Enhancing Quality of System's Response to Survivors of Gender Based Violence: Exploring Challenges and Perspectives

Report from the Pre-Conference Satellite Workshop organised as part of the Sixth National Bioethics Conference of the Indian Journal of Medical Ethics.

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Introduction

The Sixth National Bioethics Conference of the Indian Journal of Medical Ethics was held in Pune, Maharashtra, India between the 13th to 15th of January 2017. A pre-conference satellite workshop was organised on 12th of January 2017 to discuss issues related to Gender Based Violence within Medical Ethics; and explore the challenges and perspectives related to Enhancing Quality of System's Response to Survivors of Gender Based Violence. This pre-conference workshop brought together a wide range of Government bodies, NGOs, Activists, Academic institutes, Medical Personnel and Lawyers; and laid a preliminary frame for initiating dialogue on Engendering Bioethics.

Ms. Sunitha Sheel, in introducing the workshop keenly mentioned that Bioethics is a relatively new field and this pre-conference workshop is just the beginning of developing an understanding about Gender Based Violence within Bioethics. She further highlighted that in India Bioethics is not limited to academics, like several other countries, but draws on the rich experience of movements and NGOs. Here she cited the example of "Karnataka Arogya Chalval", a movement which brought to light the non-indicative hysterectomies that were performed on Tribal women in Karnataka. She emphasised that the work done by NGO's related to sexual violence is extremely relevant to discourses on Bioethics as Abortion Laws (MTP and PCPNDT) are not just related to women's rights but are crucial in contributing to the developing field of Medical Ethics.

Justice is the foundation stone of the domain of Medical Ethics, and looking through a Social Justice framework would allow strengthening the domain of medical ethics.

This introduction by Ms. Sunita Sheel is a suitable preamble to the workshop, and a lens through which we can view the other sessions, and thus make a connection between gendered experiences of violence, laws, and ethical health systems response.

Session 1: Introduction and Overview Session

Chair: Prof. Lakshmi Lingam, Tata Institute of Social Sciences

Prof. Lakshmi Lingam introduced the panel by making connections between the conceptualisation of Gender Based Violence (GBV) and the health consequences that emerge. Referring to a study related to look at "Health Systems response to cases of Sexual Assault", that she is currently pursuing, she emphasised that social gender norms affect perceptions and responses to Gender Based Violence. Advocacy efforts then have to identify all the spaces to address Gender Based Violence, highlighting inter-sector issues, and making a move towards building an inter-sector response strategy into the existing fold.

Prof. Lingam further raised the question of whether we should use the term "Violence Against Women or Gender Based Violence"? Mentioning that choosing the term Gender Based Violence allows us to be inclusive of LGBTQ persons while developing an understanding of addressing issues of Gender Based Violence within health systems and medical ethics.

Prof. Lingam said that this pre-conference workshop is just a beginning to start discussions on bringing issues of GBV into the fold of medical ethics; and introduced the speakers for the first session, who would kick off the workshop by laying out an understanding of Gender, Violence against women, sexual violence.

Speaker 1: Gender Based Violence

Manisha Gupte, Founding Trustee and Co-convener, MASUM, Pune, MH, India

Ms. Gupte's talk attempted to draw a framework of locating gender and sexual violence. She elaborated this by making the following points:

Gender needs to be understood beyond the concept biological sex, and should not be understood as something that is determined by biological sex alone. Gender then is determined by gender roles and identity.

Gender in itself is Violence as gender relations and gender roles often are systems of violence. Following gender norms can be a site of violence, and not following gender norms are also a site of violence. She referred to this as a situation of "Damned if you will, damned if you won't". Often, following gender roles are internalised forms of violence. Both men and women internalise gender roles, which puts pressure to conform and becomes sites of violence. Forms of violence, especially Marital Rape and the legal understanding of Rape are entrenched in these gendered norms. A married woman, is expected to provide her

husband with sex; and her refusal to do so violates gender roles, which may lead to violence in the form of rape. Not following gender roles leads to violence. MASUM's experience of working in village with women on issues of violence has shown that while there is an understanding that Women above the age of 45years are considered to be de-sexualised, however, incidents of sexual violence have actually increased after women turn 45 years. Older women are humiliated, often sexually, to maintain the gendered status quo and maintain hegemonic power relationships. Gender roles, thus become sites of violence.

There have also been instances of Class Struggles that have had gendered consequences. In Bangalore, a right wing group, attacked women who went to pubs. It was found, that the incident was not just related to opposing pub culture, but was a conscious attack on upper class women. The men who attacked the pubs, were students at the same educational institutes as the women who were attacked at the pub. What seemed like a mere attack on pub culture, was also indicative of class struggle, wherein lower class boys were lashing out against upper class women who could go to pubs and hang out with men, but did not speak to lower class men from their class. The pub incident was a form of revenge against upper class women who openly challenged gender roles. It was indicative of tensions between class and gender, where lower class men wanted to teach upper class women a lesson and assert their patriarchal power. This is another indicator of gender being a site of violence. The attack was directed at bodies of upper class women, not men.

Rape is a women of biological genocide, used to terrorise all people, especially women and children; and is a harsh reality of gender being a site of violence.

Viewing Gender Based Violence through an interacting lens of class, caste and gender differentials reflects that gender is inevitably a site of power.

The issue of consent is crucial, as consent divides sexual violence from sexual agency.

Gender roles put pressure on men too, but this may also lead to violence on women's bodies. In MASUM's work, they came across an 18 year old woman, who refused to go to her marital home, because her husband would consume Viagra every night and want to have sexual intercourse for hours. The husband did not want to fail in bed, which led to sexual violence against the woman. This needs to be seen from a gendered lens, to understand the gendered implications of gender norms across genders. This case helps highlight that men are also in need of liberation from patriarchal gender roles.

