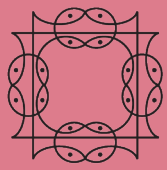
Towards Change

InfoKit for Health Care Providers to Respond to Gender Based Violence



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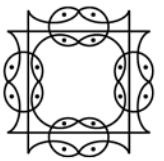


Sama Resource Group for Women and Health

Published by
Sama Resource Group for Women and Health
B 45, Second Floor, Shivalik Main Road,
Malviya Nagar, New Delhi 110 017
Phone: 91-11-65637632 / 26692730
Email: sama.genderhealth@gmail.com
Web: www.samawomenshealth.in

Published in 2016

Printed by: Drishti Printers, 9810529858

Introduction to the InfoKit

Every day, millions of women and girls experience gender based violence (GBV). This assumes many forms, including intimate partner violence, female genital mutilation, child and forced marriage, sex trafficking, and rape. GBV is not limited to the personal sphere nor is it a "private problem", that is not to be intervened in or addressed. It is, in fact, considered to be one of the most severe form of human rights violations and is universal, transcending caste, class, culture, ethnicity, identity, religion, regions and other types of marginalization.

Gender based violence is a "global public health problem of epidemic proportions" (WHO 2013). GBV seriously affects all aspects of girls' and women's health - physical, sexual, reproductive, and mental health – and their lives. This is increasingly being recognised; the 67th World Health Assembly (WHA) in 2014 adopted a resolution "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children". The resolution recognises violence against women and girls as a public health problem and urges Member States, including India, to take necessary steps in strengthening the role of the health system in responding to the survivors.[1]

Although evidence points to domestic and sexual violence as the most prevalent forms of GBV - affecting the health of a huge number of girls and women and to its impact on other health outcomes such as for maternal and child health, HIV, tuberculosis, etc., they continue to be largely invisible or insufficiently addressed by health systems through medical curriculum or in continuing medical education (CME).

Health care providers are in a unique position to offer support, counselling, information and referrals to survivors who access health care. The Health System also has a wide outreach with community based health care providers who may be able to play a critical role in care, wider dissemination of information and referral to foster access to health care for survivors[1]. However, community based health care providers also often face the risk of backlash in the absence of institutional support, which needs to be assessed and addressed effectively.

An empathetic, efficient and accountable health care system and its health care providers could make a substantive difference to reducing the barriers to access to health care and justice for survivors.

Although the resources in the InfoKit are intended for ALL health care providers, it is imperative to recognize the different contexts and the different levels of health care facilities in which health care providers work.

This Information Resource is merely one of several contributions to build understanding, perspectives, capacities and thereby, response to survivors of gender based violence. While GBV comprises a vast spectrum, this InfoKit is primarily focused on domestic and sexual violence, which are its most prevalent forms.

The information has been sourced and developed from different resources – government and non-government, domestic and international, and adapted or referenced as was appropriate. The information resources are not exhaustive and you are welcome to add your knowledge and experiences to enrich its content and also share it with us. We hope that we will collectively continue to learn and contribute to strengthening health system response to gender based violence.

Contents

Acknowledgements

We are grateful to Sudipta Mukhopadhyay, who developed and reviewed different sections of this InfoKit and thanks to Gayatri Sharma for drafting the section on domestic violence FAQs, along with Sama team members –Deepa Venkatachalam, Adsa Fatima and Susheela Singh.

We also thank all other Sama team members for their inputs to the InfoKit and their constant support.

We are grateful to the United Nations Population Fund (UNFPA) India for their support towards the development and publishing of this InfoKit.

Any errors in the information or citation in this document may please be ignored as inadvertent.

Section I

Understanding Gender Based Violence

What is Gender Based Violence?

Gender Based Violence is defined as violence that is directed against a person on the basis of 'gender', and reflects and reinforces unequal power relations. It is an outcome of gender based inequalities and discrimination, established and perpetuated by society (Sama 2013).

Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place.

Gender-based violence is "violence that is directed against a woman because she is a woman or that affects women disproportionately" (CEDAW GR 19, Article 3 Istanbul Convention).

Violence against women means all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (Article 1 DEVAW, Article 3 Istanbul Convention).

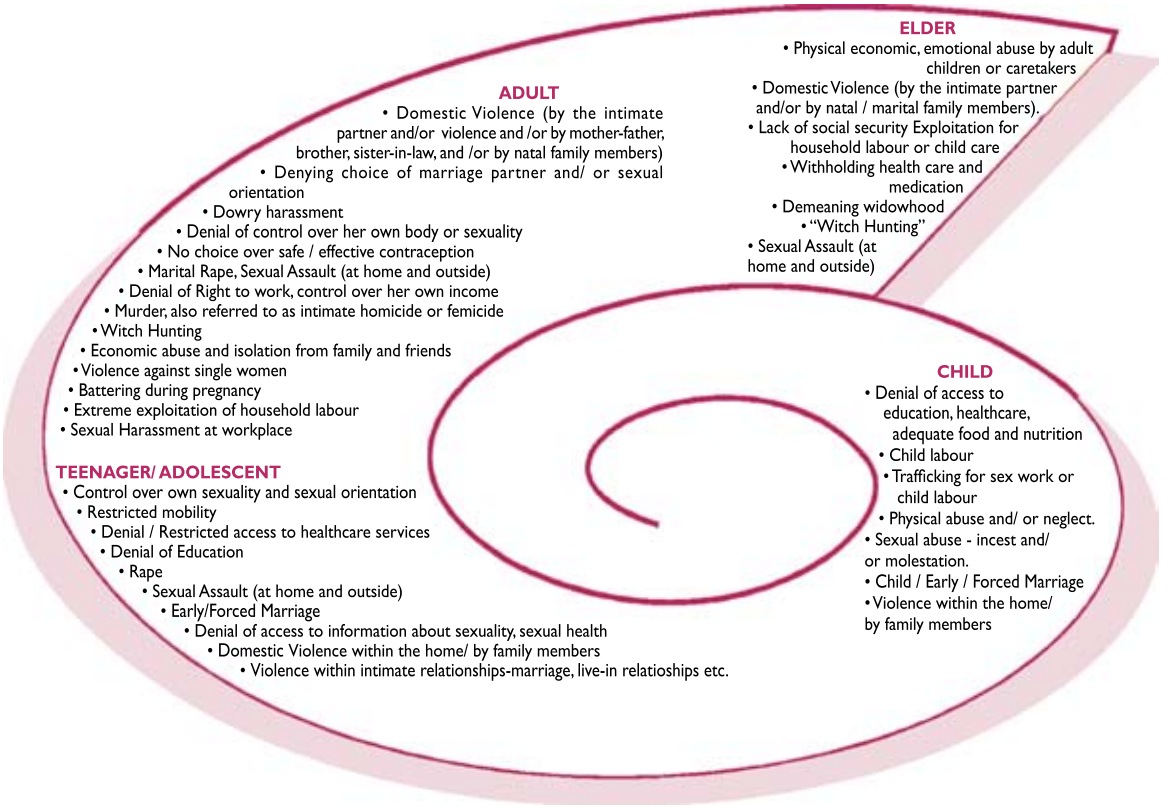
Why the focus on gender based violence against women and girls?

Women and girls are most affected by gender based violence due to their multiple vulnerabilities, as a result of patriarchal systems of thinking and behaviour in society. Girls and women face violence throughout their life-cycle, often starting before birth, and continuing till they are old. They face various forms of violence by virtue of their 'gender', the control of patriarchy and due to their subordinate status in society, where their rights are suppressed and violated.

- 1 in 3 women have experienced violence in their lifetimes
- intimate partner violence and sexual violence are major public health problems
- In India 35% of women aged 15-49 years have experienced physical or sexual violence
- Domestic violence is significantly associated with chronic malnutrition among women at the all India level
- Violence negatively affects women's physical, mental, sexual and reproductive health

Women and girls are primary targets of gender based violence but boys, men, trans and queer persons, the elderly and persons with disabilities are vulnerable too. Children, sex workers, Hijras, Kothis, Dalit and Tribal women, deserted women often face the worst forms of sexual violence; and are limited in their ability to access health care due to social discrimination, stigma, bias and stereotyping vis-a-vis their identities.

What are the forms of gender violence and discrimination?



Source: Sama (2013) *Gender Based Violence and Health*, Adapted from Lifetime spiral of gender violence: Asian and Pacific Islander Institute on Domestic Violence, San Francisco, January 2002

Table 1: Some Common Myths Related to Gender Based Violence	
Fact	Myth
Violence cannot be justified and requires a public response. Perpetrators use a combination of tactics of control and abuse that make it very difficult for women to escape the violence. Shame, guilt, lack of support from family and community, fear of escalating violence prevent women from leaving violent relationships.	Women allow intimate partner violence to happen to them.
Studies have shown that domestic violence affects women, irrespective of socio-economic status, educational achievements, ethnic origin, religion or sexual orientation.	Domestic violence happens only to a certain type of person.
Every woman has the right to safety, dignity and a life free of violence. Every woman survivor of GBV has the right of self-determination- she can decide to stay with her abusive partner or to leave him and either way she is entitled to support and protection from the state. The argument that women should stay in an abusive relationship is often justified for the well-being of the children. However, it is well established that the safety and health of children are negatively affected when children experience or witness domestic violence.	Women should tolerate violence to keep the family together.
Violence against women is a human rights violation, no matter whether it occurs in the family or in the public sphere. Under international human rights law such as CEDAW or the Istanbul Convention, states are not only entitled to eliminate all forms of violence against women, they are obligated to do so.	Domestic violence is a private family matter, in which the state has no right to intervene. How a man treats his wife is a private matter.
International definitions of rape and other forms of sexual assault focus on the type of violent acts committed, without consideration of who is the perpetrator or the survivor. Accordingly, any man who forces another person into a sexual act against her will without her consent, is committing rape, whatever her profession is.	Sex workers cannot experience rape.
As mentioned earlier, rape is defined by an action and not by the identity of the perpetrator or the survivor. Accordingly, any forced sexual intercourse is rape, irrespective of whether the survivor is married to the perpetrator or not. This statement is also grounded in international human rights law definitions, which encompasses all forms of physical, sexual, psychological or economic violence against women, no matter if they are committed in the family or in public.	A man cannot rape his wife.

