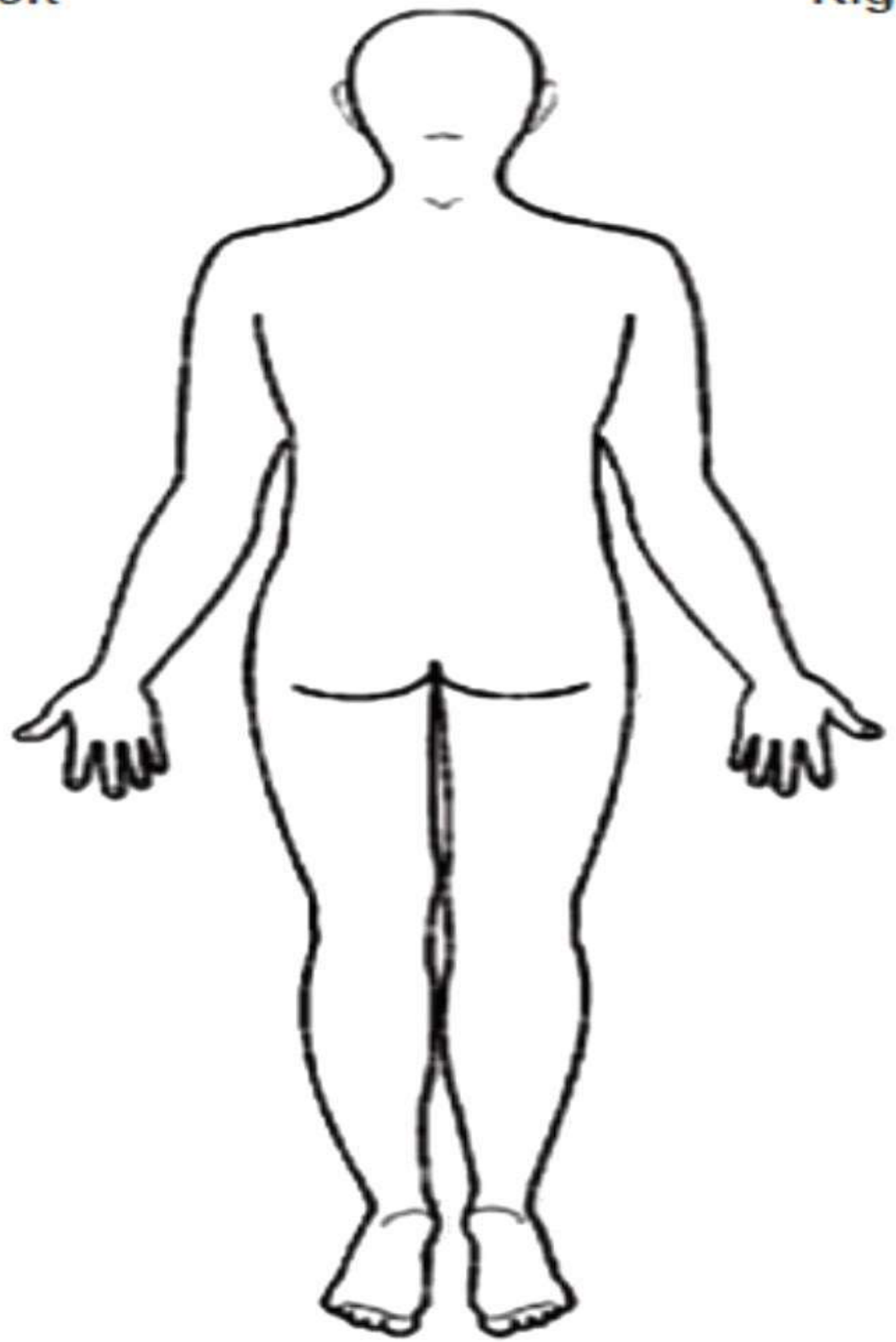


18. Local examination of genital parts/other orifices*:

A. External Genitalia: Record findings and state NA where not applicable.

Body parts to be examined	**Findings**	
Urethral meatus & vestibule		
Labia majora		
Labia minora		
Fourchette & Introitus		
Hymen Perineum		
External Urethral Meatus		
Penis		
Scrotum		
Testes		
Clitoropenis		
Labioscrotum		
Any Other		

*** Per Vaginum /Per Speculum examination should not be done unless required for detection of injuries or for medical treatment.**

P/S findings if performed……

P/V findings if performed……...