The justice Verma Committee Report conducted around 1600-1700 depositions from NGO's and proposed amendments to Criminal Laws pertaining to gender. Two categories of men were excluded from this review- Army and Husband. The husband has impunity in the house, and the army has impunity in the state. A reading of this helps us see that women's bodies become repositories of cultural violence, which is gender based.

Moral policing is imposed on women's bodies, in such a way that women, who are the victims of sexual violence are stigmatised more than the perpetrators of sexual violence. Derogatory language for women often is focussed on her body and sexuality.

Sexuality becomes an issue, where consent is worse than force. Ms. Gupte elaborated this point by sharing a case example of a Child Marriage, where the of the child herself was in favour of the child marriage, because they did not want a pre-marital pregnancy. The mother of the child explained "What will happen if someone pulls her (girl) into a field and she gets pregnant... or worse.. if she walks into the field herself?" Here, the worry of the girl consensually entering a sexual relationship was considered worse than a sexual assault.

Similarly, in case of anal rape a Judge gave a verdict of sentencing the rapist to just 1.6 years as the virginity of the child was not violated.

These cases show that sexual violence becomes more acceptable than consent.

Where it comes to medical ethics and gender based violence, this aspect of "acceptability of sexual violence over sexual consent" would mean stigmatisation of victims (transpersons, women). It would also mean that medical personnel would not want to get involved; women would be infantilized if sexually assaulted and stigmatised if consented.

The hesitation of medical personnel to address the needs of victims of gender based violence, often leads to not enough forensic evidence being collected.

Systems of caste, gender, patriarchy, heteronormativity needs to be challenged to bring about a change in these systems that discriminate and further victimise victims of sexual violence. Until then sexual violence will continue in private and in public.

Manisha Gupte called on the workshop participants to not forget the lived realities of Caste, gender, class; and to listen to voices of those who experience violence and negotiate their lives within these spaces.

Speaker 2: Gender Based Violence: Overview of Reforms

Dr. Jagadeesh N., (MBBS, MD, DNB, LLB, PGDMLE); Professor of Forensic Medicine & Toxicology, Vydehi Institute of Medical Sciences, Bangalore, Karnataka and Hon. Consultant, CEHAT, Mumbai.

Dr. Jagadeesh's presentation gave an overview of reforms pertaining to Laws Addressing gender based violence, highlighted the contradictions in the laws and then concluded by discussing the Challenges and Opportunities that arise in relation to the response of medical facilities.

Dr. Jagadeesh made strong arguments with regards to the following laws: Protection of Women from Domestic Violence Act (PWDVA), 2005 and 2010 (included Jammu and Kashmir); Criminal Law Ammendment Act, 2013; Indian Evidence Act and Protection of Children from Sexual Offences Act, 2012 (POCSO).

Through the discussions on these laws, Dr. Jagadeesh, pointed out the contradictions in laws and issues that arise within providing support to victims of Domestic Violence within medical systems.

Talking about the Prevention of Women from Domestic Violence Act (PWDVA), 2005 and 2010; he made the following key points:

The PWDVA is a law that has been highly regarded within India and emerged from engagement with the social sector. This law was extended to the state of Jammu and Kashmir in 2010, however, it is still just a piece of legislation which is on paper. While, the law includes several provisions to protect women from domestic violence, redressal in the form of judgements are weak. Here, it helps to recognise that judges are also part of the same society and their internalised gender biases affect judgements. Further, many cases are lost on the basis of minor technicalities; leading to very few convictions under PWDVA. Cases of Domestic Violence are still seen as private matters and instead of legal convictions women are pushed into making compromises and out of court settlements.

Dr. Jagadeesh, then suggests that we look at some points to consider when we think about the PWDVA:

- Speedy justice is not available through the PWDVA.
- There are Types of orders that can be given under PWDVA such as custody orders, compensation order, monetary relief, protection order and residence order. However, cases need to be argued separately for each order to get passed.
- Section 7 of PWDVA highlights the Duties of Medical Facilities. However, more than often Doctors and other medical professionals are unaware of these laws and the duties prescribed within the law. There is an extremely minimum understanding of these provisions. Care is not given to victims of gender based violence. Despite advocacy around the issue, the advocacy has not translated to care because of deep rooted gender prejudices and an ignorance of law. Further, there are deterrent effects for not following the provisions, leading to a failure in implementation of the law.

Dr. Jagadeesh then compels us to reflect whether the PWDVA is effective?

The next set of laws that Dr. Jagadeesh emphasised on is **Criminal Law Amendment Act, 2013.** Here, he looked at some of the sections amended under the Act. Below we will look at some of the sections:

Sec 357C of the CrPC provides that all hospitals run by public or private, whether run by central government, state government, local bodies or any person, shall immediately provide the first aid, or medical treatment, free of cost, to any of the victims covered under Sec 326A, 376, 376A, 376B, 376C, 376D, 376E of the IPC and immediately inform the police of such incident.

Further, Sec 166B of IPC provides that whoever being in-charge of a hospital , public or private, whether run by central government, state government, local bodies or any person, contravenes the provisions of section 357C CrPC is to be Imprisoned for 1 year or fine or both.

However, hospitals are not following these laws. Victims of sexual assault are not provided with free of cost health care, they are denied medical treatment. Mandatory reporting in cases to Police for cases of sexual assault has become a serious problem, as the medical personnel do not want to enter into an unwanted criminal procedure.

