

Guidelines For Health Facilities

TO PROVIDE QUALITY ESSENTIAL SERVICES
TO SURVIVORS OF DOMESTIC VIOLENCE





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**TO PROVIDE QUALITY ESSENTIAL
SERVICES TO SURVIVORS OF
DOMESTIC VIOLENCE**

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FOREWORD

BEFORE JUSTICE GITA MITTAL (RETD.)

CHAIRPERSON,
BROADCASTING CONTENT
COMPLAINTS COUNCIL

FORMER CHIEF JUSTICE,
HIGH COURT OF JAMMU & KASHMIR
INDIA

FORMER ACTING CHIEF JUSTICE,
HIGH COURT OF DELHI
INDIA

FOREWORD

From every wound there is a scar, and every scar tells a story. A story that says, "I survived."

-Craig Scott

It is recognised that the scars from domestic violence can be physical; or emotional and they last lifetimes. Domestic violence, an issue of discrimination against women, is widely prevalent across communities. The recent estimates from National Family Health Survey (2019- 20) show that about one in three women aged 18 to 49 years have ever experienced some form of spousal or partner violence in their lifetime. It stands recognised as a public health issue where the health system has a crucial role to play to mitigate the impact of violence on women.

In India, the Protection of Women from Domestic Violence Act (PWDVA), 2005 gave statutory recognition to a domestic relationship meaning two persons living in a shared household including persons related by marriage or through a relationship in the nature of marriage, etc. It also recognized violence in such relationships and cast a specific responsibility on health professionals to treat and respond to women and children facing it. The law declares medical institutions as 'service providers' and lays down specific responsibilities of healthcare providers in responding to domestic violence. The National Health Policy of India, 2017 has also called for efforts to build capacities of healthcare providers in providing free and sensitive care to address all forms of violence against women. Yet the response of health systems to domestic violence against women in India remains fragmented. There are few formal models of health systems' response to domestic violence, most of which stand initiated by civil society organisations.

The Centre for Enquiry into Health and Allied Themes has done exemplary work in the field of violence against women in India. CEHAT's concerted efforts have resulted in establishment and upscaling of *Dilaasa- hospital – based counselling department* for survivors of violence in 11 peripheral hospitals of Mumbai. The organisation has contributed to development and implementation of much needed guidelines for the medico- legal examination and treatment of sexual violence survivors. CEHAT's model

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on health systems' response to violence against women has now been adopted and implemented by more than 10 states of India. CEHAT has facilitated trainings of doctors in matters of sexual violence.

It is heartening to know that CEHAT has now attempted to mainstream the response of health system to domestic violence by development of formal Guidelines for ensuring that health facilities provide quality essential care to survivors of domestic violence. The Guidelines stand developed through a consultative process in conjunction with experts from the fields of law, medical sciences, women's health, and hospital administration.

These evidence-based Guidelines fill the important gap in policy and "how to implement" by outlining a minimum standard of quality of care that every health facility should provide to survivors of domestic violence. These Guidelines provide an important tool to the health facilities to monitor their progress towards addressing domestic violence under law and shall also be useful to implement the mandatory standards for providing care to survivors of domestic and sexual violence under National Quality Assurance Standards (2017) for public health facilities.

I highly recommend all health facilities, private and public, to implement these Guidelines thereby ensuring the needed health systems' response to domestic violence.


(Gita Mittal)

PREFACE

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Protocol for Health Sector to Respond to Domestic Violence

Preface

India, like many other countries, faces significant challenges in achieving the Sustainable Development Goals (SDGs) related to Intimate partner violence. The SDG 5.2 aims to eliminate all forms of violence against women and girls, including in the context of intimate partner relationships, by 2030.

National Family Health Survey (NFHS-5) conducted in 2019-2020, indicates that 29.3% women in the age group of 15-49 years in India have suffered spousal violence at least once in their lifetime. Domestic violence (DV) is the most pervasive form of violence against women, requiring a concerted effort from all the stake holders including the health system along with the other ministries of the government.

Majority of women silent suffer domestic violence considering it as part of their destiny. Doctors, nurses or other health providers are often the first point of contact for those facing violence. Healthcare providers are in a unique position to identify signs of abuse, provide medical treatment, and offer psychological first aid. Moreover, healthcare professionals can also play a crucial role in preventing future instances of violence by assisting women about healthy relationships, seeking timely help and providing information about available resources, such as counselling and legal services. There is clear evidence of the impact of violence on women's health and so the health care response becomes critical for addressing issues of violence against women and children.

The protocol and guidelines for the health sector to respond to domestic violence are an important piece of evidence-based work enabling HCPs at primary, secondary and tertiary levels to create a comprehensive response. This protocol has been developed through a consultative process with experts from the field of public health, medicine, women's rights advocates and lawyers. It comprehensively includes guiding principles; essential health services packages, identifying domestic violence from symptoms and clinical presentation, assessment and treatment. Sections are devoted to ethical and medico legal issues, health facility readiness at primary, secondary and tertiary level including public as well as private health sector. The infra structure required, drugs and supplies, financing, monitoring and accountability have been detailed. Protocol also includes action in special cases as well as self-care for health care providers.

The clinical and policy guidelines by WHO in 2013 also recommended that ministries of health must adopt a variety of models for provision of care at different levels of the health system, rather than being bogged down with a single model for the entire country. This protocol therefore fits in for variety and complexity of health systems in India and guide health administrators to integrate domestic violence response within clinical care at all levels, from primary to tertiary.

I recommend the dissemination of these guidelines and protocol across public and private health sector so that Health Care Professionals are made aware of clinical and methodical steps to assist survivors of domestic violence in keeping with their ethical and legal mandates in India



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PREAMBLE

The purpose of these guidelines is to establish and strengthen a health systems response to domestic violence (DV). Women facing violence come in frequent contact with the health system for care. This provides a crucial opportunity for the health system to identify DV survivors early and prevent further harm or death due to violence. However, healthcare providers (HCPs) do not always recognise their critical role in responding to survivors of violence.

This document provides evidence-based guidelines to establish quality essential services for survivors of DV at all levels of healthcare delivery, within a framework of guiding principles.

The guidelines are focused on public hospitals but are also relevant for the private sector. They can be used by healthcare administrators including medical superintendents, medical officers, heads of departments, and providers with supervisory roles at all levels of the health system.

The guidelines are organised into six sections. Section One establishes the need for the health system to respond to DV, and lays down the objectives of the guidelines. Section Two describes the guiding principles to be followed by all health facilities while providing care to survivors. The minimum services to be provided to survivors of DV are described in detail in Section Three. Section Four provides guidance to healthcare administrators on how to establish a facility response by strengthening health facilities and setting up training and monitoring mechanisms. Section Five describes the mechanisms required to hold health systems accountable for their response to DV. Section Six gives guidelines for specific cases of clinical enquiry, and Section Seven gives guidelines for providers' self-care.





SECTION ONE: BACKGROUND

Violence against women (VAW) is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life"¹. Such an act may be carried out within the home, in the community or by the State (such as custodial torture, violence against refugees, or rape by government officials during war or ongoing conflict).

Violence against women is legitimised by social norms, beliefs and institutions. Women with disabilities, those from marginalised communities, transwomen, bisexuals, and women in same sex relationships are more vulnerable to violence. Women with disabilities are found to be more vulnerable to violence from their partners and families because they may not be physically and financially independent and may have less access to social services². Queer and transgender women face violence from their parental families because of their sexual orientation and gender identity respectively. The available evidence is that the prevalence of partner violence in same sex relationships is the same as or higher than that in heterosexual relationships³.

The term "domestic violence" refers to violence faced by women from family members or individuals residing in shared households⁴.

In India, domestic violence is defined in Section 3 of The Protection of Women from Domestic Violence Act, 2005 (PWDVA, 2005)⁵.

Any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it:

(a) harms, injures, endangers the health, safety, life, limb or well-being, whether

¹ United Nations. (2003, December). *Declaration on the elimination of violence against women*. <https://www.ohchr.org/sites/default/files/eliminationvaw.pdf>

² Daruwalla, N., Chakravarty, S., Chatterji, S., Shah More, N., Alcock, G., Hawkes, S., & Osrin, D. (2013). Violence against women with disability in Mumbai, India: A qualitative study. *SAGE Open*, 3(3). <https://doi.org/10.1177/2158244013499144>

³ Messinger, A. M. (2011). Invisible victims: Same-sex IPV in the national violence against women survey. *Journal of Interpersonal Violence*, 26(11), 2228–2243. <https://doi.org/10.1177/0886260510383023>

⁴ Sahoo, H., & Raju, S. (2007). Domestic violence in India: Evidences and implications for working women. *Social Change*, 37(4), 131–152. <https://doi.org/10.1177/004908570703700407>

⁵ Ministry of Women and Child Development. (2005). *The Protection of Women from Domestic Violence Act (PWDVA), 2005*. Government of India.

mental or physical, of the aggrieved person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse & economic abuse; or
(b) harasses, harms, injures or endangers the aggrieved person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
(c) has the effect of threatening the aggrieved person or any other person related to her by any conduct mentioned in clause (a) or clause (b); or
(d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person.

Magnitude of domestic violence

In India, the National Family Health Survey (NFHS) is the only source of household level data on DV. The latest round (NFHS-5) reported that about 29% of ever married women in the age group of 18-49 years mentioned violence from their husband⁶. The survey reported an increase in women's experience of physical violence with age; 16% of women aged 18-19 years compared to 32% of women age 40-49 years reported violence. Physical violence was mentioned more commonly by women in rural areas (31%) as compared to women in urban areas (24%).

The National Crimes Records Bureau data in "Crime in India-2021" showed that almost one-third of all crimes against women were categorised under 'cruelty by husband or his relatives'⁷.

The evidence on DV against women with disabilities is primarily from cross-sectional studies. A study in Mumbai in 2013 among women in the age group 15-49 and with a disability found that 20% of ever-married women reported facing physical violence from their intimate partner⁸. Another study in a southern state of India found about 48% of women with learning disabilities faced DV⁹.

The NFHS does not provide disaggregated data on violence against women with disabilities, despite their increased vulnerability. The paucity of data on violence calls for specialised national level surveys to provide estimates on violence faced by women with disabilities and by people with non-binary identities.

⁶ International Institute for Population Sciences (IIPS) and ICF. *National Family Health Survey (NFHS-5), 2019-20*. Mumbai: IIPS

⁷ The National Crime Records Bureau (NCRB), under the Ministry of Home Affairs, Government of India, collects and analyses all data on crime as defined by the IPC.