Section II

Gender Based Violence - a Public Health Issue

Violence is a significant determinant of health and well being – i.e. freedom from violence is necessary to be healthy. There is increasing global recognition of gender based violence (GBV) as a major and growing public health issue - that violence can be prevented and its health impacts reduced. That such violence adversely impacts the health and well-being directly and indirectly, through the different stages of life.

This requires access to health care, and the involvement of the health system to provide necessary care and support to survivors of violence. Thus, the health system is a critical location for the provision of care and also acting as a facilitator for the survivors' access to justice.

The right to health care requires the state to ensure that appropriate physical and mental health services are available without discrimination and are accessible, acceptable and of good quality. This includes medical treatment for physical injuries, prophylaxis and testing for sexually transmitted infections, emergency contraception, and psychosocial support (MoHFW 2014)

The Right to Health is enshrined in a number of international instruments ratified by India, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of Discrimination against Women (CEDAW), the Convention of the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD). Although the Right to Health is not a fundamental right in India yet, the Supreme Court has interpreted the Right to Life as including the Right to Health.

Health Consequences of GBV

The pervasive nature of GBV and its health consequences - both in the short and long term, physical and psychological - are well established and are a primary health concern. Health consequences of GBV can be both, immediate and acute as well as long lasting and chronic; negative health consequences may persist long after the violence has stopped.

Table 2: Health Impacts of Gender Based Violence		
Non Fatal Outcomes		Fatal Outcomes
Physical consequences - Injuries - Functional impairments - Permanent disabilities	**Psycho-somatic consequences** - Chronic pain syndrome - Irritable bowel syndrome - Gastrointestinal disorders - Urinary tract infections - Respiratory disorders	- Fatal injuries - Killing - Homicide - Suicide
Psychological consequences/ Mental Health - Post Traumatic Stress Disorder - Depression, Fears, Sleeping disorders, - Panic disorders - Eating disorders - Low self-esteem - Suicidal tendencies	**Negative health behaviours** - Alcohol and drug abuse - Smoking - Sexual risk-taking - Self-injurious behaviour	
Consequences for reproductive and sexual health - Pelvic inflammatory diseases - Sexually transmitted diseases/ HIV - Unwanted pregnancy - Pregnancy complications - Miscarriage/low birth weight		
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 http://www.health-genderviolence.org/		

The Health Care System/Providers must work towards prevention and response to GBV for the following reasons:

- Gender-based violence has serious health consequences, including for girls' and women's reproductive and sexual health.
- Gender-based violence is a major cause of disability and death; responding to and prevention of GBV can improve the overall quality of health.
- The health care system is often the first point of contact for survivors; they may access health care facilities and providers for immediate treatment and psychosocial care, information as well as for medico-legal processes.

- Health care providers are uniquely located to identify children, women and other survivors at risk and experiencing violence, who may access health care routinely. Although health care providers should try and bring up the issue with survivors who have conditions or symptoms that they suspect may be related to violence, universal screening, i.e. screening all girls, women and others accessing health care for violence, is not recommended (WHO 2014).
- If health care providers are unable to ask about the violence, inadequate or inappropriate care may be provided and inaccurate health diagnosis about the survivor may be made.
- Survivors' safety is of primary importance and should not be compromised. Health care providers may inadvertently put survivors at risk if they are uninformed or unprepared in their response. Thus, the health care system must create opportunities for development of capacities of health care providers to respond to GBV at multiple levels – through medical curriculum to continuing medical education for all health care providers, including capacity building of community based health care providers.
- The health care system/providers are in a strategic position to contribute to changing social attitudes about violence against women. They enjoy an acceptability that transcends boundaries of class, caste, religion, region, etc. If the health care profession takes a position against GBV, it can foster change, strengthening access to survivors.

Towards Strengthening the Health Care System's Response to GBV

However, the health care system's response to GBV necessitates some fundamental requirements that are pertinent for the health system overall. The following Table 3 highlights some of these, in the absence of which, response to GBV will be limited. These and other requirements must be articulated by health care facilities /providers/ professional associations towards fulfilling their roles and responsibilities in a strengthened and comprehensive manner.

Table 3: Strengthening Health Care System Response to GBV
Enhancing Perspectives
Perspective change includes the need for sensitivity, confidentiality and patience for diagnosis of the immediate health problem as linked to violence. Often, it would require establishing a rapport with the survivor so that she can articulate and share the experience of violence which has caused her an injury or a medical problem. Moving beyond existing gender based stereotypes and attitudes that treat violence as a 'normal' and 'inevitable' reality of women and girls in our society is necessary both, at the individual and institutional levels.
Defining Institutional Policy, Protocols and Guidelines
Develop standards guidelines, protocols and set up systems and procedures to respond to survivors of violence, whether within the facility or through its outreach initiatives. This does not necessarily imply a singular model, but standards that become necessary to ensure that optimal quality care is provided to ALL survivors and to establish the accountability of the health system in doing so. Existing laws, international guidelines and human rights instruments also inform these policies and protocols and must be considered.
Establishing Necessary Infrastructure and Referral Systems
The availability of necessary infrastructure, including physical space to ensure privacy for treatment, counselling, examination, treatment, for storing evidence, documentation, etc., as well as requisite medicines, human resources, and other requirements will enable the health care system to respond more comprehensively. Information and data regarding organizations/ institutions for referrals should also be gathered and periodically updated. This could also be coordinated through a call or process for voluntary registration of such agencies.
Human Resources
The need for adequate sensitive and skilled health care providers is a priority for the health sector in India today, and, this includes community health workers, para-medics, nurses, doctors, senior management and support personnel for health administration. This will enhance the quality of care, and impact the health care response. The health care system may also designate, as required, skilled health care providers [2] who can lead the response to violence survivors.
Health Education and Capacity Building of Health Care Providers
Institutionalising the process of building knowledge and skills on response to GBV maybe through medical education curriculum primarily as well as through continuing medical education (CME) and workshops. While ongoing trainings, continued skill development efforts are important, it is imperative to begin the process of building conducive perspectives, and attitudes earlier on – existing health / medical curriculum needs to be reviewed and revised to make this a reality in the future.

Investment and Financing
India is amongst the lowest global spenders on health, resulting in extremely sub-standard public health sector services. This gap needs to be addressed through allocation of adequate resources and infrastructure for strengthened public health care.
Reporting, Review and Data Management Systems
The health care system should manage data with regard to GBV systematically and use it to review and plan interventions. This will facilitate improved understanding about the epidemiology of GBV, efficient functioning of the health care system and access for survivors.

Key Guidelines for Health Care Providers in Responding to GBV

- Provide quality health care to ALL; respect survivors' dignity and be non-judgemental.
- Acknowledge and empathise with the survivor even in situations where she does not want to disclose violence. This, even in the case of time constraints can make a difference to future access or disclosure.
- Do not refuse treatment or discriminate on the basis of gender, race, ethnicity, caste, tribe, disability, sexual orientation, religion, marital status, political beliefs or other characteristics.
- Refusal to provide medical care to survivors/victims for example, of sexual violence and acid attack has legal implications. It amounts to an offence under Section 166B of the Indian Penal Code read with Section 357C of the Code of Criminal Procedure.
- Be aware that violence does not fit the traditional medical model of diagnosis, prognosis and treatment. It is not a "disease" and cannot be "fixed or treated" with conventional treatment methods. However, it may result in morbidities or pose barriers for survivors to comply with treatment or medical advice.
- Provide complete information and counseling to enable the survivor to make informed decisions; health care providers must be respectful of these decisions and treatment or access to other services must not be impacted as a result. For example, a survivor's decision to not file a police report should not compromise her access to health care.
- Health care providers are duty-bound ethically and legally to provide health care to ALL and are not required to "judge" the veracity of situation. Many health care providers continue to perceive survivors' complaints as "false cases" as "normal" that results in a negative and biased response, resulting in further trauma to the survivors.

Section III

Domestic Violence and Abuse

Health care facilities and providers play a crucial role in responding to survivors of domestic violence. The role played by health care facilities/providers can be critical in rehabilitating the survivor and even saving the survivor's life. The health care facility may be in a key position to identify the cause of the health problem as domestic violence, and provide treatment, conduct an examination and collect evidence, refer the survivor to a law enforcement agency, ,and fill a "domestic incident report" that would guide the judicial process (should the matter go to court).

Domestic violence often leads to a range of adverse health consequences (Table 2). Survivors may access health care facilities/providers for treatment and / or for medical examination and evidence collection.