The other sections discussed by Dr. Jagadeesh were:

- Sec 354 – Indecent assault – with conviction that could result in imprisonment for a duration between 1 to 5 years and/or a fine.
- Sec 354A – Sexual Harassment – with conviction that could result in imprisonment for a duration of 3years (if the sexual harassment is Physical, demand are made, request for sex is made, or Porn is involved),1year (for Verbal remarks), and/or a fine is imposed.
- Sec 354B- Disrobing – with conviction that could result in imprisonment for a duration between 3years to 7years and/or a fine.
- Sec 354C – Voyeurism – with conviction that could result in imprisonment for a duration between 1 to 3 years and a fine (for First conviction) and 3years to 7years, fine (for Second conviction)
- Sec 354D - Stalking – with conviction that could result in imprisonment for a duration of up to 3years and/or fine (First) and 5years and/or fine (Second)
- Sec 375 – Peno – vaginal /anal / urethral / oral penetration -objects / fingering

  This section provides that the age of consent is raised to 18 years. However, the issue of consent is highly contested. In many cases acquittal has been raised because of discrepancies in understanding of consent.

  The section also provides that the victim cannot give consent when she is unable to communicate. In these situations, actual cases often do not come forward.

- Sec 376(1) penalizes rape with an imprisonment of 7years to Life imprisonment and a fine.
- Sec 376 (2) focuses on rape that is committed by Police, Army, Public Authority on a pregnant woman, minor, a woman with physical or mental disability, in communal riots or is a repeat offender; and provides for conviction with an imprisonment of 10 years to Life imprisonment and fine.
- Sec 376 A- criminalised Rape that would lead to death or render the victim in a Permanent Vegetative State with 20 years life imprisonment and fine
- Sec 376 B- criminalises Rape against a wife who is separated and does not consent with a provision for imprisonment between 2years to 7years & fine.
- Sec 376 C- criminalises Rape that is committed by person with authority with provision for a conviction between 5years to 10 years and fine
- Sec 376 D- criminalises Gang rape with 20years to Lifetime imprisonment and fine.
- Sec 376 E – punished repeat rape offenders with Lifetime imprisonment

Dr. Jagadeesh notes that while these laws have been put into place, they are not being implemented well and does not translate into any change. Often, higher conduct sections are written in the FIR, which leads to acquittals.

The Criminal Law Amendment Act, 2013 also takes into purview the **Indian Evidence Act.**

- Sec 114 A of the Indian Evidence Act – states that Presumption as to absence of consent in certain prosecutions for rape.—In a prosecution for rape under clause(a) or clause (b) or clause (c) or clause (d) or clause (e) or clause (g) of sub-section (2) of section 376 of the Indian Penal Code, (45 of 1860), where sexual intercourse by the accused is proved and the question is whether it was without the consent of the woman alleged to have been raped and she states in her evidence before the Court that she did not consent, the Court shall presume that she did not consent.
- Sec 146 of the Indian Evidence Act– mentions that no questions on past sexual practices of the victim are to be taken into consideration. But, the 2 finger test is still being conducted. The past sexual history of the victim, still colours the medical care a victim of sexual assault may receive.
- Further, 164 A CrPC notes that Consent of the victim is mandatory and must be taken during a medical examination of the victim. This is not always followed.

  In addition to this, social biases often further victimise a victim of sexual assault if the woman who consents to sex or has previously had sex.

The next Law that Dr. Jagadeesh looked at is the **Protection of Children from Sexual Offences Act, 2012 (POCSO).**

The POCSO Act makes reporting in cases of sexual offences against children mandatory. This puts huge pressure on doctors, as they may not want to get involved in a police/criminal case; and further as the family/child may not want to report. In such situations, mandatory reporting restricts the victim to seek medical care.

Sec 27 of POCSO pertains to medical examination of the child and mandates that in case the victim is a girl child, a woman doctor will conduct the medical examination, the medical examination has to be conducted in presence of a parent of the child or any other person who the child reposes trust or confidence or where, in case the parent of the child or other person referred cannot be present, for any woman nominated by the head of the medical institution. With this regard, the lack of women doctors (especially in rural areas) delays the examination.

Further, absolutely no psychological counselling is offered to victims.

POCSO has provision for interim compensation to the victim, however, there exist several issues in its implementation.

While POCSO is a Gender neutral law, very few cases that are reported as well as convictions of very few cases that are gender neutral.

Dr. Jagadeesh then looked at the issue of Marital Rape. He emphasised that because of POCSO any sexual activity below the age of 18 years becomes an offence. The status of marital rape however varies over various laws. In several personal laws age of marriage is below 18 years.

Guidelines and protocols: Medico-legal care for survivors of sexual violence, have been issued by the Ministry of Health, Government of India in 2014. These guidelines are not being followed.

Another law related to Gender Based Violence that is often debated is **Sec 498A of the Indian Penal Code.** This law is arbitrarily employed, and discrepancies in filing FIR have often led to acquittals because of the law. Similarly, while the issue of Burns and Dowry (Sec 304B) have been discussed within Medico-legal forums since 1961, very little has been achieved.

With regards to **Acid Attacks** on Women covered under Sec 326A and 326B of IPC, where if the victim suffers from grievous hurt, imprisonment and fine is mandated by the law, and medical expenses have to be paid to the victim. Laws also mandate compulsory treatment of acid victims in all hospitals of India. A Supreme Court order ensures that treatment should be provided as long as it is needed, free of cost. However, it doesn't always work like

this, and there are no means to resolve this. While, there is a Ban on the open sale of acid (Under The Poisons Possession and Sale Rules, 2013), the ban is not followed.

Reflecting on the **Pre-Conception and Pre-Natal Diagnostic Techniques Act, 1994** (PCPNDT). Dr. Jagadeesh mentions that the **ban** on the use of sex selection techniques after conception prevents the misuse of prenatal diagnostic technique for sex selective abortion, but several cases of this have come to fore.