⁸ Daruwalla, N., Chakravarty, S., Chatterji, S., Shah More, N., Alcock, G., Hawkes, S., & Osrin, D. (2013). Violence against women with disability in Mumbai, India: A qualitative study. *SAGE Open*, 3(3). <https://doi.org/10.1177/2158244013499144>

⁹ Mohapatra, S., & Mohanty, M. (2005). *Abuse and activity limitation: A study on domestic violence against disabled women in Orissa, India*. Oxfam

1.1 FORMS OF DOMESTIC VIOLENCE

The PWDVA Act, 2005, defines various forms of DV:

- (i) “physical abuse” means any act or conduct which is of such a nature as to cause bodily pain, harm, or danger to life, limb, or health or impair the health or development of the aggrieved person and includes assault, criminal intimidation and criminal force;
- (ii) “sexual abuse” includes any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of woman¹⁰.
- (iii) “verbal and emotional abuse” includes:
 - (a) insults, ridicule, humiliation, name calling and insults or ridicule specially with regard to not having a child or a male child; and
 - (b) repeated threats to cause physical pain to any person in whom the aggrieved person is interested.
- (iv) “economic abuse” includes:
 - (a) deprivation of all or any economic or financial resources to which the aggrieved person is entitled under any law or custom whether payable under an order of a court or otherwise or which the aggrieved person requires out of necessity including, but not limited to, household necessities for the aggrieved person and her children, if any, *stridhan*, property, jointly or separately owned by the aggrieved person, payment of rental related to the shared household and maintenance;
 - (b) disposal of household effects, any alienation of assets whether movable or immovable, valuables, shares, securities, bonds and the like or other property in which the aggrieved person has an interest or is entitled to use by virtue of the domestic relationship or which may be reasonably required by the aggrieved person or her children or her *stridhan* or any other property jointly or separately held by the aggrieved person; and
 - (c) prohibition or restriction to continued access to resources or facilities which the aggrieved person is entitled to use or enjoy by virtue of the domestic relationship including access to the shared household.

¹⁰ Marital rape is not criminalised in the Indian legal system. However, the PWDVA Act, 2005, recognises sexual violence within marital relationships irrespective of the age of the wife, and offers a civil remedy for a complaint of sexual violence.

1.2 DOMESTIC VIOLENCE- A PUBLIC HEALTH ISSUE

Domestic violence is a public health issue with immediate and long-term health and social consequences for survivors. It has a detrimental impact on the physical and mental health of women¹¹. The acute and chronic health consequences of violence include injuries, cuts, bruises, loss of appetite, poor nutrition, insomnia, sexually transmitted infections, unwanted pregnancies, miscarriages, and suicidal ideation¹².

The health system has recognised the need to play a critical role in responding to survivors of DV¹³. HCPs often come in contact with survivors of DV while treating them for mental and physical injuries¹⁴. A health facility is usually the first and only point of contact for women after experiencing violence¹⁵. HCPs can also play a critical role in primary prevention of violence by raising awareness of DV and ensuring proper documentation of cases of violence. Such evidence of the extent of DV will support the development of government programmes for its prevention. A health facility-led or an HCP-led intervention is likely to be accepted by survivors of violence¹⁶.

There are various entry points within health facilities for survivors of violence. Primary health facilities are the earliest point of contact for women seeking maternal and child health services. Women with injuries, and sexual violence survivors, most commonly present in the emergency departments of health facilities. Several other departments

¹¹ Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, 371(9619):1165–72. [https://doi.org/10.1016/S0140-6736\(08\)60522-X](https://doi.org/10.1016/S0140-6736(08)60522-X)

¹² Bacchus, L. J., Ranganathan, M., Watts, C., & Devries K. (2018). Recent intimate partner violence against women and health: A systematic review and meta-analysis of cohort studies. *BMJ Open*, 8. <http://dx.doi.org/10.1136/bmjopen-2017-019995>

¹³ García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet*, 385(9977), 1567–1579. [https://doi.org/10.1016/S0140-6736\(14\)61837-7](https://doi.org/10.1016/S0140-6736(14)61837-7)

¹⁴ Deosthali-Bhate, P., Rege, S., Pal, P., Nandi, S., Bhatla, N., & Kashyap, A. (2015.). *Role of the health sector in addressing intimate partner violence in India*. International Centre for Research on Women.

¹⁵ Chattopadhyay, S. (2019). The responses of health systems to marital sexual violence: A perspective from Southern India. *Journal of Aggression, Maltreatment & Trauma*, 28(1), 47–67. <https://doi.org/10.1080/10926771.2018.1494235>

¹⁶ Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L., & Feder, G. (2002). Should health professionals screen women for domestic violence? Systematic review. *BMJ*, 325(7359), 314. <https://doi.org/10.1136/bmj.325.7359.314>

of health facilities are accessed by women for health complaints resulting from violence. The table presents potential entry points for women across all the levels of the health system.

TABLE 1. ENTRY POINTS IN HEALTH FACILITIES FOR SURVIVORS

- Outpatient department: antenatal care, immunisation
- In-patient department: medicine, surgery, post-natal care
- Obstetrics and gynaecological department
- Emergency care department
- Orthopaedics department
- Ear, nose and throat department
- HIV testing
- DOTS centre (Directly Observed Therapy for the treatment of tuberculosis)
- Social work/community development department

However, HCPs often believe that their role is restricted to clinical treatment of disease and the physical manifestations of violence, without addressing the root cause of survivors' health complaints. Such a purely biomedical approach from health professionals is insufficient and does not provide a facilitative environment for survivors to disclose DV. Moreover, HCPs are not equipped to provide care to gender non-binary people, and have pathologised all identities which do not conform to the cis-gender heterosexual norm.

There are also certain sociocultural notions, beliefs and attitudes shared by HCPs that tend to give sanction to male dominance, and justify and reinforce violence against women—such as blaming women for the violence that they face, considering

violence to be a part and parcel of married life, and believing that the woman must have provoked the violence. It is important for HCPs not to trivialise or excuse violent behaviour. They need to understand that DV is a public health issue and not a private matter.

The PWDVA which came into force in 2005 placed a specific responsibility on health professionals to treat and respond to women and children facing DV. The Act has identified a "medical facility" as a service provider in the implementation of the Act, and describes a medical facility's responsibilities to women facing domestic violence. According to the Act, a medical facility cannot refuse treatment to the aggrieved woman under any circumstances (Section 7 read with Rule 17). Furthermore, the person in charge of the medical facility is required to make a "domestic incident report" if one has not already been made, and forward the report to the Protection Officer in that area.

The National Health Policy, 2017, mentions the need to build health professionals' capacities to address all forms of gender-based violence and to make provisions for free and sensitive healthcare¹⁷. Thus, there is a supportive legal and policy environment to articulate the role of HCPs in India.

In 2013, World Health Organization published evidence-based clinical and policy guidelines on strengthening the role of health systems to respond to intimate partner violence. There has been progress in some high-income countries in articulating the role of the health system and building the capacity of providers to respond to domestic violence¹⁸. However, little has been done in low- and middle-income countries in this context due to several individual and system-level barriers.

¹⁷ Ministry of Health and Family Welfare. (2017). *National Health Policy - 2017*. Government of India.

¹⁸ World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. <https://apps.who.int/iris/handle/10665/85240>

1.3 HEALTH SYSTEMS' RESPONSE TO DOMESTIC VIOLENCE IN INDIA

Though the health sector has been slow to respond to DV in India, some progress has been noted in the last decade as is evident from an effort to document the health systems response¹⁹.

In India, the health systems response to DV has been spearheaded by non-government organisations (NGOs) engaging at different levels of the health system. The *Dilaasa* model is the first health systems based response to VAW, including domestic violence and sexual violence, in India. It was established as a department of a public hospital in 2000 by the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai. The model focuses on institutionalising the response to DV by building the capacity of HCPs, and providing support services through a hospital-based crisis intervention department. It has been recognised as an evidence-based scalable model in the context of low and middle income countries, and has been replicated in several Indian states. It was integrated in the National Urban Health Mission, Mumbai and was scaled up in 11 peripheral hospitals in Mumbai in 2014.

There are several initiatives established by NGOs and a few by state governments that integrate the health systems response at the primary, secondary and tertiary levels in both rural and urban areas²⁰. These models range from using existing hospital resources such as infrastructure and personnel to allocating specific resources through the National Health Mission programme of the Ministry of Health and Family Welfare. Community health workers such as Accredited Social Health Activists (ASHAs) and Auxiliary Nurse Midwives (ANMs) have been involved at the primary level in creating awareness among women about DV and the services available for survivors.

¹⁹ Rege, S., Bhate-Deosthali, P., & Ravindran, T. K. S. (Eds.). (2020). *Violence against women and girls: Understanding responses and approaches in the Indian health sector*. Routledge India. <https://doi.org/10.4324/9780429285462>

²⁰ Arora, S., Thomas, D., Bhate-Deosthali, P., Baxi, A., & Rege, S. (2021). *Scaling up the health-systems response to violence against women: A review of the implementation of Dilaasa crisis centres in 11 public hospitals in Mumbai*. Centre for Enquiry Into Health and Allied Themes.

All the health systems based initiatives include building the skills of HCPs to identify women facing violence, and providing women services, including legal aid, shelter and assistance in registering police complaints. These are provided by civil society organisations. Recently, implementation research carried out in three tertiary health facilities of Maharashtra showed that capacity building of HCPs, along with system strengthening, can enable HCPs to provide a comprehensive response to survivors²¹.

1.4 NEED FOR GUIDELINES AND PROTOCOL FOR ESTABLISHING HEALTH SYSTEMS' RESPONSE TO DOMESTIC VIOLENCE

Standard protocols to provide guidance to health facilities and HCPs are important to strengthen service delivery. The lack of a uniform protocol is one of the key system-level barriers to effective health systems response to DV. A uniform protocol for responding to DV will be instrumental in implementing HCPs' legal mandate. In the case of DV, there has been no progress in the creation of a protocol and guidelines for comprehensive care to women. The present document is an attempt to fill this gap and focuses on setting a standard of quality of care for establishing a health systems response to DV.

PURPOSE

This document provides evidence-based guidance to healthcare administrators for establishing essential health services for survivors of DV at all three levels of health systems. It instructs healthcare administrators in the implementation of vital

²¹ World Health Organization, Centre for Enquiry into Health and Allied Themes, & Human Reproduction Programme. (2021). *Scaling up the health system response to violence against women: Lessons from hospital interventions in Maharashtra, India: Research Brief*. New Delhi: World Health Organization.

elements of a health systems response to survivors of DV. The protocol will assist HCPs in mitigating the impact of violence, and fulfilling their responsibility according to Indian law. This protocol is focused on responses to DV including sexual violence within marriage.