A. Towards a comprehensive response for survivors of domestic violence and abuse, health policy and the health system must recognize that:

- Survivors of domestic violence may access health care at different levels of the health system: through a community based health care provider, through a Primary Health Centre (PHC), Community Health Centre (CHC), or tertiary level health care facilities.
- Survivors may access health care at any or different department(s) of health care facilities / hospitals – dental, skin, casualty, obs-gynae, orthopaedics, burns, psychiatry, community medicine, etc.
- Response to domestic violence and abuse necessitates multi-sectoral response and therefore inter-sectoral coordination between different ministerial departments, nodal agencies, non-health sector service providers.
- Establishment of guidelines / protocols for care and referrals at these different levels is critical for survivors of domestic violence and must be initiated through a consultative process.
- Despite the law, i.e. Protection of Women from Domestic Violence Act (PWDVA), 2005 the response to domestic violence and legal compliance by the health care and other sectors is extremely weak. (Refer to FAQs on Pg 21 for more about PWDVA. Also refer to Table 3 - Strengthening Health Care System Response to GBV)

Table 4: Overview of Processes in Responding to GBV	
Identify Abuse ▪ Look for signs and symptoms of violence and abuse ▪ Inquire with sensitivity ▪ Listen to the survivor ▪ Do not force disclosure but create a milieu of support, empathy that will encourage the survivor ▪ Assure the survivor of confidentiality and make her safety a priority	**Provide Treatment and Medical Support** ▪ Assess for current and past incidences of violence ▪ Attend to all injuries, and provide treatment for physical and psychological trauma ▪ In case all support is not available at your health care facility, ensure that it is made accessible through coordination with requisite experts and services. For example, medical experts, surgeons, interpreters, etc. If this is not possible at all, facilitate referrals to the facilities / providers as per the requirement ▪ Offer specialized (medico-legal) services for survivors of sexual violence
Provide Emotional Support ▪ Listen carefully ▪ Believe in the survivor; validate ▪ Convey that violence is not the survivor's fault ▪ Assure the survivor that she is not alone	**Document/Record/ Collect and Manage Data** ▪ Register a medico-legal case ▪ Make a domestic incident report ▪ Analyse data collected routinely to develop a deeper understanding about survivors and the response
Provide Information and Referrals ▪ Inform the survivor of her rights ▪ Convey the importance of filing a police complaint ▪ Ask and assess about the survivor's safety ▪ Refer the survivor to legal and social agencies for further help	**Establish systems / processes for review, feedback and grievance redressal** Facilitate processes for feedback from those accessing services regarding their experiences, satisfaction, gaps towards future improvement. This should be voluntary and confidential, based on the physical and mental health status and ensure that that the survivor is neither traumatised nor pressured further. A nodal person should be designated whom the survivor / family can access in case of any problems / concerns.

B. Towards responding to a survivor of domestic violence or abuse who accesses the health care facility, the health care provider(s) should:

i. Be aware of the health consequences of violence and of other circumstances that may draw attention to the possibility of violence.

For example:

- Repeated visits for health care / treatment with no clear /specific ailment
- Unexplained chronic pain or health conditions such as headaches, gastrointestinal problems, sexual problems, etc.)[3]
- Injuries that are not well explained or maybe repetitive
- Stress, anxiety, depression or substance misuse; thoughts or attempts at self-harm / suicide

ii. Respond to the immediate health needs (physical and psychological) of the survivor.

iii. Ask about the domestic violence and abuse if you suspect it.

- Ask about the violence only when she is alone and not accompanied by others even if these are women or even her own children; not amidst other patients.

Note: Universal screening is not recommended, i.e. all women, children accessing health care should not be asked about violence.

- Ask when it is safe, in a space that provides privacy; designate a room in the health care facility that can be used without her safety being jeopardized.

iv. Assure confidentiality.

v. Ask about the violence with empathy, without being judgemental, using language and terms that are appropriate, that the survivor may relate to and are not intimidating.

vi. Initiate the conversation by asking her about things that will put her at ease, will not be uncomfortable for her.

Possible ways of asking about the violence initially

- How are things at home? Who lives with you?
- Are things okay at home? Are there any problems at home?

- Do you have any problems with your family/husband/partner/ father?
- Are you afraid of anyone at home?
- Have you been hurt by anyone at home?

vii. Allow time for her to talk without pressurizing her; allowing her to express her thoughts, feelings, emotions.

viii. Do NOT - insist, be authoritative, suggest that she is lying if she denies or does not disclose violence. Survivors may not disclose because of some of the following reasons:

- In the hope that the violence will stop and the abuser will change.
- Due to shame, stigma and the feeling that she will be blamed for causing the violence.
- Cultural/social norms that put pressure especially on women to "make things work", "violence as normal and a private matter".
- Due to threats from the abuser to harm either the survivor, children or other family members. Due to threats of self harm by the abuser.
- Low self esteem and lack of supportive environment.
- Other issues including financial and legal.

ix. Be respectful of her decision whether or not there is disclosure. If she discloses violence the following could be ways of validating:

- It is okay to talk about this
- I am concerned that this may be affecting your health
- This is not your fault; you are not to blame
- There are many women, unfortunately, who experience violence
- No one deserves violence; you deserve to feel safe at home

x. Assess if it is safe for the survivor to return home. Ask her about it and provide information about phone-lines, organizations, etc. whom she can get in touch with. Survivors' safety planning is a critical intervention; capacities of health care providers should be strengthened

Note: It may not always be safe for a survivor to carry written materials. Many survivors may not be able to read/ write. Discuss with her what would be safe and easily accessible for her. Do not insist if she refuses to take along the information or material being provided.

towards carrying out the assessment in appropriate settings, as it needs to be done carefully, skillfully with an understanding of the risk.

xi. Share information, contact details regarding protection officers, organizations, One Stop Centres, Shelters, legal aid, etc. in the area where she could go or who she could get in touch with.

Information and Contact Details may be compiled of:

- Protection Officers
- Service Providers (organisations) under PWDVA
- One Stop Centres
- Child Welfare Committees
- Shelters
- Helplines
- Legal Aid Organisations, District Legal Services Authority (DLSA), State Legal Services Authority (SLSA)
- Counsellors and mental health care professionals
- Interpreters
- Organisations/experts working with disabled persons, with lesbian gay bisexual trans queer intersex (LGBTQI) communities
- Crime Against Women Cells; Special Cells for Women
- Victim Compensation Scheme

The list or details about notified medical facilities, Protection Officers, Service Providers can be accessed from the Department of Women and Child Development of respective States.

xii. Discuss and schedule a follow up visit with her.

xiii. Ensure that the documentation records are stored safely.

- The documentation should include the survivor's narrative, preferably in her own words and include details about the duration, frequency, forms and severity of the violence. In case of any injuries at the time of documentation, the survivor's narration about how it occured is important to record.
- A copy of the medical examination report should be provided to the survivor.
- If the health care facility is a "notified medical facility" under the PWDVA, then it is authorized to fill in the Domestic Incident Report (DIR) if this has not already been done by the Protection Officer or the Service Provider under the Act. The DIR is a record of the reporting of domestic violence by the survivor and a copy of the DIR must be handed over to the Protection Officer or Service Provider if filled by the notified medical facility.
- In case the medical facility the survivor approaches is not notified under the Act.
  - » Provide information to the survivor about the law and the services available (it is advisable to keep ready information or pamphlet of referral services which can be shared with the survivor);
  - » Refer the survivor to a notified medical facility.

Ongoing / Initiatives in the longer term by Health Care Facilities / Providers

- Develop perspectives and skills to respond with empathy and effectively; initiate / organize capacity building orientations and workshops for all staff on domestic violence.
- Where there are no protocols, health care facilities may set up a multi-expert committee / group of external persons as well as health care providers including doctors, nursing staff, counselors and social workers and develop standard operating procedures (SOPs) towards a comprehensive response to survivors.

These are very initial but critical steps in responding to survivors of domestic violence. However, the health care system – i.e. health care facilities at different levels and health care providers must become equipped to provide a comprehensive response to domestic violence.

Guidelines for Women and Girl Survivors with Disabilities

The Convention on the Rights of Persons with Disabilities (ratified by India in 2007) requires all State Parties to take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects. The PWDVA does not contain special provisions to make filing of DIR, reporting a complaint and accessing services and reliefs easier for a disabled person.

In rape cases, where the survivor of a sexual offence is temporarily or permanently disabled, either physically or mentally, the FIR is to be recorded at her residence by the police officer. Alternately, the recording can also be done at a convenient place of the survivor's choice. An interpreter or special educator's presence during recording of the FIR is provided for under Section 154(a) of the Cr.PC.

Some general guidelines that can be kept in mind when examining a survivor with disability are:

- Be aware of the nature and extent of disability that the person has and make necessary accommodation in the space where the examination is carried out;
- Do not make assumptions about the survivor's disability and ask about it before providing any assistance;
- Do not assume that a person with disability cannot give history of violence herself. Because abuse by near and dear ones is common, it is important to not let the history be dictated by the caretaker or person accompanying the survivor;
- Make arrangements for interpreters or special educators in case the person has a speech / hearing or cognitive disability;
- Even while using the service of an interpreter, communicate with the person directly as much as possible, and be present while the interpreter or special educator is with the person;
- Recognise that the person may not have been through an internal examination before, the procedure should be explained in a language that can be understood;
- Ensure adequate counseling services are provided to the survivor;
- Understand that examination in the case of a disabled person may take longer;

- Consent – All persons are ordinarily able to give or refuse to give informed consent, including persons with mental illness and intellectual disabilities and their informed consent should be sought and obtained before any medical examination. Some specific steps may be required when taking informed consent from persons with mental illness, or those with intellectual disabilities, such as:
  - Such persons should be provided the necessary information in a simple language about the procedure involved;
  - Be given adequate time to arrive at a decision;
  - Be provided the assistance of a friend / colleague care giver in making the informed consent decision.

[The guidelines specifically pertain to examination of survivors of sexual violence, but can also apply in general when conducting a medical examination of disabled persons.]