Dr. Jagadeesh emphasised on the Contradictions that arise from gaps in laws. Below mentioned are these points

- Mandatory reporting in cases of POCSO often means that victims do not seek the medical care they require as they do not want to report the case with the police.
- Medical Termination of Pregnancy is a law which contradicts with rape laws, as rape laws apply under mandatory reporting, and so abortion is denied until the rape is reported.
- In the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013, there is no uniformity in the working pattern.
- Supreme Court recognises Transgender(TG) persons issues, but then includes Transsexuals and not other TGs...The health sector recognised Male to Female Transgendered individuals, but is not ready to acknowledge the issues of Female to Male transgender persons.
- Within Rape laws, there is no voice for forced sexual violence where the husband is the perpetrator of violence. The husband is exempted from all kinds of rape (objects, etc.) even though the health consequences are dire. Often in rape cases, people go to the police station first, instead of going to the hospital, which further may compromise evidence and medical care needed.

Having highlighted this, Dr. Jagadeesh laid out the opportunities and challenges that can arise from these laws:

Challenges

- Beliefs and cultural values are challenges in incorporating issues of Gender Based Violence into medical facilities. Laws are changing but cultural beliefs around gender issues are a challenge.
- Ignorance about laws, guidelines and protocols is another major challenge.
- Multiple Stakeholders: Addressing issues of Gender Based Violence requires the involvement of multiple stakeholders. These stakeholders may not be on the same page leading to further challenges.

Opportunities:

While, there are multiple challenges legal reforms have also provided opportunities.

- Legal changes have been incorporated to make laws more gender just.
- Advocacy efforts have put various and multiple issues of Gender Based Violence on the agenda.
- Opportunities have been initiated to address needs of multiple stakeholders.

Speaker 3: Amicus Brief : A journey from Mathura to Nirbhaya

Amicus curiae : Ms Indira Jaising

Research support by Lawyers Collective , CEHAT , Vrinda G., Madhu M., Bharati Ali, Bhumika J., Ministries

Presented by: Sangeeta Rege, CEHAT, Mumbai.

Ms. Sangeeta Rege, presented the Amicus Brief that looked at rape laws in India. Post the Nirbhaya episode, 15 petitions were pending before the Supreme Court. In an effort to capture four decades of developments with regards to rape laws from Mathura to Nirbhaya, an assessment of state actions vis a vis constitutional diligence and obligations was undertaken. CEHAT specifically contributed to chapters on emerging issues related to marital rape, mandatory reporting concerns, age of consent and victim compensation schemes.

The Amicus Brief contains: analysis of the strategies towards addressing violence against women (VAW) adopted by departments; reviews prevention mechanisms adopted by GOI; assesses infrastructure and human resources, education, awareness-generation; review of registration and investigation procedures; prosecution and punishment (including victim & witness protection); rehabilitation and reparation and reviews sex offenders registry.

The Government of India, announced a dedicated 'Nirbhaya Fund' and allocated finances to: Installing of CCTVs in certain public transport vehicles; initiating the proposed Crime & Criminal Tracking Network System (CCTNS); and Initiating 'One Stop Centres' Scheme by the Central Government.

Sangeeta Rege highlighted Key Issues of the Amicus Brief:

- Non Recognition of Marital Rape

Sexual violence in marriage is exempted from the definition of 'rape', (recognises 375B IPC non-consensual intercourse by the husband when the couple is separated). So, if women live in marriages there is no recourse in the law. The only recourse is criminal law under section 377 IPC, which is a cause for concern since it is violative of Articles 14, 15 and 21 of the Constitution.

Ms. Rege emphasized that **Marital rape as an offence and** Forced sexual intercourse within marriage should be brought within the ambit of definition of rape under section 375 IPC, by deleting Exception 2. in view of the expanded definition of rape, such cases should be registered under section 376 IPC.

- Non recognition of adolescent sexual behaviour

Consensual sexual activity particularly among young adolescents is categorised as rape. This There is a dichotomy between the policy of the law and the increased recognition that sex/sexuality education among young adolescents is the key towards encouraging responsible sexual behaviour during adolescence and adulthood. A young male below the age of 18 years but above 16 years of age if in consensual sexual relation is liable to be convicted for rape. If he is dealt with as a juvenile, he goes to a correction home for detention. If he is tried as an adult under the proposed new amendment to the Juvenile Justice Act, he will have a criminal record for the rest of his life even though the sexual intercourse may be consensual.

Discrimination against adolescent/young adult males who are criminalized for consensual sexual relationships are contrary to public interests.

- Mandatory reporting of sexual violence

Ms. Rege raised several concerns regarding the issue of mandatory reporting. Mandatory reporting on the part of health systems jeopardizes their therapeutic role and becomes a barrier in providing care to victims of sexual violence. Mandatory reporting further leads to refusal for accessing care, which in turn jeopardizes health of survivors. Notions of shame and honour associated with rape prevent survivors from divulging the crime. Insensitivity and long delays of the criminal justice system deter survivors from reporting the crime to the police.

- Gaps in victim protection services schemes

Witness and victim protection programs need to expand outside the court. The lack of mechanisms for victims to report to another system without having to go through police makes it difficult for victims to seek protection. Further there is a lack of recognition that survivors may not wish to go through the Criminal Justice System, and that they may be in need of counseling, compensation, rehabilitation and health care.

- Concerns with Sex offender registry

The Ministry of home affairs seeks to publish a sex offenders' registry online, which will track offenders. This registry would be inclusive of suspected, under trail, charge-sheeted offenders and will not be restricted to convicts. CEHAT takes a stand to do away with sex offenders registry which is public. This registry will comprise of details such as name, age, sex, types of crimes committed, address, nature of diseases suffered etc. This registry would

be a violation of the right to privacy of suspected offenders without judicial determination of guilt, considering lack of accountability of police, this can become a tool of harassment in the hands of police and certain kinds of communities as people may suffer more harassment.