OBJECTIVES

The objectives of the guidelines are:

1. To assist healthcare administrators in establishing, improving and monitoring health systems response to DV;
2. To equip HCPs of all cadres at the primary, secondary and tertiary levels to respond to DV through early identification, provision of first-line support, referral services, and documentation of cases of violence;
3. To equip HCPs to integrate enquiry into and documentation of violence into their routine clinical practice.



SECTION TWO: GUIDING PRINCIPLES FOR ESTABLISHING A QUALITY ESSENTIAL HEALTH SERVICES PACKAGE

Essential health services in the context of DV are those minimum services that must be provided to a survivor of DV who reaches a health facility of any level -- primary, secondary and tertiary. Certain principles must be followed in order to maintain the quality of these essential health services for the rights, safety and well-being of DV survivors. This section provides a description of these guiding principles.

2.1 GUIDING PRINCIPLES

All HCPs within a health facility should follow a set of basic principles when providing services to survivors:

- **A SURVIVOR-CENTRIC APPROACH:** This includes the right to the highest attainable standard of health and the right to self-determination. Women are entitled to make their own decisions, including sexual and reproductive decisions; to refuse medical procedures, and/or to take – or refuse to take --legal action. Thus, care to survivors of violence should be provided in a manner that facilitates making their own informed choices. HCPs should inform survivors in detail about the available services and procedures. Consent should be taken from the survivor while providing services including treatment, support services and referrals. In the case of referrals, information about the survivor should be disclosed only after seeking the survivor's consent. The survivor should also be informed about the information that will be recorded in medical records, and her consent should be sought for the same. The HCP should respect the survivor's informed refusal.

- **AVAILABILITY:** There should be adequate human resources, infrastructure and supplies for quality and effective delivery of essential health services. Resources in the form of protocols, guidance documents, modules for building capacity of HCPs, documentation formats, referral directories, and resource materials such as leaflets for distribution, and infographics and posters to be put up on the hospital should be available. There should be sufficient stocks of supplies for medico-legal examination and evidence collection in cases of sexual violence (following the Ministry of Health and Family Welfare or MoHFW protocol), and medicines for emergency contraception, abortion care, and HIV and sexually transmitted infection (STI) prophylaxis. Within the health facility, there should be a safe, private space for ensuring confidentiality of survivors of violence. A mental health professional or a trained staff member should be available for mental health assessment and care. The facility should have established mechanisms of referral for support services outside the health facility.

- **ACCESSIBILITY:** Survivors should be able to get essential health services when needed without facing physical, financial, administrative, social, and information barriers. These services should be provided to survivors within health facilities, and integrated into existing health services, rather than provided as stand-alone services. They should be available at all levels of health facilities, but priority should be given to integrating first-line support (see Table 8 on LIVES, the components of first-line support) at the primary level. This facilitates immediate and wider accessibility for survivors of violence.

Referral systems should be developed keeping in mind the accessibility of services in terms of the distance, availability of transport, and cost involved. The facility should offer safe and accessible means for follow-up during subsequent medical care. All essential services must be affordable for all people, including survivors of violence. Under The PWDVA, 2005, government medical facilities cannot refuse to provide medical aid to survivors of violence. Further, according to MoHFW guidelines, survivors of sexual violence should be provided free medical aid by government facilities. The guidelines also emphasise that private hospitals should do the same under their corporate social responsibility programmes. Health facilities should have mechanisms for community outreach to spread awareness among women about the availability of services for survivors of violence with the health facility.

- **ACCEPTABILITY:** All survivors of violence should be treated with dignity and respect, and providers should take into account survivors' culture, social vulnerabilities and specific health needs. Providers need to be objective and fair, and provide care without discriminating on the basis of age, class, caste, marital status, religion, disability sexuality, and any other marginalised status. Providers should adopt a non-judgmental attitude towards women facing violence and should provide services in a way that conveys the message that violence is unacceptable.
- **ENSURING PRIVACY, CONFIDENTIALITY, AND SAFETY:** Services to survivors within health facilities should be provided in private, with confidentiality and safety ensured. HCPs should express concern about the well-being and safety of survivors; their primary concern should be restoring and maintaining the safety of survivors while providing care.

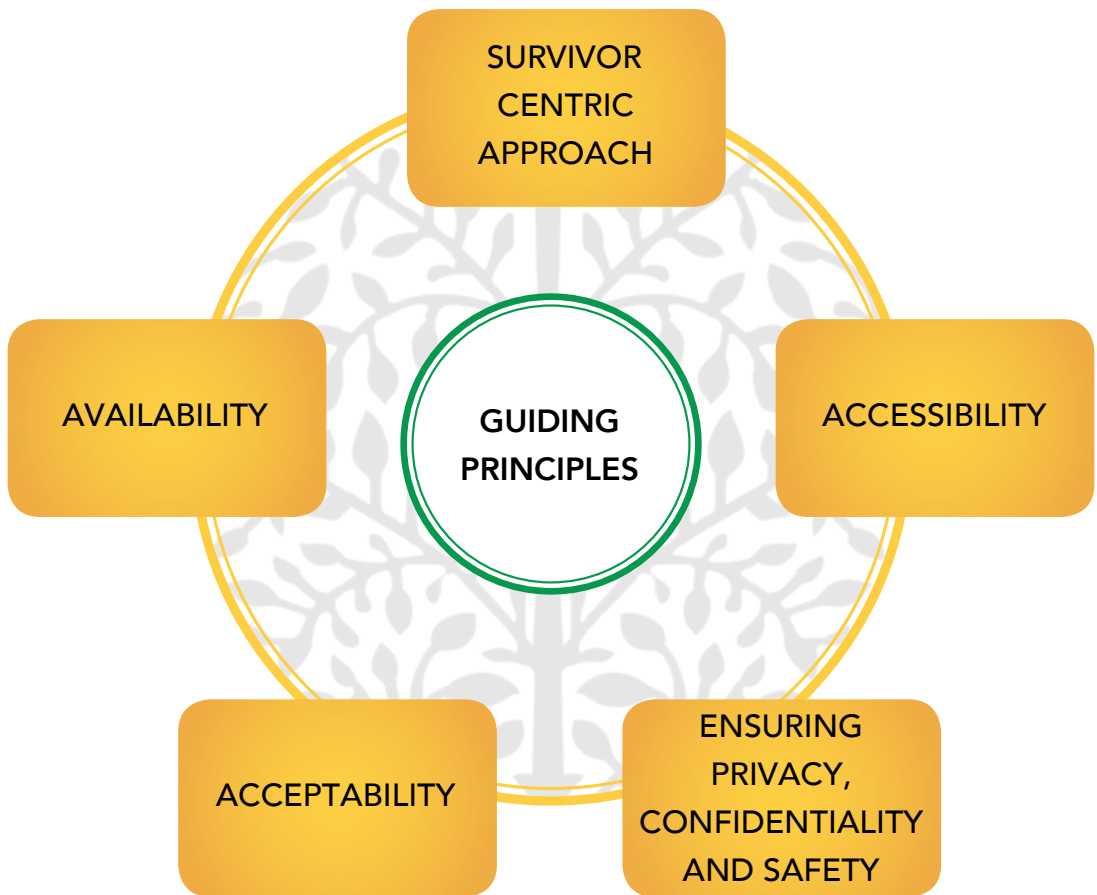


FIGURE 1. GUIDING PRINCIPLES

2.2 ESSENTIAL HEALTH SERVICES

The minimum required services to secure human rights, safety and well-being of survivors of DV include:

- Identification of survivors of DV;
- Provision of first-line support;
- Care for injuries;
- Urgent and long-term medical treatment for presenting health conditions;
- Examination for collection of evidence of sexual violence and care for injuries due to sexual violence;
- Mental health assessment and care;
- Medico-legal documentation of information;
- Referrals to support services; and
- Community outreach

These are mentioned in detail in the SECTION THREE





SECTION THREE: ESSENTIAL HEALTH SERVICES PACKAGE

Facilities at the three levels of the health system – primary, secondary and tertiary – should be strengthened alongside capacity building of providers to identify women facing DV, providing them first-line support and medical care, and conducting medico-legal examination and documentation. If these minimum requirements for sexual violence examination and mental health assessment and care cannot be met, providers should refer survivors to higher facilities. This section provides details of an essential services package within a health facility for survivors of DV.

3.1 IDENTIFICATION OF CASES OF VIOLENCE AS PART OF CLINICAL ENQUIRY

HCPs within health facilities at all three levels should be trained to be proactive in asking women with certain complaints if they are facing violence. These providers include doctors, nurses, social workers, and counsellors.

- HCPs must look for signs and symptoms that might indicate violence in all patients they see, at both in-patient departments and out-patient departments (OPDs).
- HCPs should ask women about violence as a part of the clinical enquiry only when specific health complaints are reported. Universal screening or routine enquiry²² is unviable in resource-constrained settings with high prevalence of DV and limited referral support services.
- Universal screening or routine enquiry about violence is advisable only in antenatal and mental health settings, and is warranted by the increased vulnerability of women due to pregnancy or mental health status. The minimum requirements to be met before the HCP can actually ask about violence are given in Table 4.

²² Universal screening or routine enquiry includes asking all women at all encounters within the health facility, whether they have faced violence.

A. HEALTH COMPLAINTS ASSOCIATED WITH VIOLENCE

- Women facing violence come to a medical facility with “health consequences” or health conditions, health complaints or injuries, and there are common patterns of injury associated with DV.
- The most common of these are injuries due to assaults, and suicide attempts by consumption of poison or setting oneself on fire. Unwanted pregnancies, repeated pregnancies, reproductive health complaints, and STIs may also be indications that a woman is being subjected to violence.
- The table below lists some health complaints associated with violence. These symptoms are categorised department-wise and work as a ready reckoner for HCPs. The list is not exhaustive but serves as a guide for HCPs to consider the possibility that health complaints may be signs of violence. When recording a woman’s medical history, the following signs and symptoms can be indicators that she may be in a violent relationship.

What are some of the signs and symptoms that can help you in identifying women facing domestic violence?