Source: MoHFW Guidelines and Protocols, 2014.

These processes can be initiated with the help of experts, organizations working on the issue and one stop and other such centres that are already functional. Write to <sama.genderhealth@gmail.com> for contacts of organizations in your State whom you can get in touch with in this regard.

Frequently Asked Questions (FAQs) For Health Care Providers/ Facilities Based on the Law for Domestic Violence in India

The following FAQs aim to provide information about domestic violence based on the law in India. Health care providers may often be under the mistaken impression that only married women experience "domestic violence" or that sexual violence is not faced by unmarried women or within marriages or in other live-in relationships.

What is domestic violence?

The concept of domestic violence is relatively new in Indian law. Prior to 1983, general criminal law provisions such as assault, hurt / grievous hurt or murder, were used in cases of violence by family members as well as in other cases of violence. These offences, however, did not capture the nature of violence in its entirety. Unlike abuse by strangers, domestic violence is rarely a one off incident. A pattern of violence – such as beatings, accompanied

Although marital rape is exempt as an offence from criminal law (provided that the woman is above 15 years of age), the PWDVA covers cases of sexual violence, including rape or other forms of unwelcome sexual conduct. Forcing the woman to abort, or forcing her to become pregnant, forcing her to perform oral / anal sex are all examples of sexual violence. Rape by the husband of his wife during a period of separation is a criminal offence and can also be a case of domestic violence.

by sexual violence, emotional threats, etc. – tends to emerge in domestic violence cases.

In 1983, section 498A was introduced to the Indian Penal Code, 1860 (IPC), which makes "cruelty" by a husband or the relatives of the husband, a criminal offence.[4] Hence, "cruelty" is not limited to physical acts of violence, but includes mental harassment of a married woman, which is likely to drive the woman to commit suicide. Harassment for dowry forms part of the definition of cruelty. The definition of cruelty in criminal law is open to interpretation depending upon the background of the parties, their economic situation and other relevant factors.

In 2005, the Protection of Women from Domestic Violence Act (PWDVA) was enacted. The law, for the first time, provided a clear definition of "domestic violence". As per the definition (PWDVA/Section 3), .. any act, omission or commission or conduct of the respondent (person who commits the violence) shall constitute domestic violence in case it harms or injures or endangers the health, safety, life, limb or wellbeing, whether mental or physical, of the aggrieved person (survivor) or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse.

Dowry demands are covered in the definition as acts of domestic violence.

- Physical violence can range from slapping and beating to more extreme forms of violence such as burning the woman, breaking her limbs, or endangering her life.
- Sexual violence includes any sexual conduct that is humiliating or degrades the woman.
- Mental violence would include threats, repeated harassment, or insults such as constantly telling a woman she is dark skinned or taunting her for not giving birth to a male child. Forcing a daughter to get married by using mental violence is also covered by the law.

In determining what is mental violence, each case would need to be assessed on its own merits. For example, repeated insults would fall within the definition, but a one-off argument may not fall within the definition.

- Economic violence would include denial of basic necessities such as food or medicines. Throwing a daughter or mother or wife out of the house, denying a sister her right to her share in property provided in a will, or taking possession of a wife's stridhan items are all examples of economic violence.

What are the main features of the PWDVA?

The PWDVA is a civil law and not a criminal law. Offences under the Act do not attract criminal prosecution and imprisonment. The Act provides for civil remedies, specifically, injunction orders (Protection order or "stop violence" orders), maintenance, residence orders, temporary custody orders and/or compensation. However, criminal prosecution

would lie in case of breach of a court order.

The PWDVA covers all women who are in a domestic relationship with the respondent. The intention of the Act is to protect all women in an intimate relationship or domestic relationship, i.e., who are living with the perpetrator(s) of violence or have lived with the perpetrator(s) in the past. It covers mothers, sisters, live-in girlfriends,[5] wives or adopted daughters. It does not cover women in professional relationships living with the perpetrator (such as a domestic worker).

The Act is for women only. Men cannot use the Act to file cases of domestic violence. However, an aggrieved woman can file a case of domestic violence along with her minor child. The respondent means any adult male person who is / has been in a domestic relationship with the aggrieved woman. Women can also be respondents under the Act.[6] A case can be filed against a relative of the husband or male partner (such as mother in law).

The PWDVA provides for support services for the survivor:

1. Protection officers – State governments are required to appoint Protection Officers who essentially form a link between the aggrieved woman and the Magistrate. They essentially assist the aggrieved woman in filing a case.

   Health care facilities, health care providers should procure a list of protection officers in their respective states; this information should be provided to the survivors.
2. This includes having the survivor examined and forwarding the medical report to the Magistrate and police. The Protection Officer has a duty to assist the survivor and any child in obtaining health care (physical and psychological) at a health care facility including providing transportation to get to the facility.[7] The PO has a duty to get the survivor medically examined, and forward a copy of the medical report to the police station and the local Magistrate.[8]
3. Service Providers registered under the Act are also authorized to get the aggrieved woman medically examined and ensure she receives shelter.
4. Counselors / Welfare Experts – Counseling of the parties may be directed by the Magistrate at any time with a member of a Service Provider (SP). The courts may also take the assistance of welfare expert.
5. Registered Medical Facilities –State governments are required to notify medical facilities under the Act.
6. The police have the duty to inform the aggrieved woman about her rights and refer her to a Protection Officer (PO). In case of an emergency, the police should be informed of the occurrence of domestic violence, and it is their duty to accompany the PO or the SP to the place of occurrence.

Which are the registered medical facilities under the PWDVA and what is their role?

The PWDVA requires notification of medical facilities by the State government. In most states, government run hospitals and health facilities have been notified as medical facilities. Notified medical facilities have the following role to play under the Act:

a) Medical aid cannot be denied to an aggrieved woman (Section 7 PWDVA)

b) Medical aid should be provided to survivors free of cost

c) The aggrieved woman, PO or the SP may make such a request for medical aid in writing. In case the PO is making the request for medical aid, a copy of the domestic incident report (DIR) shall accompany such a request.

   If the aggrieved woman is unable to write, the notified medical facility should provide assistance to her for recording the request for medical treatment.

   In case no DIR is provided, the person in charge of the medical facility shall fill in the DIR and forward the same to the local PO.[9]

d) Filling up of Domestic Incident Reports – Medical facilities are empowered to fill up the DIR. The DIR acts as a record of domestic violence, and is made in the prescribed form, on the receipt of a complaint from an aggrieved person. Section 12(1) requires the Magistrate to take into consideration the Domestic Incident Report.

e) Providing a copy of the medical examination report to the aggrieved woman free of cost – As per the Rules, a copy of the medical examination report has to be provided to the aggrieved woman free of cost.[10]

What is a domestic incident report?

A DIR is a report that can be filled up by (i) the Protection Officer (PO); (ii) the Service Provider (SP); or (iii) the notified medical facility. It contains information regarding the particulars of the aggrieved woman and the respondent, the incidents of domestic violence, the orders that she needs from the court, and any assistance that she needs.

The notified medical facility is authorized to fill in the DIR and forward it to the local PO, who in turn shall present the same to the Magistrate. The DIR is not mandatory for passing orders by the Magistrate, and shall be taken into consideration only in cases where it has been filed.[11] However, in practice, most courts do ask for a DIR to be submitted.

It is essential to fill in the DIR in all cases where the survivor comes to a notified medical facility for a medical examination and does not have a DIR.

The survivor of domestic violence does not want medical examination conducted. Is it mandatory to conduct the medical examination on her?

No. The medical examination can only be conducted with her consent.

Consent of the survivor is essential for conducting medical examination for evidence collection. In case of a child, where the child is above 12 years of age, his/her consent should be taken (section 90 of the Indian Penal Code).

In case of a child, the medical examination can be conducted with the consent of the parent / guardian if the child is below 12 years of age.

The court has ordered a medical examination as the husband has stated his wife has a mental disorder and he wants a divorce. She does not want to go through the procedure. What should be done?