- Concerns about Non Implementation of MOHFW medico legal care guidelines

The Ministry of Health and Family Welfare in collaboration with World Health Organisation brought out Guidelines and Protocols for Medico-Legal Care for Survivors/Victims of Sexual Violence.

Out of 23 states and Union Territories only 9 states have passed the government orders pertaining to the implementation of the guidelines. The Medico-Legal care guidelines over-emphasize on forensic examination that continues in medical systems. The therapeutic role is still not recognized by the medical systems. There is an overemphasis on infrastructure and paraphernalia for examination.

Further, there is lack of understanding among police and courts vis-a-vis medico legal evidence and its scope. For example, hymen status is still checked even when victim is saying that there was oral penetration.

There are contentions whether health is a state subject which leads to shrugging of responsibility for undertaking the guidelines by the Union Government. Since, health comes under the concurrent list, the Union government can take a stand, but it is refraining from doing so.

In conclusion Ms. Rege made the following points:

- Forensic Science is emerging as a new area of science. As it is still emerging, an over dependence on forensic often means that police are not investigating the case properly. This may lead to evidence being lost. This is supported from evidence from other countries, where police tends to under investigate a case when they think doctor has done forensic investigation. A DNA test is not as important when the offender is known.

- Further, emphasis is still laid on injuries. Injuries can happen in consensual as well as non-consensual sexual acts. Therefore, there is a need to step away from over emphasis on injury and forensic evidence.

Summing up the session Prof. Lakshmi Lingam connected the discussions of the above speakers with the theme of the pre-conference workshop and laid the ground the forthcoming sessions.

Session 2: Child sexual abuse with focus on POCSO

This session focuses on the The Protection of Children from Sexual Offences Act 2012 (POCSO) and the issues of implementation of the Law cutting across various institutional settings within which children are located – schools, institutional homes, residential schools, street children and so on.

Chair: Kranti Agnihotir-Dabir, MASUM, Pune, MH, India

The session was chaired by Ms. Kranti Agnihotir-Dabir. She introduced the session by briefly speaking on the subject of Child Sexual Abuse and then introduced the panellists.

Ms. Kranti outlined the challenges that emerge in the implementation of POCSO and compelled the workshop participants to look beyond POCSO while discussing issues of Child Sexual Abuse(CSA), and differentiate between POCSO and CSA. CSA needs to be seen from a broader perspective, through a lens of child rights. CSA is about control and ownership of children by adults and an abuse of the dependence that children have on adults.

Through her years of experience working on the issue of CSA, she highlights that Children do not talk about issues of CSA, as children first of all, lack the language to address sexuality and thus CSA. Children also lack a space to talk. They do not comprehend “abroo” or reputation/shame, but that the home will lose its reputation and this will impact the family/relatives/home/community if they talk about CSA. Children as young as aged 9years old develop this understanding and keep silent about CSA. All this has a physical as well as psychological impact on the child. In some cases children have long lasting issues related to CSA, as their genital organs tear and they have to undergo surgery. There are cases where intestines have torn out, and for decades after the sexual assault the girl will have to go to a doctor every month for the rest of her life.

The psychological effects are even grave. Just because they don’t speak about it doesn’t mean that children forget. They go into depression, they often become crude. Similarly, they may get into addictions as a way to escape this. They go astray from their parents as they feel that their parents are not supporting them. Usually the perpetrator is a family member and severe power relations come into play. In some cases children may also commit suicide. There are incidents where victims of CSA become abusers too. There is a long term loss of childhood because of this.

While discussing the issues of CSA and “abroo”. The abroo is not just of the family, but of the family and the child as well. Working with parents is crucial in addressing cases of CSA, as parents are not in the position to do anything about this. Schools are more worried about protecting the honour of the school and not protecting the child.

With regards to the police, the police feel that it is an additional burden and are negative towards registering the cases. Even while doing mandatory reporting there are issues.

Working with health system has its own challenges, as young girls are admitted in gynaecology wards and boys in adult male wards of hospitals. It is only in cases of CSA that young children are treated as adults and they are not treated as children in the medical facilities.

POCSO is in existence since 2012, but a lot of work has been done on the issue much before that. POCSO does not empower children. Further, issues of children between ages of 16-18 years still needs to be re-thought within POCSO. Overall, a scrutiny needs to be conducted to look at CSA with a wider perspective; to create better spaces in implementation of POCSO.

Having laid the ground for the session, Ms. Kranti Invited the first speakers.

Speaker 1- Issues, Conceptualisation and Case Studies related to POCSO.

Adv. Medha Deo, Sr. Programme Officer, Resource Centre for Interventions on Violence Against Women; and Ms. Jyoti Sapkale, Regional Coordinator, Special Cell for women and Children

The speakers are affiliated with the Special Cell for Women and Children and bring legal and field practice insights that have emerged through the collective experiences of Special Cell - Social Workers, who work on cases of POCSO through their location of being in Police stations.

Adv. Medha highlighted the issues that have emerged through the case work done through Special Cell, and Ms. Jyoti spoke about the conceptualisation of POCSO and shared case studies. Their points are collectively presented below.

Based on Special Cell data, it was highlighted that the highest number of cases under POCSO are reported from within the family. This also means that there is emotional familial pressure, which is heightened if the perpetrator is a financial provider in the family which may further lead to resistance to move the case forward.

Since, Special Cell works within the Police System, Special Cell has to mandatory report cases of CSA if they come forward. Some organisations have taken a stand against mandatory reporting and do not do this, but Special Cell follows the POCSO mandate for reporting cases of CSA. Therefore, in cases which are complicated and the family may not want to report a case of CSA, Special Cell will still have to report it. Special Cell is women

centred in its work approach, but in this case special cell has divulged from this approach due to the provision of mandatory reporting within the law.