Gynaecology/ Obstetrics	Medicine	Casualty	Pediatric	Surgery
<ul style="list-style-type: none"> • History of assault • Repeated Pregnancy • Repeated birth of girl child • Spontaneous abortions • MTP cases • Reversal of TL • Unwed mothers/ Pregnant widows • Chronic Leukorrhoea • Post-partum psychosis • Injury marks on labia, breast, and/or other sexual organs • Abruption of placenta • Pelvic Inflammatory Disease • Infertility • Multiparity • All ANC/cases • History of fall during pregnancy 	<ul style="list-style-type: none"> • History of consumption of poison • Breathlessness • Fainting spells • Swelling/tenderness • Repeated health complaint with normal reports • Chronic Anemia • Constant body ache, headache, and/or backache • Sudden weight loss • Tuberculosis (TB) • Pyrexia of unknown origin • Chronic patch of TB • Convulsions • Irritable Bowel Syndrome • Loss of appetite 	<ul style="list-style-type: none"> • Assault • Poisoning / Attempted Suicide • Burns • Fractures • Falls • Pregnancy with history of fall / assault • Women with unexplained bruises, CLW, lacerations, and/or abrasions • Repeated health complaints despite normal reports 	<ul style="list-style-type: none"> • Child abuse (all cases) • Sexual abuse • Lack of concentration • Chronic abdominal pain • Repeated headaches • IW, contusion, lacerations, bruises • White discharge prior to attaining puberty • Burning micturition • Child not breast-fed • Bed-wetting • Anemia 	<ul style="list-style-type: none"> • History of assault • Abdominal trauma • Burns • Reporting Falls • All women with IW, Contusion, lacerations, and/or bruises
				Skin
				<ul style="list-style-type: none"> • STIs • RTI • HIV+ and AIDS patients • Repeated allergies • Eczema/Eczematous change • Allergic rashes around the neck, thighs, waist, and/or forehead • Fungal infection
		Psychiatry	ENT	Dentistry
	Orthopaedic	<ul style="list-style-type: none"> • Depression • Insomnia • Attempted Suicide • Anxiety / tension • Self harm • Obsessive Compulsive Disorder • Eating disorders • Substance abuse • Repeated health complaints 	<ul style="list-style-type: none"> • Perforated eardrum • All injuries and fractures • Locked jaw • H/o reduced hearing capacity • Chronic discharge from ears • Sudden loss of voice • Difficulty in swallowing 	<ul style="list-style-type: none"> • Jaw fracture • Broken teeth
Ophthalmology			VCTC	
<ul style="list-style-type: none"> • Eye injury • Bruised eye 	<ul style="list-style-type: none"> • All fractures • All falls/assaults at home • Minor sprains • Ligament injury • Contusions • Chronic ache in back, shoulder, neck 		<ul style="list-style-type: none"> • All HIV+ cases • All remaining patients 	

TABLE 2. Health complaints that should lead the health provider to consider whether the woman is either facing domestic violence or is at risk of domestic violence

Some non-specific clinical signs that can be due to violence include repeated headaches, lethargy, sleep disturbances, anxiety, weight loss, and loss of appetite. There are several non-clinical signs that may indicate that the woman is facing violence. A delay in seeking healthcare such as antenatal care, or a failure to follow TB treatment or anti-retroviral therapy, can indicate that the woman is facing violence at home. Emotionally disturbed women approaching a health service, women getting admitted to a health service without a companion, and women giving an inconsistent medical history, can be facing violence.

Recognition of these signs by providers can result in early identification of women facing violence.

TABLE 3. NON CLINICAL SIGNS OF VIOLENCE²³

- Delay in seeking care;
- Unaccompanied women patients in the in-patient department;
- Non-adherence to treatment;
- Unmarried pregnant women;
- Lack of access to important documents like ID proofs;
- The demeanour of the woman while consulting with the HCP;
- Inconsistent medical history given by the woman or her abuser or other person accompanying her;
- Any indication from the survivor that she is afraid of disclosing her HIV status to her partner;
- Request for contraception, or change of contraceptives, while indicating that the husband/partner should not learn about this request;
- Intrusive relatives/family members.

²³ Centre for Enquiry into Health and Allied Themes. (2012). *Establishing a comprehensive health sector response to sexual assault*.

B. ASKING ABOUT DOMESTIC VIOLENCE

The guidelines for asking about abuse and providing first-line support are based on WHO's Clinical and Policy Guidelines, 2013²⁴.

It is the HCP's duty to identify signs and symptoms of violence against a woman and encourage her to report the violence and seek care. HCPs need training to develop the skills necessary to ask women to speak about abuse. The different approaches and steps to integrate asking about abuse into the clinical enquiry are discussed in Tables 5, 6 and 7. Most importantly, certain minimum requirements must be met before a provider may probe about abuse.

TABLE 4. MINIMUM REQUIREMENTS FOR ASKING ABOUT ABUSE

- A standard operating protocol (SOP) describing the steps to be followed by the HCP;
- Training on how to ask about violence and providing first-line support;
- Availability of a private setting: the HCP must exercise caution in asking about abuse if the woman is accompanied by family members, and must ensure that privacy is provided to survivors;
- Guarantee of confidentiality: the HCP must assure the survivor that the information she gives is confidential, and revealing the abuse to the provider will in no way endanger her health or life; and
- An established referral system.

²⁴ World Health Organization. (2013). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. <https://apps.who.int/iris/handle/10665/85240>

The HCP may choose to ask questions about violence in a direct or indirect manner, but must take care to ask the questions in a private space and with a demeanour that communicates concern. The issue of violence should not be raised unless a woman is alone. Any disclosure by a woman regarding violence should be kept confidential.

Tables 5, 6 and 7 below describe the different ways in which the HCP can ask about violence. Table 5 shows the ways in which the provider can speak *before* asking direct questions about violence; Table 6 describes direct ways of asking about violence, and Table 7 shows a combination of direct and indirect ways of asking about abuse.

TABLE 5. STATEMENTS THAT HCPS CAN MAKE TO RAISE THE SUBJECT OF VIOLENCE BEFORE ASKING DIRECT QUESTIONS

- “Many women experience problems with their husband or partner, or someone else they live with (family members).”
- “I have seen women with problems like yours who have been experiencing trouble at home.”
- “Because violence is so common in women’s lives, we have started asking all patients about it.”

If the HCP suspects violence, s/he should not pressurise the woman to disclose that she is living in an abusive relationship. The woman should be informed about the effect of violence on her health, and the availability of support services, and she should be offered a follow-up visit.

TABLE 6. EXAMPLES OF DIRECT QUESTIONING

- “Are you afraid of your husband/ partner/family member?”
- “Has your husband/partner or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when has it happened?”
- “Does your husband/ partner /family member or someone at home bully you or insult you?”
- “Does your husband/ partner/family member try to control you by for example not letting you have money or go out of the house?”
- “Has your husband/ partner/ family member forced you into having sex or forced you to have any sexual contact you did not want?”
- “Has your husband/partner/family member threatened to kill you?”
- Has your husband/partner ever forced you to have sex when you didn't want to? Has your partner/husband ever insisted on unsafe sex?

TABLE 7. EXAMPLES OF INDIRECT DIRECT QUESTIONING

- Your injuries do not look like they are accidental. I am concerned that they may have been caused by someone hurting you. Did someone cause these injuries?
- Your complaints seem to be related to stress. Do you face any tensions with your husband/partner/ family member at home?

3.2. PROVIDING FIRST LINE SUPPORT TO SURVIVORS

The HCP should, as a minimum, offer first-line support when women disclose violence. First-line support provides practical care and responds to a woman's emotional, physical, safety and support needs without intruding on her privacy. Often, first-line support is the most important care that HCPs can provide. The various components of first-line support are mentioned in Table 8.

TABLE 8. PROVISION OF FIRST LINE SUPPORT (LIVES)

LISTEN



Listen to the woman closely, with empathy and without judging; this forms the basis of offering first-line support. The HCP should refrain from looking for reasons or excuses as to why a particular woman faced violence. Rather, s/he should try to demonstrate that s/he is willing to learn about the abusive situation without judging the woman.

The HCP must pay close attention to what the woman is saying as well as what she may not be saying, and her body language. The HCP can convey empathy through her/his own body language by listening actively (eye contact, nod), by acknowledging the woman's feelings, and by not rushing her to finish her narration.

The HCP must not assume that s/he knows what is best for the woman. The woman is in a position to make decisions for herself; the HCPs job is not to solve her problem, but to lend an ear and offer support.

Give her the opportunity to say what she wants. Ask: "How can we help you?"

Encourage her to keep talking if she wishes. Ask: "Would you like to tell me more?"

Don't judge what she has or has not done, or how she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived."

**INQUIRE
ABOUT
NEEDS AND
CONCERNS**



Empathetic listening enables the HCP to understand the varied needs -- physical, emotional, and economic needs, safety concerns and/or the need for social support -- that the woman may have. These needs may not be spelt out by the woman, but the HCP can, through active listening, enable identification of these needs. *The HCP may then look for confirmation that it is her need by saying for example, "It sounds like you may need..."*

The HCP may seek information about the safety of the woman and her children and whether she feels safe to go back home. The HCP may also ask the woman about the intensity of violence and the frequency. If a woman indicates that there a threat to her life the HCP must make temporary arrangements for her safety by admitting her in a medical ward.

The HCP must involve the hospital social worker in assessing the woman's short-term and long-term needs and deal with practical issues such as care of any children. S/he must help her identify and express her needs and concerns:

"Is there anything that you need or are concerned about?"

"It sounds like you may need a place to stay."

"It sounds like you are worried about your children."

VALIDATE



Women's experiences regularly confirm that the police, judicial systems as well as their own families do not believe them when they disclose that they are being subjected to violence.

The HCP must therefore make efforts to demonstrate that s/he believes the woman's narration, and directly convey to her that there is no excuse for violence and she is not to blame, that everyone deserves to feel safe at home and the HCP is here to help.

Communication of such positive messages will validate the woman's feelings while helping her deal with emotions of guilt, self-blame and helplessness.

The message that violence is not justified under any circumstances should be emphasised.

Important assurances that HCPs can give:

- "It's not your fault. You are not to blame."
- "What happened has no justification or excuse."
- "No one deserves to be hit by their partner in a relationship."
- "You are not alone. Unfortunately, many other women have faced this problem too."
- "Your life, your health, and you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

**ENHANCED
SAFETY**



A woman who reports DV may decide to go back to an abusive home because she has children to care for, or other responsibilities. In such circumstances, the HCP must communicate concern for her safety.

The HCP should seek the social worker's assistance to enable the woman to keep herself safe when she returns to an abusive home. The woman should be given suggestions on how to enhance her safety, such as alerting neighbors, calling the police helpline, and stepping out of the house if she anticipates physical violence.

The HCP must encourage the woman to follow up at the level of the medical facility and also with the social worker for an assessment of whether there has been a change in the situation or if the violence has been aggravated. If there is a threat to the woman's life, the HCP can offer to admit her to the hospital (where such a facility is available) for up to 72 hours, to allow the woman some time to think about her next steps.

Questions to assess the immediate risk of violence

- ***“Is the physical violence happening more often or has it gotten worse over the past 6 months?”***
- ***“Has he/she ever used a weapon or threatened you with a weapon?”***
- ***“Do you believe the abuser could kill you?”***

Elements of safety planning include:

Asking if she has a safe place to go: “If you need to leave your home in a hurry, where could you go?”