Record reasons if P/V of P/S examination performed……

C. Anus and Rectum (encircle the relevant)

Bleeding/ tear/ discharge/ oedema/tenderness

D. Oral Cavity - (encircle the relevant)

Bleeding/ discharge/ tear/oedema/ tenderness

19. Systemic examination:

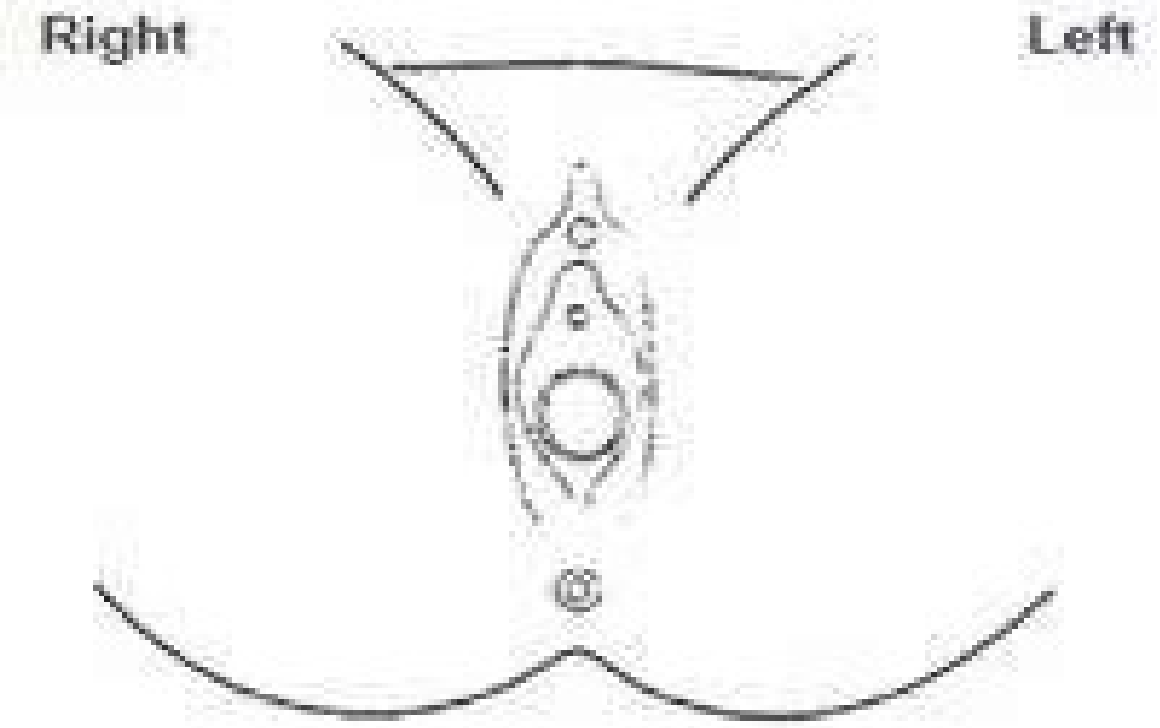
Central Nervous System: ……..

Cardio Vascular System:……..

Respiratory System:……..

Chest:……..

Abdomen:……...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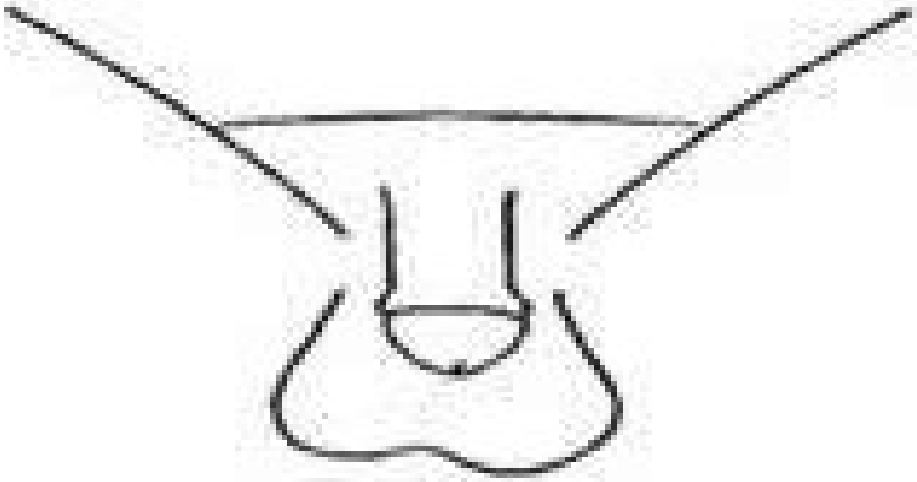