Another issue is that of Sexual Assault within marriage, especially in the case of child marriage as there are several overlapping laws like IPC, personal laws, POCSO that address this. POCSO overrides all other existing laws. So, if the person is below 18 years, and is married then it becomes a case of CSA. However, at the same time there are several court judgements where personal laws have primacy and not POCSO, especially in the case of marriages, wherein the perpetrator will be marrying victim.

POCSO has another issue where it comes to Consensual sexual relations between young adults who are below the age of 18 years. These cases are being referred in the police station as Sairat case. Sairat is a popular Marathi movie, where an upper caste girl and a Dalit boy fall in love, and resist family pressure, police pressure and elope. Sexuality for teenagers then becomes unacceptable, where force is acceptable but consent is not.

As per POCSO all sexual activity below the age of 18 years is CSA. Therefore, in a self-arranged relationship, where there is a caste difference, POCSO is being implemented to arrest the man. POCSO is selectively being used, though its reporting is mandatory.

There are several challenges in the implementation of POCSO:

- It is difficult to file an FIR.
- There is a provision in POCSO for a Support person to be present with the victim. However, there is no clarity on who this support person should be.
- Mandatory reporting is a pandora's box of issues. Especially, within the medical field as people self-medicate to have abortions at home instead of seeking health care, exposing to health hazards.
- The Act does not have any provision to protect those persons who do mandatory reporting. There is no whistleblower protection. There have been cases where the counsellor who has reported a case of CSA has lost their job.
- Criminalisation of young love happens under POCSO, as all sexual activity below the age of 18 years is considered CSA.
- POCSO is not Survivor centred. There is no clarity regarding compensation etc. Further, POCSO's implementation relies on other government infrastructure such as shelter homes, health services etc. And these systems are unable to take care of the needs of CSA survivors.
- There is an absence of mental health services.
- POCSO provisions conflict with those of personal laws.

Expectation from medical system

- Medical examination should be consensual (constructive role of doctors in getting consent)

- Due to case load the attitude of doctors is very casual, and lacks a survivor centric approach even in cases of CSA. This breaks the confidence of the survivor.

Some case studies were shared to elaborate the issues in implementation of POCSO :

- Mandatory reporting of cases:

Mandatory reporting may not always be child centric. In a particular case, a witness saw a grandfather sexually abusing his granddaughter. The mother was estranged from the family and did not live with the children. After the witness brought in the case, the mother was called to the Police Station from another village. The mother and child were both fearful. The mother refused to give consent. Since, the grandfather was running the house and was the financial provider it created issues in reporting. The condition in shelter homes is bad, so the state isn't exactly looking after the child well if the child taken into shelter. The child had no place to go.

- Child Doesn't want to report

A boy in 10th standard was being sexually abused since he was in 4th standard. He doesn't want to report the case. But he needed psychological help. Special Cell took the case as a One Time Intervention, as the child did not want to register a case.

- Working with systems

A case of CSA came to Special Cell. An 11 year old girl was six months pregnant when the case came in, and eventually delivered a baby. There was no clarity regarding who would be the support person for the child.

The girl claimed that her cousin brother (maternal uncle's son) was the father of the child. Cultural opinion was to get her married to the cousin. But her uncle beat her and threw her out of the house. Medical personnel blamed the mother for the pregnancy of the child. The entire family went against the mother and the girl. The house that the girl lived in was broken. The Special Cell, found it extremely difficult to find shelter for the girl, since there was also a baby involved. There was physical violence against the girl. The case was extremely complicated. Finally, a DNA test was done to assert paternity, this test came negative. By this time the cousin was convicted. This complicated the case further. It took 3-4 years for a judgement in this case.

- Pregnancy and POSCO

A 12 year old girl was pregnant. Her mother wanted her to abort the foetus but the child did not want to. Due to delays in consent and several other issues, the girl ended up having the baby.

In the labour room there is no provision for understanding children.

Further, Shelter homes have no provisions/infrastructure for child victims of CSA.

Summing up the case studies, Ms. Jyoti Sapkale highlighted the need to look at difference between CSA and POCSO, and to centre the laws around the child?

Speaker 2: Challenges in POCSO

Nandita Ambike, Lead, Muskan

Ms. Nandita spoke about the challenges that emerge in POCSO. She asserts that the basis of the challenges lies in the perception of the family, which is embedded in a system that needs to guard its reputation (abroo). The manner in which the POCSO case unfolds depends on several factors that emerge from the need to safeguard "abroo". So if the CSA is perpetrated by a bread winner, chances of reporting are low; or if it a case of inter-caste love, or inter-religious love between minors then POCSO is immediately reported. Moral policing of love manifests itself by the misuse of POCSO.

In the same culture, child marriages of girls aged 15 or 16 years is accepted, when the families arrange it. But when young adults make romantic choices outside their communities (caste, religion) then POCSO is applied.

In one case, a 4 or 5 years old girl, was sexually abused by an older man aged 22-23 years old. When the girl spoke up against it and a case was going to be made, political people made the case into a Hindu-Muslim issue and dissolved the case. The need of the child was not considered at all.

POCSO, gets misused where it became a class/caste issue. In a housing society in Pune, the sweeper held the hand of a girl and put her aside because he wanted to sweep. This was escalated by the society and a POCSO case was filed against the sweeper. The argument was – "why did the sweeper touch the child?". The child herself said that there was no sexual abuse and that the sweeper had only held her hand and led her to a side. She said that she continued to play even after that. So, while there was no sexual abuse, a case of POCSO was applied against the sweeper because a person of a lower class/caste should not be touching the children.

The Police are often unaware of POSCO. Further, the police are also clouded by gender biases such as the father can't be an offender, the girl is at fault, boys can't be abused... The police have perceptions, which may hinder POCSO's implementation.