Planning for her children: “Would you go alone or take your children with you?”

Asking if she has transport: “How will you get there?”

Asking if she has any items to take with her: “Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?”

Asking if she has money: “Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?”

Asking if she has the support of someone close by: “Is there a neighbour you can tell about the violence who can call the police or come with help for you if they hear sounds of violence coming from your home?”

Assessing suicidal ideation: The HCP should assess the woman for suicide ideation and encourages her to think of ways to overcome such thoughts. S/he should explain that counselling can help in dealing with those feelings and, if the woman consents to counselling, refers her to appropriate services.

SUPPORT



A woman seeking to move out of an abusive home must deal with several practical issues. She must look for a new place to stay, support services, and, possibly, school admissions for her children.

With the help of a resource directory containing contact details of the relevant agencies, HCPs should link survivors with other sectors and agencies through referral and coordination.

HCPs should ensure that the helplines, shelter homes, or other referral support services offered to women with disabilities are accessible.

If an HCP is not able to assess a woman's safety, and (due to the patient load) not able to do safety planning and referral services, s/he must ensure that someone else in the facility does this. The woman in any case should get first-line support (LIVES) before leaving the health facility. In such a scenario, health facility social workers and counsellors in the department of HIV and the department of adolescent healthcare must be trained to provide first-line support to women who are referred by HCPs of the facility.

3.3 CARE OF INJURIES

- It is the HCP's primary duty to provide care for physical and emotional health. The HCP on duty must immediately attend to the injured woman and render emergency care without waiting to complete procedural formalities.

- In the case of severe or life-threatening conditions whose treatment is beyond the capacity of the facility, the HCP must refer the woman to the appropriate facility for urgent care.
- Head, chest, and abdomen injuries, respiratory distress, swelling, and inability to walk or hear, require immediate attention.
- Superficial injuries can be treated on site. Wounds should be cleaned and treated as necessary, and the appropriate medications such as antibiotics, analgesics, and anti-tetanus injections administered.

3.4 URGENT AND LONG-TERM MEDICAL TREATMENT FOR PRESENTING HEALTH CONDITIONS

- The health consequences of violence can be acute, long-lasting and chronic. Health facilities must have protocols for urgent as well as long-term medical treatment of survivors of violence.
- A physical examination should be done to determine what medical care is required.
- Vital signs such as pulse, blood pressure, respiratory rate and temperature should be assessed and documented.
- Diagnostics such as ultrasonography, x-ray and pregnancy testing should be done if the health complaints suggest their need.
- The HCP should inform the woman of any health conditions requiring long-term treatment, and make plans, in consultation with her, for follow-up of long-term treatment.
- During follow-up visits, the HCP should assess the woman's emotional state and mental status, and make the appropriate referral if it is felt that basic psychosocial support is needed.

3.5 SEXUAL VIOLENCE EXAMINATION AND CARE

In cases of sexual violence, the HCP should take a proper history with information on the time since the assault, the type of assault, any risk of pregnancy, risk of HIV and other STIs, and the woman's mental health status. The HCP should follow the MoHFW guidelines for medico-legal examination and treatment of sexual assault cases.

TABLE 9. CARE IN CASES OF SEXUAL ASSAULT

- **Emergency contraception:** Offer emergency contraception to survivors of sexual assault presenting within 5 days of the assault, ideally as soon as possible after the assault, to maximise effectiveness.
- **Abortion care:** If a woman presents after the time within which emergency contraception can be offered (5 days), if the emergency contraception fails, or if the woman is pregnant as a result of rape, she should be offered safe abortion, in accordance with the Medical Termination of Pregnancy (MTP) Amendment Act 2021.
- **HIV post-exposure prophylaxis:** Consider offering HIV post-exposure prophylaxis (PEP) if a woman presents within 72 hours of a sexual assault. Use shared decision-making with her to determine whether HIV PEP is appropriate.
- **Post-exposure prophylaxis for sexually transmitted infections:** Women survivors of sexual violence should be offered prophylaxis for chlamydia, gonorrhoea, trichomonas, and syphilis, depending on the prevalence of these infections in the community. The choice of drug and regimens should follow national guidelines. Hepatitis B vaccination without hepatitis B immune globulin should be offered as per national guidelines.

Adapted from *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013*).

3.6 MENTAL HEALTH ASSESSMENT AND CARE

- Survivors of DV experience emotional or mental health consequences. Most of them feel better once the violence or the situation is addressed. The HCP should ensure that the survivor gets LIVES at every encounter in the health facility.
- HCPs can provide basic psychosocial support to survivors to reduce their stress and improve their well-being. This includes: improving their coping methods, exploring the availability of social support, and encouraging and providing follow-up services.

TABLE 10. STRENGTHENING POSITIVE COPING METHODS

- Build on her strengths and abilities. Ask what is going well currently and how she has coped with difficult situations in the past.
- Ask her to continue her normal activities, especially activities that used to be interesting or pleasurable.
- Advise her on relaxing activities that she can undertake to reduce her anxiety and tension.
- Ask her to keep a regular sleep schedule and avoid sleeping too much.
- Advise her to engage in regular physical activity.
- Advise her to avoid using self-prescribed medications,
- Teach her how to recognise thoughts of self-harm or suicide and instruct her to come to the health facility as soon as possible for help if these thoughts occur.

- However, some women will require additional care (if symptoms persist) and it is important for HCPs to recognise this and help survivors to obtain care.
- Mental health assessment should be done by a trained HCP or a specialised mental health practitioner. If this service is not available in the facility, appropriate referrals should be made.
- Psychological support such as problem solving counselling, interpersonal therapy, cognitive behavioural therapy and behavioural activation should be provided only by a specialised therapist

3.7 DOCUMENTATION OF INFORMATION

- HCPs play a vital role in medico-legal documentation in cases of DV; such documentation provides critical (often the only) evidence of violence, which can be of tremendous use to the woman if she decides to access the legal system.
- Every health facility should have a standard format to document cases of DV that it reports.
- HCPs should be sensitive and thorough while recording history and examining survivors.
- Providers should review papers and medical records that are made available by the survivor and avoid asking questions that have already been answered in these papers and records.
- HCPs should explain each procedure in detail and take consent from the survivor during examination, treatment, evidence collection and referrals.
- Providers should look for injuries, scars or health complaints that might be present as a result of the violence, and attend to them. Survivors reporting severe injuries should be referred immediately for emergency treatment.

A.MEDICO- LEGAL DOCUMENTATION

1. Every woman who reports an injury caused by violence must be recorded as a medico-legal case (MLC). An MLC is a case of injury or illness resulting out of sexual or other violence, poisoning, or any suspicious circumstances, which leads the attending doctor, after eliciting the history of the patient and on medical examination, to decide that an investigation by law enforcement agencies is essential to understand and establish the criminal responsibility for the harm. The HCP treating a woman with such health complaints must probe the history of such health complaints for the medico-legal implications.
2. The HCP should inform the woman that whatever is documented in the hospital in form of an MLC can be used by her in a court of law if she decides seek legal recourse. The HCP should explain to the woman the importance of filing a police complaint, and the significance of both a Non-Cognizable Complaint (NC) and a First Information Report (FIR). An NC is an entry in a police diary that does not warrant any investigation whereas a FIR is a “written document prepared by the police when they receive information about the commission of a cognisable offence” (Section 154 of Criminal Procedure Code).
3. The history that the HCP elicits from the woman should include details of the injury or injuries, and of the violent episode (such as the location of the incident, the survivor’s relationship to the abuser, the severity and frequency of earlier episodes of violence, and other health consequences not immediately apparent at the time of the medical visit). All these details along with the findings of the clinical examination should be recorded in the MLC register as well as on the case paper.
4. Even if the HCP does not work in the emergency department, if s/he comes across any abused woman in the OPD or in the wards, s/he must document the violence as part of the history in the survivor’s indoor / OPD papers and refer her to the emergency department to get an MLC recorded.
5. Health professionals are legally bound to inform survivors of DV about the PWDVA (2005) and its provisions, and provide a referral to a protection officer (Domestic Incident Report).

B. ROUTINE DOCUMENTATION OF DOMESTIC VIOLENCE CASES

Every health facility should have a uniform mechanism or protocol for documenting cases of DV, just as there are protocols for the documentation of other healthcare services within a facility. This protocol is useful in assessing the quality of care being provided to survivors by the health facility, identifying the challenges faced by providers in responding to survivors, and for provision of follow-up services to survivors.

Figure 2 below is a simple 2-page structured format that can be filled by doctors, nurses, social workers and counsellors at the primary, secondary and tertiary levels to document cases of DV. This format (also given in Annexure) has been successfully used in three tertiary health facilities of Maharashtra in implementation research²⁵. It contains the following details:

- a. The process by which DV is reported or disclosed at the health facility by women.

The HCP is asked about violence and the woman discloses it (active identification):

The HCP should tick this option if s/he has suspected violence based on the woman's health complaints, has asked the woman about it, and the woman has disclosed it to her/him.

The woman reports violence to the HCP: *The HCP should tick this box if the woman has reported violence on her own to her/him. This may happen in cases of assault in which the woman gives DV as the cause of her injuries while providing history to the HCP.*

The HCP has suspected violence but the woman has denied it: *The HCP should tick this option if s/he suspects violence based on the woman's health complaints, asks the woman about it, and the woman denies it. The documentation of such cases is important if the woman come to the health facility to seek support services at another time.*

²⁵ World Health Organization, Centre for Enquiry into health and Allied Themes, & Human Reproduction Programme. (2021). *Scaling up the health system response to violence against women: Lessons from hospital interventions in Maharashtra, India: Research Brief*. New Delhi: World Health Organization.

- b. Demographic information of the woman and her safe contact details necessary for any follow-up support services. The HCP's name, along with her/his department and designation, is documented to monitor the facility response.
- c. A record of the presenting signs and symptoms which required the HCP to document the case of DV.
- d. The HCP's documentation of the woman's experience of violence after asking about the forms of violence she experienced and her relationship with the abuser(s).
- e. The HCP's documentation of the services that were provided to survivors of DV.