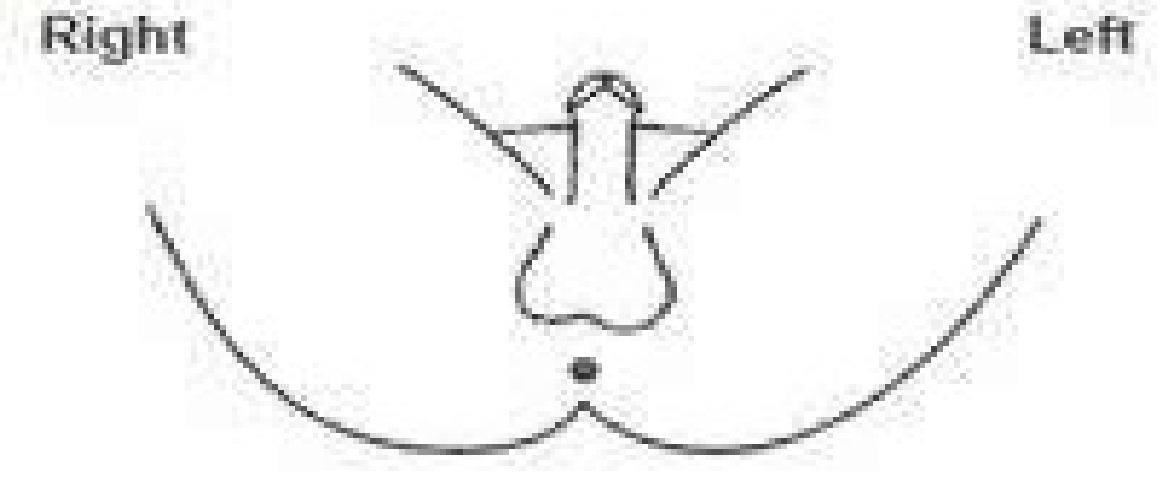
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20. Sample collection/investigations for hospital laboratory/ Clinical laboratory

1) Blood for HIV, VDRL, HbsAg
2) Urine test for Pregnancy
3) Ultrasound for pregnancy/internal injury
4) X-ray for Injury

21. Samples Collection for Central/ State Forensic Science Laboratory

List details of clothing worn by the survivor at the time of incident of sexual violence

1) Debris collection paper
2) Clothing evidence where available – (to be packed in separate paper bags after air drying)
3) Body evidence samples as appropriate (duly labeled and packed separately)

	Collected/Not Collected	Reason for not collecting
Swabs from Stains on the body (blood, semen, foreign material, others)		
Scalp hair (10-15 strands)		
Head hair combing		
Nail scrapings (both hands separately)		
Nail clippings (both hands separately)		
Oral swab		
Blood for grouping, testing drug/alcohol intoxication(plain vial)		
Blood for alcohol levels (Sodium fluoride vial)		

Blood for DNA analysis (EDTA vial)		
Urine (drug testing)		
Any other (tampon/ sanitary napkin/ condom/ object)		

1) **Genital and Anal evidence** (Each sample to be packed, sealed, and labelled separately-to be placed in a bag)

* Swab sticks for collecting samples should be moistened with distilled water provided.

	Collected/Not Collected	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two Vulval swabs (for semen examination and DNA testing)		
Two Vaginal swabs (for semen examination and DNA testing)		
Two Anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans of penis/clitoropenis		

*Samples to be preserved as directed till handed over to police along with duly attested sample seal.

22. Provisional medical opinion

I have examined (name ofsurvivor).....M/F/Other.....aged.....
reporting_ (type of sexual violence and circumstances). ....., XYZ days/hours after the incident, after having(bathed/douched etc.)..... My findings are as follows:

• Samples collected (for FSL), awaiting reports
• Samples collected (for hospital laboratory)
• Clinical findings
• Additional observations (if any)

23. Treatment prescribed:

Treatment	Yes	No	Type and comments
STI prevention treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post exposure prophylaxis for HIV			
Counseling			
Other			

24. Date and time of completion of examination ……...……...
This report contains …… number of sheets and …….....
number of envelopes.

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

25. Final Opinion (After receiving Lab. reports)

Findings in support of the above opinion, taking into account the history, clinical examination findings and Laboratory reports of bearing identification Marks described above, hours/ days after the incident of sexual
violence, I am of the opinion that:

Signature of Examining Doctor

Name of Examining Doctor

Place: Seal

COPY OF THE ENTIRE MEDICAL REPORT MUST BE GIVEN TO THE SURVIVOR/ VICTIM FREE OF COST IMMEDIATELY.

References

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4. Short video on Understanding Gender Equality by World Fish center.org, 2014- https://youtu.be/4viXOGvvu0Y
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6. Towards Change Info Kit for Healthcare Providers to Respond to Gender-based Violence by SAMA, 2016- https://india.unfpa.org/sites/default/files/pubpdf/InfoKit_for%20%20providers.pdf
7. WHO–Violence against women: Strengthening the health system, 2016 https://youtu.be/Qc_GHITvTmI
8. Human Rights Advisory on the Rights of Women in the Context of COVID 19, 2020- http://www.samawomenshealth.in/wp-content/uploads/2020/11/Advisory-on-Rights-of-Women.pdf
9. Strengthening Health Sector Response to Violence: A Kit by Dr. Jagadeesh Narayanareddy, 2017- https://india.unfpa.org/sites/default/files/pub-pdf/Violence%20Kit-1.pdf
10. Respectful Maternity Care Charter: Universal Rights of Mothers and Newborns- https://www.whiteribbonalliance.org/respectful-maternity-care-charter/#:~:text=The%20charter%20articulates%20the%20rights,upholds%20the%20dignity%20of%20both
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