Further, due to pressure from home, victims often retract statement.

Police deter parents from making a complain.

Police is unable to write in the language of the child.

The guidelines are not being taken into account.

Police cannot often go in civil dress for getting statements. They assert that children are not scared of police and so whether they go in uniform or in civil clothes does not make a difference. In one case a police officer used manipulation, by telling the child that the hospital has a test to make her tell truth, so she should tell it herself, and sought the statement of the child. This particular police officer used to pride herself over her strategy to gain the statements of children and was called whenever such a case came up.

There have been cases, where Social workers who were helping the child were not given access to talk to the child, but parents/family who want to cover up the incident are given access to the child. The child loses faith and trust on social workers. Further, the family manages to coerce the child into agreeing to say what they want her to.

Further, while filing a POCSO case, the police often do not write the appropriate clause in the FIR.

The law also has some shortcomings. Instead of 30 days, the children should be taken to the magistrate in 8 days. Delays due to lack of availability of court dates need to be avoided. It takes a long time for a case to stand. May be fast track courts should be started.

In special courts, often there are no separate waiting rooms for the victim and perpetrator. The perpetrator glares at the child and the child gets scared. The victim and perpetrator in many cases are brought to court in the same vehicle. Court systems are not equipped to deal with sensitivity in such cases.

The Manodharya scheme provides compensation to victims of sexual assault. While funds are available, there are problems in implementing the schemes. In many cases of CSA, the parents relocate (can't find them), police don't send papers to avail the scheme because they are not sure of the process, banks refuse to open accounts for minor children, delays in getting passbooks etc. This means that compensation is not easy to access.

While victims and parents both need psychological counselling, attitudes about psychological counselling are negative, and counselling services are also not easily accessible.

Speaker 3: Looking at POSCO as a law that has to safeguard children

Manisha Tulpule, Women's Rights Lawyer, Mumbai, MH, India

Manisha Tulpule emphasised that first we need to remember that POCSO is an act for children. The judiciary, police, health systems lacks sensitivity about children. In January 2016 a judgement came from Thane court about a 19 years old, who had made a complaint at 16 years of age, about being raped by her father. In cross examination, she said it was a false complaint. And the Public Prosecutor wanted to make a case of perjury against the girl. At the time of the workshop the child had been brought before Juvenile Justice Board. Now, the girl is hostile. According to POCSO, no case can be put on the child, but this Thane court case, is a violation of that. Now, lawyers are challenging the Thane court judgement.

If we inspect the Thane case further, we see that the girl did not get the necessary support as per POSCO. Was a thorough home visit conducted? Was she provided shelter?

Who then misused POCSO, the child or the state?

In cases where there is abuse in the family, there is need for shelter. If some relative is taking the child to their house, is there any check done to see if the child is safe?

There is insensitivity about children, and because of which cases of acquittal are high.

Trainings on POCSO are not provided to CWC (Child Welfare Committee) members, they are only trained on the Juvenile Justice Act. CWC is not aware of their role in rehab.

Further, under the Juvenile Justice Act a Standard Operating Procedures book is made to guide its implementation, there is no such provision for POCSO.

A list of “support persons” for the child needs to be streamlined.

In many districts child protection officers are not appointed.

As per POCSO, the accused and victim should not come in contact; but in courts, in hospitals... this happens.

The Act makes provisions for audio-visual recording of the child’s statement, but if children are not comfortable they do not speak. Further, the recordings are often done on mobile phones, and there is no confidentiality maintained.

There is no sensitivity towards children.

Medical systems are still looking for puberty, injury and conducting the 2 finger test to determine sexual assault.

If the families of children are sensitive, there is a huge positive difference in the way the case pans out.

In many cases the victim of CSA is further victimised as she is considered as a bad influence on other girls. The victim is stigmatised.

Ms. Tulpule shared a positive case as well, emphasising that POCSO can be well implemented. Stree Mukti Sanghata (NGO) was conducting a training in Raigad with children at a children's home. Here the children spoke and said that a teacher was sexually abusing them. Under the Juvenile Justice Act (JJ Act) and POCSO positive orders were called and the children were moved to different homes. 18 children were moved from this home. 3 social workers (ngos + 1 cwc + cehat + lawyers collective) were appointed to take this case. Role of CEHAT was imperative. The counsellor was good. So children gave statements. The team was able to do a lot of things for the children.

Ms. Tulpule suggests that Standard Operating Procedures should be made for POCSO, to guide its implementation.

A completely ignored part in implementation of POCSO is the issues of CSA among transgendered children, who have no security. There is no sensitisation among the CWC. These cases come to the hospital and then disappear. Issues of TG children are blind in discussions about CSA.

Open Discussion on session 2:

The Chair of the session opened up a discussion based on the papers presented. She summed up the papers and presented the following key points for us to reflect:

There are many questions, but very few answers to the issue. There needs to be a sharper understanding of where are children safe? Children may not be safe at home? Are children safe at Children's homes/shelters? Why is it that the abuser continues to be safe at home, while the child is displaced.

Need to look at cases of CSA from the point of view of the child.

All systems (Police, health, shelters, courts) view the issue of CSA from an extremely insensitive manner. Public Prosecutors and the Police often scare children and their families to drop the case or refrain from reporting.

Questions/comments from the audience:

- Dr. Jagadeesh made the following observations:
- Sec 41 POCSO is troubling, because it says that medical exam has to be done with consent of parent.... What if the parent is the abuser? Or the parent is unable to give consent?
- CEHAT has been opposing the mandatory reporting right from the start, but several disagreed on it... now many more people are on board.

Session 3: Sexual Violence and Intimate Partner Violence: Health Systems Response

This session covers issues emerging with the Ministry of Health & Family Welfare Guidelines on GBV to be adhered to by public and private health institutions. This session attempts to understand cases of sexual assualt as well as intimate partner violence (IPV) within marriage and outside and the health systems response to the same.