FORMAT FOR DOCUMENTING CASE OF DOMESTIC VIOLENCE			
Serial No: _____			
Please tick one option which is applicable			
Provider asked about violence and woman disclosed			
Woman reported violence to health-care provider			
Provider suspected violence but woman denied			
:Name	:Date		
:Gender: Male / Female / Trans gender	:Age (in completed years)		
:Safe Contact details	:Patient ID		
:Name of healthcare provider	:Department		
:Designation			
Disability: If yes then specify			
:Physical	Yes	No	
:Intellectual	Yes	No	
Presenting Signs & Symptoms:			

Form of Violence (Please tick all the options which are applicable)			
Physical	Emotional	Sexual	Financial
(Others (specify) _____)			
Relationship with individuals who are abusive (Please tick all the options which are applicable)			
Husband/Partner/boyfriend	(Marital family (specify	(Natal family (specify	
Children	(Others (specify		
Services provided by healthcare provider			
Medical treatment	LIV	b. ES. a	Medico- legal case documentation
Internal Referral to other departments (please specify name of department)	Provision of emergency shelter	Information about Protection Officer	
(Others (specify			
External referrals			
Clinical care at higher facility	Shelter home	Referral to legal aid agency	
Referral to Protection Officer	Livelihood support	Referral to Child Welfare Committee	
Referral to Police	Others (specify		
Signature of provider			

FIGURE 2. FORMAT FOR DOCUMENTATION OF DOMESTIC VIOLENCE CASES

3.8 REFERRAL

Every health facility should have robust referral linkages for providing support services to survivors of DV. Health administrators can follow certain steps to establish the appropriate coordination and referral mechanisms within the health sector.

1. **Map the available services:** If certain types of services are not available in the health facility, the health administrator should identify and map what is available within a reasonable distance of the facility or in the catchment area, and specify the geographic distance or catchment area within which s/he will refer women in order to ensure access.
2. **Create a directory:** The health administrator should include the contact details of a focal person in each unit, facility or service, a description of the services available, and their cost. A copy of this directory should be provided to every service or unit/department in the health facility.
3. **Identify a focal person in the health service:** The focal person is responsible for facilitating access to care at each service delivery point and for following up with women on the care received and referrals made. In health facilities where social workers or community development officers are available, they can take on this role. Good coordination and communication across different units/services within the health system is important. Hence, the focal person should meet regularly with HCPs from the different health units/departments or institutions to review cases, resolve any challenges, and monitor survivors' access to and quality of care.
4. **Seek feedback from stakeholders:** A mechanism to seek feedback on referral linkages should be developed. For example, a monthly meeting can be held with the Protection Officer to assess and discuss the number of cases referred, the support provided, and any challenges faced in referring survivors.

3.9 COMMUNITY OUTREACH

Community outreach includes raising awareness with communities, as well as with women who come to clinics for general healthcare, about the services available to address DV and the need to seek timely healthcare. Community outreach includes challenging the stigma that women face in the community in seeking care for DV.

This outreach can be done by community health workers (CHWs) with the development of awareness material, and in partnership with community-based organisations.

- CHWs including accredited social health activists (ASHAs) and auxiliary nurse midwives (ANMs) can play an important role in raising awareness in the community on the issue of DV. They can play a significant role in primary prevention of violence by increasing its recognition among community members. However, their role should be limited to creating awareness; not only are they already overburdened, asking them to actively identify and respond to women facing violence in the community would put them at risk of violence.
- Trained CHWs should build awareness among girls and women about the forms of violence, the health consequences of violence and the available support services at nearby health facilities for establishing an upward referral system.
- Group education and individual discussion on violence in the context of family planning, maternal and child health can be used by CHWs for awareness building.

TABLE 11. KEY QUESTIONS ABOUT WHICH CHWs CAN PROVIDE INFORMATION

- What is violence against women?
- How does it impact the physical and mental health of women?
- Why is it important to seek timely service without blame and stigma?
- How can violence against women be prevented?
- How can community members support survivors of violence?
- What are the health and support services available for survivors in nearby health facilities?
- What is the role of HCPs in responding to survivors of violence?
- What are the rights of survivors with respect to healthcare, and what are the redress and grievance mechanisms available if these rights are violated?

Source: WHO²⁶

However, for CHWs to perform this role, the following minimum requirements must be met:



- CHWs must be equipped with information and resources such as the contacts of local NGOs, helplines and referral services.
- An established institutional framework with written protocols should be in place to indicate the actions to be taken if there are threats to the CHW's safety.

²⁶ World Health Organization. (2017). *Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers.*

- A mechanism of grievance and redress at primary health facilities should be available to address CHWs' concerns.
- Monthly meetings at primary health facilities should provide CHWs the opportunity to voice their concerns regarding safety, and discuss any action taken by authorities.

These minimum requirements are important since CHWs are from within the community and responding to cases of DV can jeopardise their safety. Further, ASHA workers are from marginalised groups in the community. They are not considered staff of the formal health system, and they are often overburdened. They are paid less than minimum wages and are not provided with any benefits including maternal leave. The honorarium and incentives they receive are not directly proportional to the amount of the work they carry out.





SECTION FOUR: ESTABLISHING RESPONSE TO SURVIVORS OF DOMESTIC VIOLENCE

This section contains guidance to healthcare administrators and providers on how to establish, monitor and sustain a response to DV. It provides evidence-based guidelines for strengthening health facilities, and setting up and integrating training and monitoring mechanisms at the level of the facility.

4.1 LEADERSHIP AND GOVERNANCE

Leadership and governance refer to the role and functions of healthcare administrators -- HCPs who have managerial responsibilities, including implementation of policy frameworks, supervision, mentoring other HCPs within the facility, and establishing coalitions and monitoring mechanisms. Healthcare administrators must have commitment to and ownership of the programme to implement, monitor and integrate an essential health service package for survivors of violence. They should make efforts to enhance providers' understanding about the legal framework and their obligations. They should identify the procedures necessary to operationalise survivors' autonomy and confidentiality under the laws mandating reporting of DV. Finally they should contribute to the capacity building of providers, implementation of protocols, setting up of facility-based monitoring mechanisms, and strengthening multi-sectoral linkages. In every health facility, "champions" should be selected from among the healthcare administrators to play a supervisory and mentoring role and build capacity of HCPs.

A. AT PRIMARY HEALTH FACILITIES

Medical officers at primary health facilities have an important role in establishing a response to survivors of DV. Their responsibilities are as follows:

- To implement the protocols for responding to DV and to guide and supervise the facility response;
- To build the capacity of nurses, paramedical staff and community health workers with support from providers at secondary and tertiary facilities;
- To facilitate coordination and referral with higher facilities in cases requiring examination for sexual violence, mental health assessment, and higher level care;
- To facilitate monthly review meetings to monitor the quality of care provided to survivors of violence;
- To establish linkages with other sectors, existing centres and agencies for support services.

B. AT SECONDARY AND TERTIARY HEALTH FACILITIES

The medical superintendent, the heads of clinical departments and the nursing officers should lead the work of establishing responses at secondary and tertiary facilities. Their responsibilities are as follows:

- To implement the protocols for responding to DV, and supervising and monitoring the facility response;
- To build the capacity of doctors, nurses and paramedical staff to identify survivors of violence based on health complaints, and provide first-line support;
- To facilitate and monitor the provision of forensic care and linkages with police in cases of sexual violence;
- To facilitate monthly review meetings to monitor the quality of care provided to survivors of violence;
- To establish linkages with other sectors and agencies for support services such as Protection Officers and legal aid;
- To improve coordination with one stop crisis centres (OSC) which are located within or in the vicinity of hospitals. A woman reporting violence and seeking treatment from a hospital should be informed of this facility and referred there (with her consent).

Similarly, OSC staff should be oriented to recognise the health needs of survivors of violence and refer them to the health facility.

The heads of departments at tertiary health facilities with medical colleges should integrate training on responding to violence into undergraduate and postgraduate teaching.

4.2 HEALTH WORKFORCE DEVELOPMENT

Capacity building of HCPs to respond to DV survivors should be part of medical education as well as in-service training. Champions from each health facility should be given additional training to conduct capacity building of HCPs using participatory methods. Training on DV should be integrated in the orientation training of new staff members. All cadres of HCPs including doctors, nurses and social workers should be trained together to increase the ownership for delivering care, and to break traditional hierarchies among providers. Building and enhancing skills in responding to DV should be part of the roles and responsibilities of each cadre of HCP. Health administrators should support capacity building activities by facilitating the deputation of HCPs and relieving them from their clinical duties during the training. The training of providers should include discussion of concepts such as sex, gender, intersectionality and patriarchy so as to enable them to understand the root causes of VAW. This helps them recognise their own biases against survivors of violence, and also helps them build empathy and improve communication with survivors.

A. AT PRIMARY HEALTH FACILITIES

The medical officer with the support of HCPs of secondary and tertiary health facilities should conduct regular capacity building activities for the staff at primary health facilities. This training should include information on the impact of violence on health, the role of HCPs, their legal mandate, the importance of identifying women facing violence, and providing first-line support and referral services.

B. AT SECONDARY AND TERTIARY HEALTH FACILITIES

Every secondary and health facility should have a group of HCPs who have undergone intensive training on the health systems response to survivors of violence. This group can be formed by including providers across cadres with managerial and administrative responsibilities within health facilities. These could be the head of the clinical department, the head nurse, the medical superintendent, and the medical officer. The role and responsibilities of core group HCPs include:

- Conducting training of other HCPs in the health facility to build their capacity to provide care to survivors of DV. This can be done by integrating training on DV in the regular training of hospital staff.
- Monitoring the facility's response to DV by organising periodic reviews to assess the quality of care being provided to survivors in the health facility. A monthly report on the quality of care provided to survivors of violence should be given to the head of the facility.
- Facilitating survivors' access to services within the health facility. These services include providing emergency shelter, abortion services and assistance in medico-legal procedures.

The core group is most effective when it is active and engaged, when there are standard operating protocols within the health system, and when the facility is prepared with the necessary infrastructure, supplies, drugs, and commodities.

4.3 SERVICE DELIVERY

Every health facility should have Standard Operating Protocols (SOPs) to deliver quality care to survivors of violence. The SOP should provide guidance to HCPs to ensure privacy, confidentiality, and safety to survivors. The protocol should map patient flow and guide HCPs on the various points at which first-line support can be offered to survivors within the health facility. It should provide guidance to align the health systems response with the legal framework. Information, education and communication material is useful for spreading awareness among women about DV services within the health facility, and job aids for HCPs help them recall skills and improve service delivery.

4.4 HEALTH FACILITY READINESS: AVAILABILITY OF INFRASTRUCTURE, DRUGS AND SUPPLIES

Readiness is defined as the availability of the components required to provide services. These components include basic amenities, basic equipment, medicines and commodities. A health systems response to DV requires preparedness of health facilities in addition to capacity building of HCPs. System readiness, in the form of availability of protocols, infrastructure, equipment, and commodities, provides a supportive environment to trained HCPs. The experience of different health systems based models for responses to DV in India has shown that no additional resources are required for improving system readiness; infrastructure and other requirements are minimal and are adequately fulfilled by the resources that are already required to be available at all three levels of health facilities.