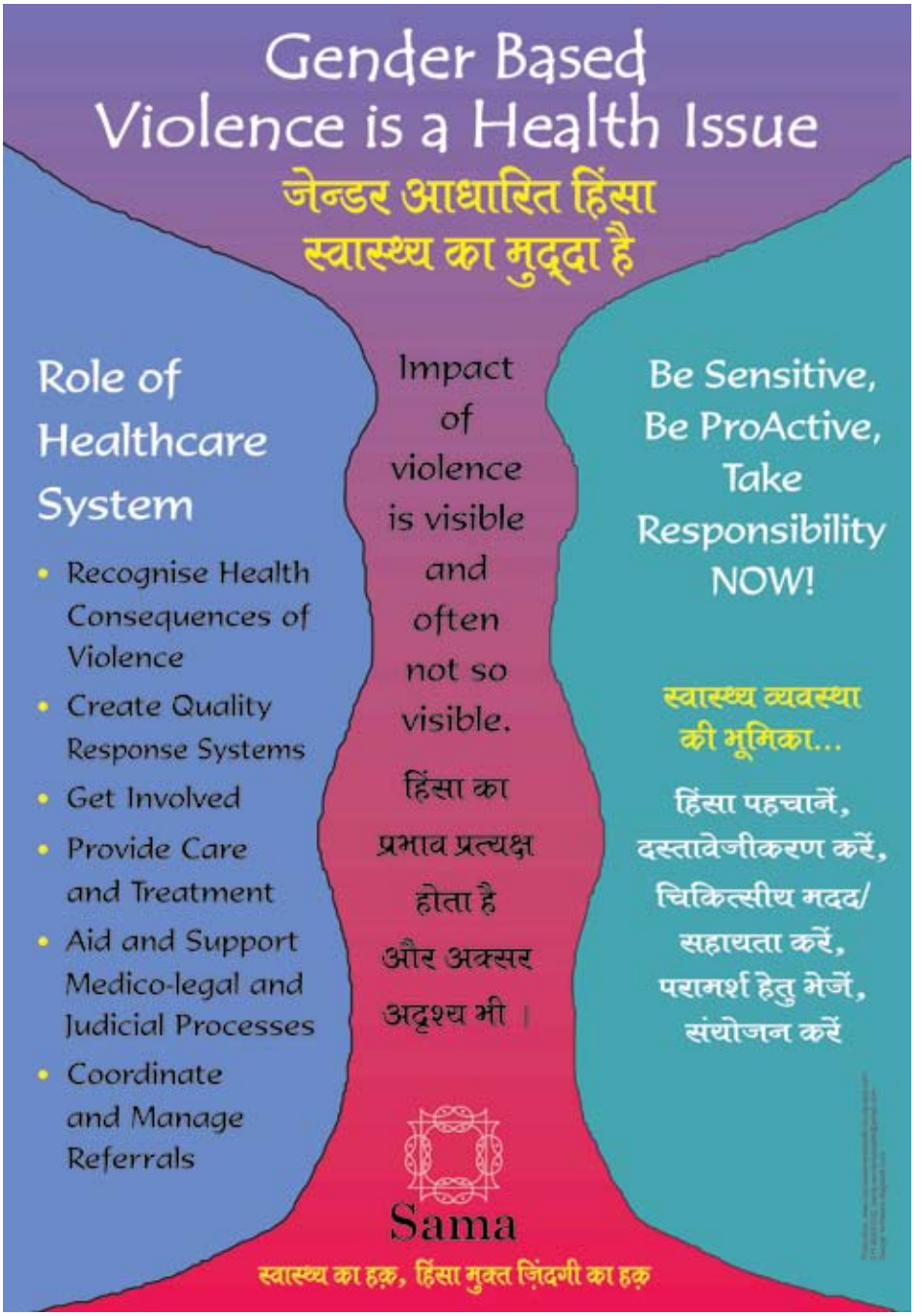
The wife has a right not to submit herself to forcible medical examination. However, the court will draw an adverse opinion against her.[14] In case the aggrieved woman refuses to undergo medical tests –

(i) The advice given to the aggrieved woman should be recorded;

(ii) The hospital should take in writing a declaration from the woman that this refusal is an informed decision to refuse the test;

(iii) If the aggrieved woman is unwilling to sign an informed refusal, this should be recorded in writing by the hospital authorities;

(iv) If the aggrieved woman is incapable of giving consent, she must be cared for as best the hospital authorities deem fit.


Gender Based Violence is a Health Issue
जेन्डर आधारित हिंसा स्वास्थ्य का मुद्दा है
Role of Healthcare System
• Recognise Health Consequences of Violence
• Create Quality Response Systems
• Get Involved
• Provide Care and Treatment
• Aid and Support Medico-legal and Judicial Processes
• Coordinate and Manage Referrals
Impact of violence is visible and often not so visible.
हिंसा का प्रभाव प्रत्यक्ष होता है और अक्सर अदृश्य भी।
Be Sensitive, Be ProActive, Take Responsibility NOW!
स्वास्थ्य व्यवस्था की भूमिका...
हिंसा पहचानें, दस्तावेजीकरण करें, चिकित्सीय मदद/ सहायता करें, परामर्श हेतु भेजें, संयोजन करें
Sama
स्वास्थ्य का हक़, हिंसा मुक्त ज़िंदगी का हक़

Section IV

Sexual Violence

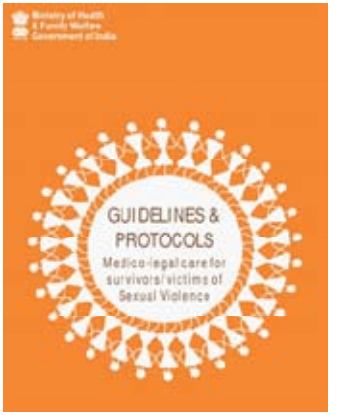
Sexual Violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (WHO World Report on Violence and Health, 2002).

The Criminal Law Amendment Act (CLA) 2013 has expanded the definition of rape to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/ fingers and non-penetrative (touching, fondling, stalking, etc.) and has recognised the right to treatment for all survivors/victims /victims of sexual violence by the public and private health care facilities. Failure to treat is now an offence under the law. The law further disallows any reference to past sexual practices of the survivor (MoHFW Guidelines and Protocols, 2014).

Table 5: Forms of Sexual Violence	
▪ Coerced/forced sex in marriage or live in relationships or dating relationships. ▪ Rape by strangers. ▪ Systematic rape during armed conflict, sexual slavery. ▪ Unwanted sexual advances or sexual harassment. ▪ Sexual abuse of children. ▪ Sexual abuse of people with mental and physical disabilities. ▪ Forced prostitution and trafficking for the purpose of sexual exploitation.	▪ Child and forced marriage. ▪ Denial of the right to use contraception or to adopt other measures to protect against STIs. ▪ Forced abortion and forced sterilization. ▪ Female genital cutting. ▪ Inspections for virginity. ▪ Forced exposure to pornography. ▪ Forcibly disrobing and parading naked any person.

GUIDELINES & PROTOCOLS for Medico-legal Care of survivors/ victims of Sexual Violence by Ministry of Health and Family Welfare, Government of India, 2014

These Guidelines and Protocols were developed in order to ensure uniformity in approaching, treating and documenting cases of sexual violence, mainly against women and girls. The guidelines have specially been drawn up for medico-legal care for survivors of sexual violence. The guidelines are essentially for health care providers in government and private health care facilities towards comprehensive response for survivors. This includes guidelines for treatment, examination and evidence collection as well as documentation towards facilitating healing and the survivor's access to justice.



Which guidelines or protocols are you or is your health care facility using for medico-legal care for survivors of sexual violence? Does your health care facility have standard operating procedures (SOPs)?

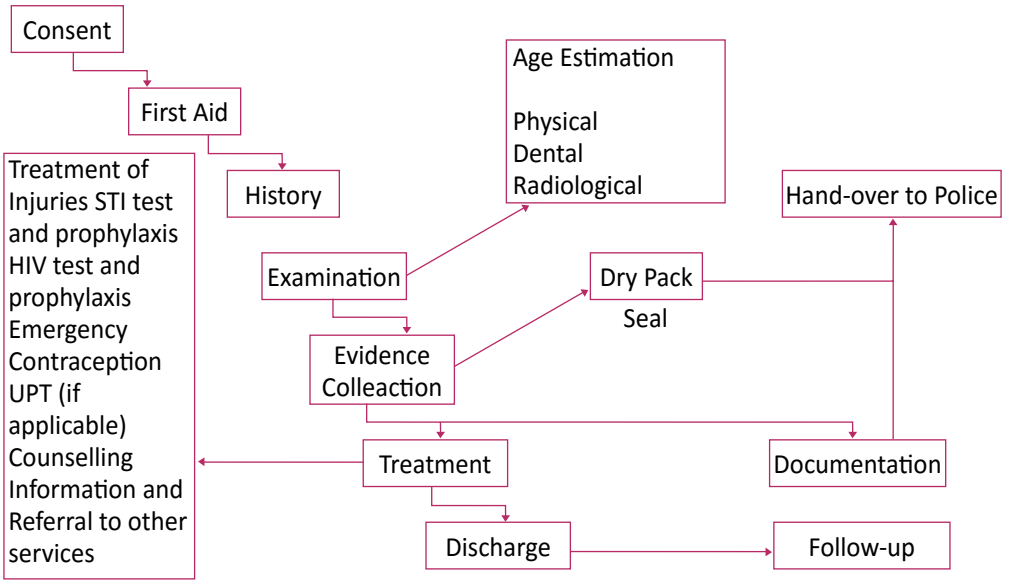
The MoHFW Guidelines and Protocols aim to achieve the following:

- Operationalise informed consent and respect autonomy of survivors in making decisions about examination, treatment and police intimation.
- Specific guidance on dealing with persons from marginalised groups such as persons with disabilities, sex workers, LGBT 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 survivors.
- Focus on history by recognising 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.
- Lays down Standard Treatment protocols for managing health consequences of sexual violence. Focuses not only on medico legal aspects but also on providing care and free treatment.

- Lays down Guidelines for provision of first line psychological support.
- Strives to create standard practices across health care facilities' response to survivors.
- Revised proforma for medical examination report for sexual assault survivors in compliance with the amended legal provisions and guidelines.
- Mandates providing of a copy of the documentation of the medico-legal record of the examination/evidence collected to the survivor.
- Emphasises improved interface of health professionals with other agencies including police, judiciary, child welfare committees, etc.
- Provides clarity about examination and evidence to be collected based on the history of sexual violence as well as on opinion to be provided by health care providers.

Please contact the Ministry of Health and Family Welfare (MoHFW) for copies of the Guidelines and Protocols. These can also be downloaded from MoHFW website available in English and Hindi languages.
(English)<http://www.mohfw.nic.in/showfile.php?lid=2737>
(Hindi) <http://www.mohfw.nic.in/showfile.php?lid=3602>

Components of a Comprehensive Health Care Response for Sexual Violance Cases



Source: MoHFW Guidlines and Protocols, 2014

Table 6: Health care facilities and providers frequently have queries and clarifications with regard to their response to survivors of sexual violence. While several of these may become clear on a careful reading and understanding of the Guidelines and Protocols by the MoHFW, several doubts remain and continue to emerge in operationalisation.
The following are a few of the frequently raised clarifications that Sama has encountered.