The infrastructure in the health facility should ensure privacy and confidentiality of survivors, and the necessary drugs and supplies should be available to provide quality essential services. At least one private space should be available in every health facility to ensure the survivor's complete privacy. The private space should not have any signs to indicate that it is a survivor's room and it should be equipped with all the necessary drugs and supplies.

A. INFRASTRUCTURE AND EQUIPMENT

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

B. FURNITURE AND SUPPLIES

- Chairs for the survivor, her companion, and the HCP (a minimum of three chairs in the consultation/examination room);
- A writing table between the HCP and the survivor;
- A door, curtain or screen for visual privacy during physical examination;
- An examination table for examination of physical injuries;
- A washable or disposable cover for the examination table;
- Adequate light source in the examination room/space;
- Angle lamp or flashlight for the pelvic exam;
- Access to a lockable cabinet, room or other unit for secure storage of survivors' paper files/register and protocols for documenting DV; and
- Access to a lockable medical supply cabinet or a lockable room where medical supplies can be stored.

C. ADMINISTRATIVE SUPPLIES TO BE AVAILABLE IN ALL OUT-PATIENT AND IN-PATIENT DEPARTMENTS

- Printed copies of standardised guidelines and protocols for responding to DV;
- Job aids in the language of the provider and the client population (LIVES and Signs and Symptoms associated with VAW);
- Printed copies of the protocol for documenting cases of DV;
- Printed copies of the Domestic Incident Report format; and
- A referral directory containing details of the organisations and stakeholders providing support services to survivors of violence.

D. ESSENTIAL DRUGS AND COMMODITIES TO BE AVAILABLE AT ALL TIMES AND IN ADEQUATE NUMBERS AS PER THE CASELOAD

- Rapid test HIV kits: 8-10 kits;
- Pregnancy test kits (Nischay Kit): 30 kits;
- Emergency contraception pills (Ezy Pills) or IUCD: 30 units;
- HIV post-exposure prophylactics (Nevirapine/equivalent brand);
- Drugs for treatment of STIs (Kit 1, Kit 2, Kit 3, Kit 4, Kit 5, Kit 6, Kit 7);
- Drugs for pain relief (e.g. paracetamol, diclofenac);

- Local anaesthetic;
- Catgut thread for suturing;
- Broad spectrum antibiotics and dressing for wound care;
- Tetanus vaccine (Tetvac); and
- Essential drugs, injectable, intravenous sets, gloves.

E. HUMAN RESOURCES

- HCPs including doctors, nurses, paramedical and social workers at all levels of health facilities should be trained to provide care to survivors.
- Secondary and tertiary level health facilities should have a trained HCP 24x7 for providing care to sexual violence survivors.
- Trained providers for mental health assessment and provision of mental healthcare should also be present at secondary and tertiary health facilities.

4.5 FINANCING

Government funding is essential in order to sustain health systems response to DV. However, in most countries including India, the response to DV is spearheaded by UN agencies and NGOs, and there are no funds made available in national health programmes for addressing DV. In India, despite the National Health Policy's emphasis on VAW, there is no action plan in place for the health systems response. The MoHFW does not have any budget allocation for implementation of medicolegal guidelines for examination and evidence collection in cases of sexual violence. There is no specific budget line for DV services at the health facility level, district level and state level which would demonstrate the government's commitment.

A government-funded health systems response to DV can be based on incorporating services for DV into other programmes such as those for sexual and reproductive health, capacity building of HCPs, prevention of sexual harassment at the workplace, and standards of quality care.

For this purpose, healthcare administrators should estimate the cost of service delivery to DV survivors within a facility. This can be done by recording the number of DV survivors reaching the health facility every month, mapping the available resources including infrastructure, supplies, and human resources, and identifying gaps in resources.

This estimate should include resources for building multi-sectoral linkages, monitoring the health facility's response, advocacy and outreach efforts, developing information, education and communication material, and outreach activities.

Health facilities should establish mechanisms to address the financial barriers that survivors of violence face in accessing health services. Fees for accessing services like ultrasonography, x-ray, and abortion should be reduced or waived for survivors of violence. All medicines for post rape care should be included in the list of essential medicines.

4.6 MONITORING AND EVALUATION

Monitoring the quality of services provided to survivors of DV should be an integral part of a health systems response. Healthcare administrators should regularly monitor the health facility's response to DV. The plan for such monitoring should identify indicators for monitoring, such as changes in HCPs' practices, documentation of cases, aggregated numbers, and number of referrals. It should specify who will review the monitoring data and how often. Monitoring should also include feedback from survivors, NGOs providing support services, Protection Officers, community workers and other stakeholders.

TABLE 12. MONITORING PLAN

The monitoring plan should:

- Identify the indicators needed to measure progress towards establishing essential health systems' response to DV;
- Include indicators on availability, access, acceptability and quality of services for women subjected to violence, as part of routine monitoring;
- Specify how often monitoring and evaluation (M&E) data will be reviewed to identify problems;
- Specify the stakeholders to ask for feedback on M&E data (for example, members of a multisectoral mechanism or referral network, community members);
- Specify how M&E data will be used in supervision and to improve SOPs, and HCP training;
- Specify how and when follow-up will be conducted to evaluate the progress in making changes to service delivery based on the M&E data








SECTION FIVE: ACCOUNTABILITY OF HEALTH SYSTEMS' RESPONSE



Processes to ensure accountability of the health systems response to DV include monitoring service delivery, feedback from survivors about the quality of care, and measures for redress if the health facility fails to provide adequate services to survivors. In a health facility, healthcare administrators in supervisory roles are accountable for the care provided to survivors. Administrators can implement these measures as follows:


- Develop a code of conduct for HCPs and make them aware of their legal obligations.
- Implement a facility-based protocol for responses to DV.
- Establish mechanisms for confidentiality by which women can give feedback in the local language, without fear, about the quality of services. Women should be made aware of these facility-based mechanisms through information, education and communication within the health facility as well as through community outreach.
- Develop a plan for redress of complaints, provision of remedies, and to strengthen the facility response to DV.
- Involve nongovernmental organisations and community-based organisations in monitoring the quality of services. For example, the administrator can agree to an NGO conducting an independent review of the facility's response to DV.
- Form a working group at the facility level to monitor the facility response. This group can include representatives from NGOs, protection officers, police representatives, HCPs and other stakeholders.
- Include a description of the HCP's legal obligations in the SOPs for health facilities' response to DV.


TABLE 13. LAWS AND LEGAL MANDATES AND THEIR IMPLICATIONS FOR HCPS IN THE CONTEXT OF DOMESTIC VIOLENCE

LAWS AND PROVISIONS	LEGAL MANDATE	IMPLICATIONS FOR HCPS
<p>Section 357C of the Code of Criminal Procedure</p> 	<p>Under the CrPC, all hospitals, public or private, whether run by the Central Government, the State Government, local bodies or any other person, shall immediately provide first-aid or medical treatment, free of cost, to the survivors of sexual violence and acid attack. No hospital can refuse to record a medico-legal case (MLC) of a survivor who has come to the hospital without police referral.</p>	<p>Refusal of medical care to survivors/victims of sexual violence and acid attack amounts to an offence under Section 166B of the Indian Penal Code and is punishable with imprisonment for up to one year, or a fine, or both.</p>
<p>The Preconception and Prenatal Diagnostics Techniques (Prohibition of Sex Determination) Act 2003</p> 	<p>The Act prohibits sex selection before or after conception. It also prohibits misuse of pre-natal diagnostic techniques for determination of the sex of the foetus.</p> <p>The basic requirements of the Act are:</p> <ol style="list-style-type: none"> 1. Registration under Section (18) of the PC-PNDT Act; 2. Written consent of the pregnant woman before use of any diagnostic techniques under Section 5 of the Act; 	<p>Sex selection, determination or communication can result in temporary suspension of the establishment's and the HCP's registration numbers from the time of framing the case up to its disposal.</p> <p>If the provider is found guilty, the punishment for the first offence is jail of up to 3 years, a fine of up to Rs 10,000, and</p>

LAWS AND PROVISIONS	LEGAL MANDATE	IMPLICATIONS FOR HCPS
	<p>3. Prohibition from communicating the sex of the foetus under Section 5 of the Act;</p> <p>4. Maintenance of records as provided under Section 29 of the Act;</p> <p>5. Creating awareness among the public at large by displaying a board on the prohibition of sex determination.</p> <p>This act is relevant to domestic violence since a lot of times women are coerced to undergo sex selective abortion</p>	<p>removal of the HCP's name from the Medical Council of India's register for 5 years.</p> <p>The punishment for the second offence is jail of up to 5 years, a fine of up to Rs 50,000 and permanent removal of the HCP's name from the MCI's register.</p> <p>Any further offences will be punished with a jail term of up to 5 years and a fine of up to Rs 50,000.</p>
<p>The Medical Termination of Pregnancy Amendment Act (2021)</p> 	<p>The Act permits abortion of a pregnancy by medical doctors (with specified specialisation) on certain grounds.</p>	<p>Anyone forcing a pregnant woman to undergo an abortion, or performing one without her consent, may be punished with imprisonment of up to 10 years and/or a fine.</p> <p>Performing an abortion in a place that is not authorised by the government may be punished with rigorous imprisonment of between 2 and 7 years for the doctor and the</p>

LAWS AND PROVISIONS	LEGAL MANDATE	IMPLICATIONS FOR HCPS
	<p>A registered medical practitioner may reveal the details of a woman whose pregnancy has been terminated, only to a person who is authorised by law.</p>	<p>owner or in-charge of the unauthorised service.</p> <p>Unlawful disclosure of details is punishable with imprisonment up to a year, a fine, or both.</p>
<p>The Protection of Children from Sexual Offences Act, 2012</p> 	<p>The Act includes a requirement to report offences. Any person (including an HCP) who apprehends that an offence under this Act is likely to be committed, or has knowledge that such an offence has been committed, shall provide this information to the Special Juvenile Police Unit, or the local police.</p>	<p>Failure to report is punishable with imprisonment of up to 6 months or a fine or both.</p>
<p>The Protection of Women from Domestic Violence Act (PWDVA), 2005</p> 	<p>The Act aims at protecting women from violence in domestic relationships. It provides women facing domestic violence a simplified procedure to access civil and quasi criminal remedies.</p> <p>It identifies HCPs as important stakeholders in the implementation of the</p>	<p>Failure to fulfil duties under the Act is not punishable.</p>