Questions / Issues	Clarifications	Legal provisions, Policy, Guidelines
Health Care providers can conduct examination of the survivor of sexual violence without a police requisition	Yes The survivor has the right to report directly to the health facility instead of the Police / Court.	Section 27 POCSO Act and Rule 5 Section 357 C CrPC
If a person has come on his/her own to the hospital and does not want to lodge a Complaint but requires a medical examination and treatment	In such cases, although the doctor is bound to inform the police as per law, however neither court nor police can force the survivor to undergo medical examination. It has to be with the informed consent of the survivor/ parent/ guardian (depending on the age). In case the survivor does not want to pursue a police case, an MLC must be made and she must be informed that she has the right to refuse to file an FIR. An informed refusal must be documented in such cases. Similarly if she refuses any part of the examination, her informed refusal should be documented.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014
Examination of the girl /women survivor of sexual violence must be conducted by an Obstetrician/ Gynecologist	No Any registered medical practitioner can conduct the medical examination of the survivor of sexual violence.	Section 164 A CrPC MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014

Taking consent for conducting medical examination from the survivor or competent guardian	Yes The doctor conducting the medical examination of the survivor has to take the consent of the woman survivor or of a person competent to give such consent on her behalf.	Section 164 A CrPC
Do health care providers have to mandatorily inform the police	Yes Health care providers / health care facilities must inform the police in cases of sexual violence. Mandatory reporting causes problems in terms of causing barriers to access to care when survivors do not want to report especially in situations of access to abortion. However, this informing is not the equivalent of filing of an FIR.	Section 19 POCSO Section 357 C CrPC
Only government hospitals can be accessed for health care and examination	No All hospitals – public and private – are responsible for providing treatment to the survivors of sexual violence.	Section 357 C CrPC
Provide free treatment to the survivors of sexual violence	Yes Both public and private hospitals are legally bound to provide free of cost treatment to the survivors of sexual violence.	Section 357 C CrPC
Injuries are present in all sexual violence cases	No Only in 33% of survivors there are injuries (WHO 2003) Injuries maybe absent because the survivor maybe: - Unconscious due to trauma - Unconscious due to being drugged or intoxication - Intimidation of survivor or someone dear to her/him - Use of lubrication may minimise injuries Non-resistance by the survivor does not imply consent and absence of injuries as a consequence of non- resistance cannot be construed as consent nor vice-versa	

Only a female doctor can conduct examination of survivors of sexual violence	No - Any doctor can conduct the examination with the consent of the survivor Yes - In the case of children (persons below 18 years) only female doctor can examine a female child survivor.	164 A CrPC Section 27 POCSO
Nothing can be done by the health care facility or health care provider in case of delayed reporting by a survivor	The health care facility / provider regardless of the time duration since the sexual violence, must provide psychological and other health care as required. Medico-legal examination and evidence collection will depend on the time lag and the nature of the assault. The narrative of the survivor is critical and should be recorded as per the proforma/ guidelines, even if examination /evidence collection may not be possible or unavailable (e.g. clothes) due to the time lapse.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014
Commenting on past sexual history, status of hymen	No Only the history relevant to the episode of sexual violence has to be recorded. Similarly, commenting on status of hymen is irrelevant as it can be torn due to several reasons such as cycling, or riding among other things. An intact hymen does not rule out sexual violence, hymen has to be treated like any other part of the genitals.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014
Opining whether rape has taken place or not	No. Rape is a legal term. It is not for the doctor to ascertain whether rape happened or not, or the 'truth' of the case, as that role lies with honourable judiciary and courts. The doctor should give opinion based on the clinical observations, while correlating it with the detailed history of violence as narrated by the survivor.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014
Writing negative opinion in absence of injuries	No The doctor should write in his/her opinion that sexual violence cannot be ruled out and possible reasons for the absence of injuries.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014

Leave the opinion blank in MLC report	No A provisional opinion has to be immediately drafted after the examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor. The opinion must draw an inference between the history of sexual violence and clinical findings.	MoHFW Guidelines and Protocols on Medico legal care for survivors of sexual violence, 2014

The MoHFW Guidelines and Protocol include the following components of a comprehensive response to sexual violence:

- Providing necessary medical support to the survivor of sexual violence.
- Establishing a uniform method of examination and evidence collection by following the protocols. [in the Sexual Assault Forensic Evidence (SAFE) kit]
- Informed consent for examination, evidence collection and informing the police.
- First contact psychological support and validation.
- Maintaining a clear and fool-proof chain of custody of medical evidence collected.
- Referring to appropriate agencies for further assistance (eg. Legal support services, shelter services, etc).

The following guidelines are recommended towards building rapport with the survivors:

- Never say or do anything to suggest disbelief regarding the incident.
- Do not pass judgmental remarks or comments that might appear unsympathetic.
- Appreciate the survivor's strength in coming to the hospital as it can serve to build a bond of trust.
- Convey important messages such as: the survivor is not responsible for precipitating the act of rape by any of her actions or inactions.
- Explain to the survivor that this is a crime/violence and not an act of lust or for sexual pleasure.
- Emphasize that the violence is not a loss of honour, modesty or chastity but a violation of his/her rights and it is the perpetrator who should be ashamed.
- Take the help of a counselor, if required.

What is a SAFE kit? Is it mandatory to use a SAFE kit? How can the health care facility or health care provider procure it?

SAFE kit is Sexual Assault Forensic Evidence (SAFE) Kit consisting of items used for collecting and preserving physical evidence following sexual assault. This Kit can be assembled at the hospital level as the items are commonly available in hospitals or procured through their purchase departments or as per the existing system in the hospital.

Table 7: Safe Kit Includes	
▪ Large sheet of paper to undress over ▪ Paper bags for clothing collection ▪ Catchment paper ▪ Sterile cotton swabs and swab guards for biological evidence collection ▪ Comb ▪ Nail cutter ▪ Wooden stick for finger nail scrapings ▪ Small scissors ▪ Urine sample container ▪ Tubes/ vials/ vaccutainers for blood samples (Ethylenediaminetetraacetic acid – EDTA, Plain Sodium Fluoride) ▪ Syringes and needle for drawing blood	▪ Distilled water ▪ Disposable Gloves ▪ Glass slides ▪ Envelopes or boxes for individual evidence samples ▪ Labels ▪ Lac (sealing wax) Stick for sealing ▪ Clean clothing, hygiene items for survivors to use after examination ▪ Forms for documentation. For example, the proforma by the MoHFW Protocols and Guidelines for Medico-legal care of victims / survivors of sexual violence

The proforma for the medico-legal examination provided in the Guidelines and Protocols is the most critical part of the SAFE Kit. This is the format for documentation of consent, history, examination and evidence collected, opinion, etc.

Ensure that the SAFE Kit that is being used in the health care facility includes the proforma/ documentation format provided by the 2014 Guidelines (Annexure II provides the format for your reference). The survivor must be given all documentation (including that pertaining to medico-legal examination and treatment) free of cost.

One Stop Centres Located in Health Care Facilities

One Stop Centers are expected to provide comprehensive and coordinated care and medico-legal services for ALL survivors of gendered violence including sexual violence, domestic violence child sexual abuse, survivors of acid attack, etc.

One Stop Centres should not be limited to providing health care and other services only for survivors of sexual violence. Thus all necessary resources – infrastructure, human and financial – must be ensured towards an effective one stop centre.

A One Stop Centre should include at the least:

- A separate room / private space, with attached washroom/toilet located in an area that is easily accessible in the health care facility.
- Clear signages in health care facilities guiding survivors or visitors to the One Stop Centre.
- Information resources on laws, guidelines; pamphlets, posters with positive messages of validation for survivors, referral contact details.
- Infrastructure including medicines, SAFE Kit, clothes, toiletries, etc.
- Skilled and adequate human resources – managers, doctors, nurses, counselors, social workers, etc. Prominent Display of names and contact details of team coordinating the One Stop Centre. Ensure a multidisciplinary team comprising of members from emergency and casualty department, obstetrics and gynecology department, pediatrics department, psychiatric department, forensic department available on call as per the requirement.
- Standard operating procedures for the efficient functioning of the Once Stop Centre.
- Documentation registers, formats for medical examination records, Domestic Incident Reports with provisions to provide copies to the survivor.
- Grievance Recording and redressal mechanisms to monitor and continuously update the system functioning towards One Stop Centre.
- Systems for storage and management of information/data and confidential survivor related information.
- Special infrastructure, skills/ human resource to meet special needs of survivors – for example of children, persons with physical, intellectual disabilities, etc.

Health System Response for Survivors of Acid Attack

The Criminal Law Amendment, 2013 include the survivors of acid attack as well within the purview of sexual assault. The Supreme Court of India in the case of Lakshmi versus Union of India issued important and specific guidelines with regard to the role of hospitals in responding to the survivors of acid attack. This judgment of Supreme Court brings in the private hospitals as well to follow the guidelines.

- Full medical assistance should be provided to the acid attack survivors, and private hospitals along with public hospitals should also provide free medical treatment to such survivors.
- No hospital or clinic can refuse treatment citing lack of specialized facilities.
- First-aid must be administered to the victim/survivor and after stabilization, the victim/patient could be shifted to a specialized facility for further treatment, wherever required.
- The hospital where the victim/survivor of acid attack is first treated should give a certificate that the individual is a victim/survivor of acid attack. The victim/survivor may use this certificate for treatment and reconstructive surgeries or any other entitled scheme of the government for acid attack survivors.

(Source: Supreme Court Judgement Lakshmi v/s UOI; available at <http://courtnic.nic.in/supremecourt/temp/wr%20 12906p.txt>)

Section V

Domestic and Sexual Violence Against Children

Sexual violence is experienced by children (persons below 18 years of age) in varied locations - from home to schools, neighbourhoods as well as in prisons, shelter homes, detention centres and other residential institutions outside their homes. A survey report by the Ministry of Women and Child Development in 2007 on child abuse revealed that more than 53 per cent of the children interviewed had been subject to sexual abuse, of which 53 per cent were boys and 47 per cent girls. Nearly 42 per cent of Indian girls have gone through the trauma of sexual violence before their teenage years, according to a survey by United Nations International Children Education Fund (UNICEF) conducted from 2005 to 2013; ten per cent of Indian girls might have experienced sexual violence during 10–14 years of age. Every second child in the country experiences one or the other form of sexual abuse and every fifth child its critical forms. While male children are also affected by sexual violence, girls experience higher rates of violence due to prevalent gender norms and power relations in society.

However, the proportion of sexual violence against children that gets reported is limited and the systems for collation of data and its availability are largely absent. Thus, the estimates of violence against children may not be an accurate reflection of the ground reality.

The children who experience sexual violence have increased risks of adverse outcomes for their health and well-being is well established. The WHO World Report on Violence and Health reports on the immediate and long term health consequences of child abuse.

The Protection of Children from Sexual Offences Act, 2012 (POCSO)[15] provides for mandatory reporting or apprehension regarding sexual abuse of a child. A sexual offence may range from inappropriate touching, fondling, to rape and more severe forms of rape, such as incest or gang rape.

Both men and women can be perpetrators of sexual violence and face criminal charges as per POCSO. Consent to the sexual activity is irrelevant in a POCSO case.

POCSO applies to all children defined as those persons below 18 years of age. The offence would have to be reported to the police in accordance with POCSO. While a domestic violence case can be filed, criminal proceedings would have to be initiated and cannot be avoided.

Children may be referred for examination by the CWC. Health professionals must explain the limitation of medical evidence; thus even if medical evidence of sexual violence is not found, this in no way should be construed as a child lying about sexual abuse.

The Protection of Children from Sexual Offences (POCSO) Act, implemented in 2012, recognise the health system and health care providers as important service providers and mandates the health system and health care providers to provide care and treatment as well as conduct a medico-legal examination of the child survivors of sexual violence. The Act also recognises the significant responsibility of the health care provider in detecting situations of sexual assault amongst children, as health care providers are often the first contact or referral. They are also critical locations for further follow up and referrals for other needs, towards a comprehensive response to the children who have experienced sexual assault and their parents/guardians.

Role of Medical Professionals under POCSO Act:

i. Having an in-depth understanding of sexual victimization

ii. Obtaining a medical history of the child's experience in a facilitating, non-judgmental and empathetic manner

iii. Meticulously documenting historical details

iv. Conducting a detailed examination to diagnose acute and chronic residual trauma and STDs, and to collect forensic evidence

v. Considering a differential diagnosis of behavioural complaints and physical signs that may mimic sexual abuse

vi. Obtaining photographic/video documentation of all diagnostic findings that appear to be residual to abuse

vii. Formulating a complete and thorough medical report with diagnosis and recommendations for treatment

viii. Testifying in court when required

Source: Ministry of Women and Child Development. (September, 2013). Model Guidelines under Section 39 of The Protection of Children from Sexual Offences Act, 2012

The Guidelines and Protocols for medico-legal care for survivors of sexual violence (MoHFW 2014) referred in the previous section provide directions for health care providers in this regard. The guidelines recognise the vulnerability of children and reinforce specific follow up by health care providers.

Child Survivors of Domestic Violence

Children (whether male or female) are entitled to reliefs under the PWDVA, and the woman survivor can make an application on behalf of a minor child.

Some of the principles, guidelines vis-à-vis response for survivors of domestic violence and abuse covered previously in the InfoKit are also relevant for child survivors.

Table 8: Health Impacts of Child Abuse	
Physical ▪ Abdominal/thoracic injuries ▪ Brain injuries ▪ Bruises and welts ▪ Burns and scalds ▪ Central nervous system injuries ▪ Disability ▪ Fractures ▪ Lacerations and abrasions ▪ Ocular damage	**Psychological and behavioural** ▪ Alcohol and drug abuse ▪ Cognitive impairment ▪ Delinquent, violent and other risk-taking behaviours ▪ Depression and anxiety ▪ Developmental delays ▪ Eating and sleep disorders ▪ Feelings of shame and guilt ▪ Hyperactivity ▪ Poor relationships ▪ Poor school performance ▪ Poor self-esteem ▪ Post-traumatic stress disorder ▪ Psychosomatic disorders ▪ Suicidal behaviour and self-harm
Sexual and reproductive ▪ Reproductive health problems ▪ Sexual dysfunction ▪ Sexually transmitted diseases, including HIV/AIDS ▪ Unwanted pregnancy	**Other longer-term health consequences** ▪ Cancer ▪ Chronic lung disease ▪ Fibromyalgia ▪ Irritable bowel syndrome ▪ Ischaemic heart disease ▪ Liver disease ▪ Reproductive health problems such as infertility
(Source: WHO World Report on Violence and Health, 2002)	

The definition of a "child in need of care and assistance" as per the Juvenile Justice Act is broad and includes a destitute child, a child living with a person who is abusive, a child likely to be inducted into drug abuse or trafficking, or a missing child whose parents cannot be found after making a reasonable inquiry.[16]

A child facing domestic violence would also fall under the category of a "child in need of care and assistance" as per the Juvenile Justice (Care and Protection) of Children Act, 2015. A "child in need of care and protection" may be produced before the Child Welfare Committee by any nurse, doctor or management of a nursing home, hospital or maternity home.[17]

However, not every incident of domestic violence would necessitate production of the child before the CWC. For example, in a case where a mother and child were experiencing domestic violence, but the mother left the abusers home in order to safely reside with her relatives may not require intervention by the CWC.

Some suggested guidelines for when to produce a child facing domestic violence before the CWC are:

- In cases where it appears to the medical facility to be in the best interest of the child to change its custody, to remove the child from the family home, or provide a temporary living arrangement for a child.
- In cases where the child is destitute, the child is living with an abusive person, or the child is institutionalized and in need of care and assistance, the child should be produced before the CWC.

The child shall be produced before the Committee without any loss of time but within a period of twenty-four hours excluding the time necessary for the journey.[18]

- Health professionals should communicate to the child the need for the health professional to disclose the abuse to the CWC so that the latter can take immediate steps to protect the child from abuse.

Endnotes

[1.] 'Survivor' when used for women and children who experience gender based violence signifies the recognition of the agency and the capabilities of the person for taking decisions despite having faced victimization, humiliation and trauma as a result of the violence.
[2.] It is important to note that child survivors of violence (especially sexual abuse) may need specialized persons different from those who work with adult women.
[3.] These are merely indicative. Please refer to the Table 2
[4.] 498A. Husband, or relative of husband of a woman subjecting her to cruelty –Whoever, being the husband or the relative of the husband of a woman, subjects such woman to cruelty shall be punished with imprisonment for a term which may extend to three years and shall also be liable to fine.
Explanation – For the purpose of this section, "cruelty" means –
Any willful conduct which is of such a nature as is likely to drive the woman to commit suicide or to cause grave injury or danger to life, limb or health (whether mental or physical of the woman; or harassment of the woman where such harassment is with a view to coercing her or any person related to her to meet any unlawful demand for any property or valuable security or is on account of failure by her or any person related to her to meet such demand.
[5.] In D. Velusamy vs. D. Patchaiammal (2010) 10 SCC 469, the Supreme Court held that a 'relationship in the nature of marriage' requires the following:
The couple must hold themselves out to society as being akin to spouses;
They must be of legal age to marry; They must be otherwise qualified to enter into a legal marriage, including being unmarried; They must have voluntarily cohabited and held themselves out to the world as being akin to spouses for a significant period of time.
[6.] Sandhya Manoj Wankhade v. Manoj Bhimrao Wankhade and Ors MANU/SC/0081/2011
[7.] Rule 8 (vi) of the PWDV Rules, 2006
[8.] Section 9 (g) of the PWDVA
[9.] Rule 17 (3) of the PWDV Rules, 2006
[10.] Rule 17 (4) of the PWDV Rules, 2006
[11.] Shambhu Prasad Singh v. Manjari, Delhi High Court[(190) 2012 DLT 647] , Nand Kishor v. Kavita and Anr. [2010 (1) KHC 852]
[12.] Sharda vs Dharampal AIR (2003) SC 3450
[13.] Bhabani Prasad Jena vs. Orissa State Commission for WomenAIR (2010) SC 2851
[14.] Sharda vs Dharampal AIR (2003) SC 3450
[15.] The Protection of Children from Sexual Offences Act, commonly known as POCSO, was implemented in India in 2012. It is a comprehensive law to provide for the protection of children from sexual assault by safeguarding the interests of the child at every stage of the judicial process by incorporating the child friendly mechanisms for reporting, recording of evidence, investigation, and speedy trial of offences through designated Special Courts.
[16.] Section 2 (14) of the Juvenile Justice Act
[17.] Section 31 (1) of the Juvenile Justice Act
[18.] Section 31 of the Juvenile Justice Act

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Annexures

Annexure I

Format of Domestic Incident Report (DIR) as per PWDVA

Protection of Women from Domestic Violence Rules, 2006 [F-1]

FORM-I

[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 shared household:
   (4) Present Address:
   (5) Phone Number, if any:
2. Details of Respondents:

S.No.	NAME	Relationship with the aggrieved 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 a present residing

4. Incidents of domestic violence:

S. No.	Date, place and time of violence	Person who caused domestic violence	Types of Violence / Physical Violence	Re-marks
			Causing hurt of any kind, please specify	

(i) Sexual Violence

Please tick mark [√] the column applicable

			☐ Forced sexual intercourse ☐ Forced to watch pornography or other obscene material	
			☐ Forcibly using you a entertain others ☐ Any other act of sexual nature, abusing, humiliating, 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 bringing ☐ 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	

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

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

5. 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		

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

S. No.	Orders	Yes/No	Any other detail
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)		

7. Assistance that you need

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

8. Instructions 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 1974).

(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.