LAWS AND PROVISIONS	LEGAL MANDATE	IMPLICATIONS FOR HCPS
	<p>Act and gives them certain responsibilities and duties under the Act.</p> <p>If a survivor or, on her behalf, a Protection Officer or a service provider asks the person in charge of a medical facility (notified under the state government) to provide any medical aid to her, the person in charge of the medical facility must provide her medical aid.</p>	
<p>Medico-legal case (MLC)</p> 	<p>An MLC is a case of injury/ illness which the attending doctor, after eliciting history and examining the patient, judges that investigation by law enforcement agencies is essential to establish responsibility for the case in accordance with the law.</p> <p>MLC documentation also facilitates the process of availing of compensation under the victim compensation scheme put in place under Section 357A CrPC.</p> <p>The police must be informed in cases of (I) suspected homicide, (II) deaths by suicide, (III) a patient who is</p>	<p>HCPs who fail to discharge this duty may be charged under Section 201 of the Indian Penal Code and the punishment may be 3 months of imprisonment or a fine of up to Rs 500, or both.</p> <p>Section 177 of the Indian Penal Code states that any person who is legally bound to disclose information to a public servant regarding the commission of an offence but provides false information will be</p>

LAWS AND PROVISIONS	LEGAL MANDATE	IMPLICATIONS FOR HCPS
	<p>unknown and unconscious, (IV) death on the operation table, (V) suspected unnatural death, (VI) sudden, unexpected, violent and unexplained death, (VII) instant death after treatment or reaction of medicine, and (VIII) a married woman dying within seven years of marriage due to any reason.</p>	<p>subject to imprisonment of 2 years or a fine or both.</p> <p>A medical practitioner who attends a medicolegal case can be punished for providing false information.</p>
<p>Informed consent (IPC Sections 88-90)</p> <p>Section 164A CrPC (for medical examination of a rape survivor/victim)</p> 	<p>No treatment and/or examination is lawful without the consent of the patient. The patient can give her/his own consent if s/he is aged 12 years and above. The guardian's consent must be taken in the case of a child below 12 years of age</p> <p>Consent given under fear of injury or misconception of facts is not free and wilful, hence not a defence for performing any medical examination and treatment. This requirement may be waived in cases of emergency care.</p>	<p>If a doctor tries to operate on a person without the legitimate consent of that patient, s/he will be liable and punished and the patient will be compensated for the same.</p> <p>The procedure for this lies in both Tort Law and Criminal Law. If a person proceeds as per Tort Law s/he will file for compensation for the harm. Under criminal law, medical experts or staff found guilty will be punished with imprisonment or a fine, depending on the circumstances.</p>



SECTION SIX: SPECIFIC CASES OF CLINICAL ENQUIRY AND PROVISION OF CARE

This section provides guidance to HCPs about meeting specific needs of survivors of DV cases. The specific needs stem from the nature of health consequences, both physical and mental, and the medico-legal role of providers in certain cases like burns.

6.1 CASES OF ACCIDENTAL BURNS

Women admitted to tertiary hospitals with burns often report that the burn was accidental. The law makes investigation mandatory for all cases of injuries and deaths *possibly* resulting from DV. Investigation is also mandatory for all unnatural deaths of married women within seven years of marriage. HCPs play an important role in recording the dying declaration, and in determining whether the injuries preceded the woman's death or occurred after her death, and whether the burns were homicidal, accidental, or suicidal. The following points should be considered for comprehensive care in cases of burns resulting from violence:

- a. The provision of acute treatment in cases of burns should not be linked with the percentage of burns (salvageable/non-salvageable). All patients should be provided immediate acute treatment in the form of fluid management, dressing, excision of burnt tissue and psychological care ²⁷.
- b. Uniform clinical protocols for resuscitation, treatment and referral should be developed.

²⁷ Bhate-Deosthali, P., & Lingam, L. (2016). Gendered pattern of burn injuries in India: A neglected health issue. *Reproductive Health Matters*, 24(47), 96–103. <https://doi.org/10.1016/j.rhm.2016.05.004>

TABLE 14. THE MEDICO-LEGAL ASSESSMENT IN BURNS CASES SHOULD INCLUDE INFORMATION ON:

- History of violence in the household;
- Extent of burns -- degree, depth, percentage of the body affected;
- Reference to causative agents – dry flame, chemical, electrical, kerosene;
- Whether the person who sustained the burn injuries was fit enough to give a statement or was of sound mind to give a dying declaration;
- Cause of the burn injury -- whether it is suicidal, accidental or homicidal;
- The time since the injury occurred and the pattern of injuries; and
- Whether the burn injuries were sustained before or after death.

Source: Report: Building a holistic support system for women burns survivors of violence- The International Foundation for Crime Prevention and Victim Care (PCVC) and CEHAT, 2017

6.2 CASES OF SUICIDE ATTEMPT

Cases of attempted suicide reaching secondary and tertiary hospitals are often recorded as accidental consumption of poison. Neither the underlying factors that triggered the attempt nor the mental health aftermath of suicide attempts is addressed by the health system. HCPs need to identify cases of DV among women who get admitted in hospitals with “accidental consumption of poison”, and provide them adequate support services.

a. HCPs should treat survivors reporting attempted suicide sensitively; they should not use a victim blaming approach while providing them treatment.

b. Women may not reveal the actual reason for the attempt, for various reasons. The HCP has a number of ways to distinguish between a deliberate attempt and an accident. S/he must record his/her observations, and probe the women about the

possibility of violence. This is an important part of comprehensive care to patients.

c. In such cases, the primary concern should be the prevention of another attempt. The role of the HCP is to provide referrals, support and treatment.

d. All cases of suspected violence are required to be registered as MLCs when the women seek medical intervention. Cases of assaults, falls, attempted suicide, burns, sexual violence and accidents are routinely registered as MLC. The affected women may not be aware of this practice. HCPs must explain the procedure of MLC to women presenting with suspected DV.

6.3 CLINICAL ENQUIRY DURING ANTENATAL CARE

There is significant evidence that women face an increase in violence during pregnancy, with consequences for maternal health as well as birth outcomes. For this reason, it is recommended that pregnant women routinely be asked whether they are being subjected to violence. This should be asked at every stage of pregnancy, as violence may begin/escalate at any point. The HCP must not assume that the woman is 'safe' during pregnancy.

Routine enquiry entails asking every pregnant women about abuse (irrespective of her health complaints) at every ANC visit.

The minimum requirements for such enquiries are:

- a. availability of standard format for routine enquiry,
- b. availability of private space,
- c. mechanisms for ensuring confidentiality and safety,
- d. availability of trained human resources, and
- e. availability of referral mechanisms.

It is important to note that in resource-poor settings where the patient load is high and the minimum requirements for routine enquiries are not met, HCPs should ask pregnant women about violence based on their health complaints; routine enquiry when the minimum requirements are not met can jeopardise survivors' safety.

TABLE 15. FORMAT FOR ROUTINE ENQUIRY OF VIOLENCE DURING PREGNANCY

Many women experiencing violence with their husband or partner, or some other family member, are unaware that this violence can lead to all kinds of health problems. Because violence is so common in many women's lives, and because there is help available at X hospital for women being abused, we now ask every woman coming for ANC about her experiences with violence. Please be assured that your answer to these questions will be kept strictly confidential.

- Are you currently afraid of your husband / partner or someone else in your family? Yes/No. If yes, from whom?
- Does your husband / partner give you money for household expenditure? Does your husband or someone else in your family demand money, vehicle, house or anything else from you?
- Has your husband / partner or someone else in your family threatened to hurt you or physically harm you in some way? Yes/No
- Has your husband / partner or someone else in your family forced you to have sex or to have any sexual contact you did not want? Yes/No
- Since you have been pregnant, are you facing any of the above mentioned problems? Yes/No. if yes, which one?





SECTION SEVEN: SELF- CARE OF HEALTHCARE PROVIDERS

HCPs caring for women facing violence can experience burnout and fatigue. They can have strong reactions when listening to women about violence, especially if they have personal experience of violence. Providers should be aware of their own emotions and get the support needed. Institutional mechanisms should be established as part of a DV protocol to support providers.

At an individual level, providers can take care of themselves through stress reduction exercises. Some examples are given below.

TABLE 16. STRESS REDUCTION EXERCISES FOR HCPS

1. First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
2. Put your hands on your belly. Think about your breath.
3. Slowly breathe out through your mouth, completely, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
4. Breathe deeply and slowly. You can count 1-2-3 on each breath in and 1-2-3 on each breath out.
5. Keep breathing like this for about 2 minutes. As you breathe, you will feel the tension leave your body.

Source: Healthcare for women subjected to intimate partner violence or sexual violence- A clinical handbook, WHO

At the institutional level, senior HCPs and members of the core group at the facility should offer support and create an enabling environment within the facility for HCPs to ask for help if they identify symptoms of burnout.

- During training, providers can be given an orientation on burnout, how to prevent it, and the support mechanisms available within the health facility.
- One effective way to prevent burnout is to ensure adequate training and resources to HCPs for delivering care to survivors.
- Regular in-house training and workshops offer skills development as well as a change from the routine. Going for external meetings and workshops keeps HCPs updated and makes them aware of other skills and potentials that they may have.
- Creating a space to discuss difficult cases, emotional issues and conflicts of values with other HCPs and seniors can also help to prevent burnout. Monthly monitoring meetings can be used as a platform for this purpose.
- Peer support mechanisms should be established at the level of the health facility where HCPs can seek support.



ANNEXURE

FORMAT FOR DOCUMENTING CASES OF DOMESTIC VIOLENCE

Serial No:

Please tick one option which is applicable

Provider asked about violence and woman disclosed	
Woman reported violence to health-care provider	
Provider suspected violence but woman denied	

Name:	Date
Gender: Male / Female / Trans gender	Age (in completed years):
Safe Contact details:	Patient ID:
Name of healthcare provider: Designation:	Department:

Disability: If yes then specify

Physical:	Yes	No	
Intellectual:	Yes	No	

Presenting Signs & Symptoms:

Forms of Violence (Please tick all the options which are applicable)

Physical	Emotional	Sexual	Financial	Others (specify)
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Relationship with individuals who are abusive (Please tick all the options which are applicable)

Husband/Partner/boyfriend	Marital family (specify)	Natal family (specify)
Children	Others (specify)	

Services provided by healthcare provider

Medical treatment	a. LIV b. ES	Medico- legal case documentation
Internal Referral to other departments (please specify name of department)	Provision of emergency shelter	Information about Protection Officer
Others (specify)		

External referrals

Clinical care at higher facility	Shelter home	Referral to legal aid agency
Referral to Protection Officer	Livelihood support	Referral to Child Welfare Committee
Referral to Police	Others (specify)	

Signature of provider



CENTRE FOR ENQUIRY INTO HEALTH AND ALLIED THEMES

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service, welfare and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realising the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through database and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.

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