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

Place: (Counter Signature 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 II

Medico Legal examination report of sexual violence as per MoHFW Guidelines and Protocols

(Source: Guidelines and Protocols: Medico-legal care for victims/survivors of Sexual Violence)

Medico-legal Examination Report of Sexual Violence

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

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 the survivor.....

(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 blackmailing, etc.) if any: . .....

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

vi. Any other: .....

15 D.

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/s and/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, Forced Manipulation of genitals of assailant by survivor			Y	N		DNK
Exhibitionism (perpetrator displaying genitals) (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
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 is 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/o painful urination/ painful defecation/ fissures/ abdominal pain/pain in genitals or any other part since the incident of sexual violence

16. General Physical Examination-

i. Is this the first

ii. examination --..... Pulse.....

iii. ..... BP .....

iv. Temp. ..... Resp. Rate ..... Pupils

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

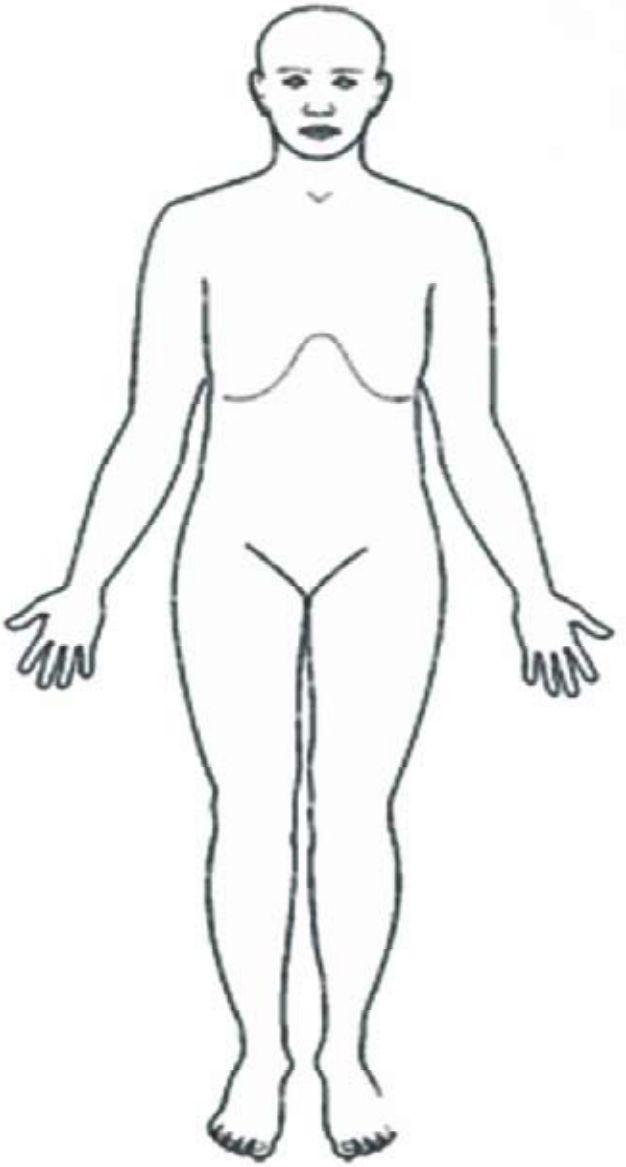
17. Examination for injuries on the body if any

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 specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks) Note the Injury type, site, size, shape, colour, 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 haemorrage 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 limbButtocks	
Other, please specify	

Right Left



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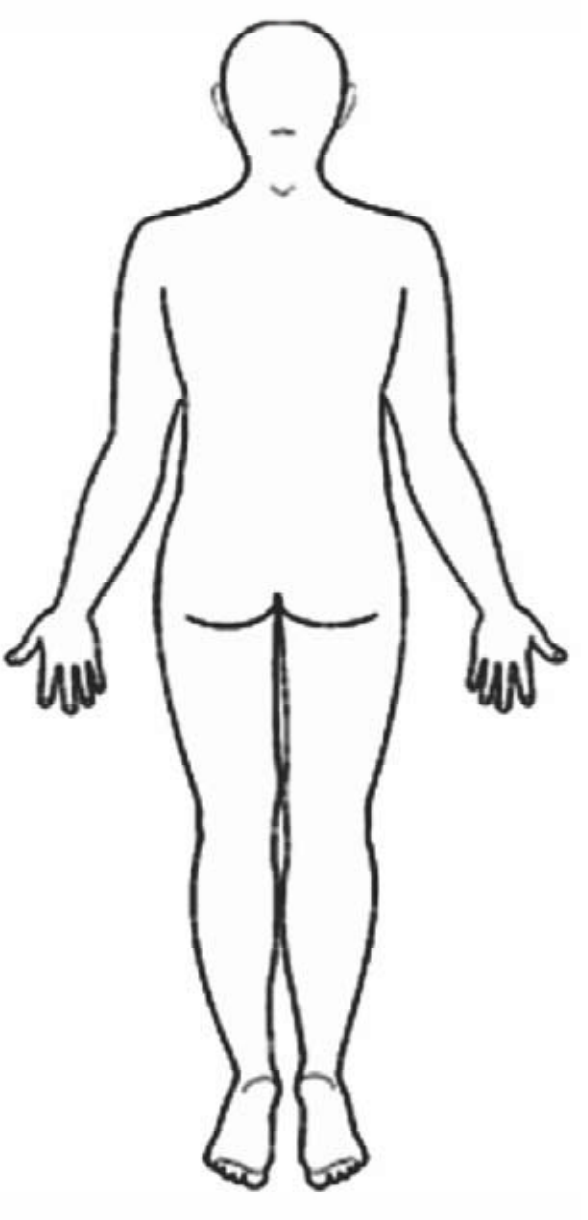

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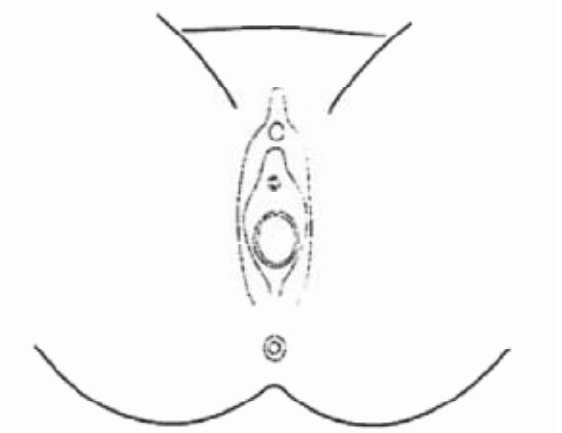

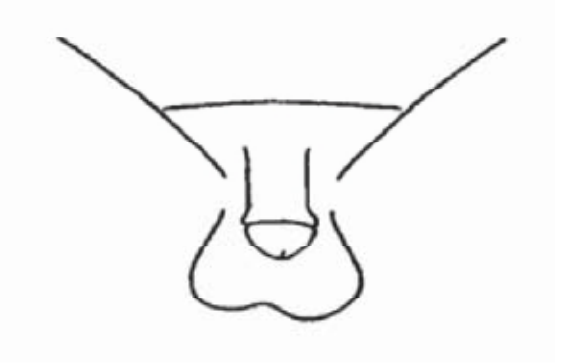

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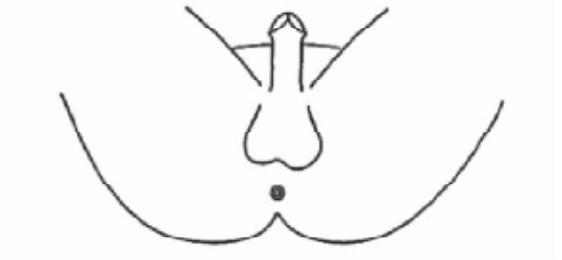


18. Local examination of genital parts/other orifices*:

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: ....

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

1) Debris collection paper
2) Clothing evidence where available - (to be packed in separate paper bags after air drying)

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

3) Body evidence samples as appropriate (duly labeled and packed separately)

Swabs from Stains on the body (blood, semen, foreign material, others)	Collected/Not Collected	Reason for not collecting
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)		

4) Genital and Anal evidence (Each sample to be packed, sealed, and labeled 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 of survivor).....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			
Counselling			
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)

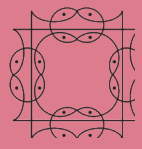
Findings in support of the above opinion, taking into account the history, clinical examination findings and Laboratory reports of ..... bearing identification marks described above, ... hours/ days after the incident of sexual violence, I am of the opinion that:

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



Sama Resource Group for Women and Health

B-45, 2nd Floor, Main Road Shivalik, Malviya Nagar, New Delhi-110017

Ph: 011-65637632/26692730

sama.genderhealth@gmail.com • www.samawomenshealth.in