Chair: Sangeeta Rege, CEHAT, Mumbai

Ms. Sangeeta Rege chaired the session. She introduced the session by speaking about "Guidelines and Protocols for Medico-Legal Care for Survivors/Victims of Sexual Violence" which have been brought out by The Ministry of Health and Family Welfare in collaboration with World Health Organisation. She shares that these guidelines are extremely nuanced and were complied by an expert committee comprising of experts from different disciplines. The guidelines go beyond the collection of forensic evidence and actually focus on varied aspects of medico-legal care. However, while, this guideline was brought out in 2014, and issued by the Ministry of Health, not all states have adopted the guidelines.

This session would keep the guidelines in focus and is looking at experiences of married women, transpersons and gay persons within this session.

Speaker 1: Village Level Interventions for Combating Gender Based Violence

Kavita Jagtap, MASUM, Purandar Taluka, Pune, MH, India.

Ms. Jagtap shares insights into working on issues of sexual violence in rural Maharashtra through her engagement with MASUM.

She began speaking about Violence within the family, emphasising that families are sites of violence and the family is not always safe for women, even though cultural perceptions lead us to believe that women are safe within the family. MASUM has been working on the issue of women's rights from over 30 years in Purandar Taluka and she shared her learning from this experience.

Women experience Verbal abuse in their daily lives from several persons. There have been several instances where women experience sexual harassment and even forced sexual contact from men in the families such as Father-in-law, brother-in-law.

Women also experience violence, if the husband or family has a suspicion that she is in a sexual relationship with someone other than the husband.

Speaking about the violence in their lives often leads to violence, and this makes women fearful of the repercussions of talking about this violence. Even young girls are aware of this and do not talk about the violence. Mostly, younger girls keep silent, because speaking about sexual violence means that their education will be stopped, and their mobility will be curtailed.

Ms. Jagtap elaborated using a case from a village in Purandare Taluka. A single mother of two young boys lived in this village. She was in a sexual relationship with a man (her boyfriend) who was not her husband, and it was public knowledge in the village. Due to this, several other men in the village would approach her for sex, which she would decline.

Her boyfriend wanted to marry her, and she accepted the proposal. However, she soon found out that the sole purpose for him to marry her was because she owned property. When she confronted him about this, he attempted to murder her. She was brutally battered and needed help.

The lady had no support and her children were young. All the women from the village came to her support. They took turns and stayed with her in the hospital till she was discharged, they looked after her children in her absence, they found a shelter for the children. After she was discharged from the hospital, the women from the village took care of her, cooked for her, fed her, ensured that provisions were supplied in her house, and she was nursed back to health.

Ms. Jagtap draws from her work experience and notes that combating sex-based violence at the village level needs to be addressed through interventions emerging from the village itself. It is the responsibility of the people from the village (not NGOs or government). There are limitations to the scope of intervention of NGOs. Awareness campaigns are necessary to build sensitivity at the village level. Women from the village were collectivised, aware and sensitive about gender issues and thus were able to combat the violence.

In another case, a doctor from the village was abusing women. The women from that village, collectively posed this issue in front for the Gram Sabha and the Gram Sabha took it up as an issue that the village would address. They took the case to the Police. The doctor was arrested and the hospital was closed. The entire village took initiative and helped the police to file the charge sheet and investigate the case.

Aadhar groups (women's support groups) are important in a village, because a community worker cannot reach everywhere. An Adhar group at the village level builds the capacity of the women from the village to address issues of local violence.

Women are dis-empowered but through Aadhar groups initiatives have been undertaken to put the wife's name on the house plate too. This has given women a sense of entitlement and right over the house, and assert that they cannot be thrown out of the house. The groups provide women with solidarity. The groups have come up with nuanced ways to dealing with difficult problems. Such as in cases where a man has two wives, they have been able to ensure both women's rights are upheld.

Ms. Jagtap elaborated that violence and health are inter-connected closely. MASUM also conducts uterus cancer check camps irrespective of caste, religion, HIV status. Women use this space to come and speak about the violence they experience at various levels. So many health issues are outcomes of gender based violence.

Sexual health is also discussed through the intervention of MASUM.

Further MASUM has taken an effort to communicate with the family to talk about issues related to violence, especially with regards to sexual violence.

Sometimes, the family and husband, have requested MASUM to take the woman for treatment, but effort is made to ask the family to take responsibility for the health needs of the woman.

For hysterectomy (atropy), women should take care of themselves but the family should also take care of women. And we work with the family to take care of women when they are recovering.

When women seek to go to the Police, they often are treated roughly and police intimidate women to not file complaints. MASUM believes that any person needs to be treated with dignity... whether they go to police, hospital etc. In lieu of this, MASUM conducts trainings with Block/Taluka level hospitals, police etc.

Within the health system, there are perceptions of what profile of women would need what kind of sexual health care. If older women go to doctor with infections, doctors sometimes ignore it or are unable to diagnose it. MASUM works with ASHA, anganwadi, and government health systems to create awareness about this. Since, the ASHA worker is a lady from the village, she becomes a point to whom the women can talk about violence and seek help.

Ms. Jagtap had much more to talk about, but due to the shortage of time she wrapped up the session saying that- Village level mobilisation of women to address issues of Sexual Harassment are needed to be able to address sexual violence and its health repercussions at the village level.

Speaker 2: Intimate partner violence and Women in sex work

Tejasvi Sevekari Director, Saheli Karyakarta Sangha, Pune, MH, India

Ms. Sevekari spoke about the invisibilised issue of intimate partner violence among sex workers. Whenever the issues related to the rights of sex workers are discussed, people get fixed on the issue of HIV/AIDS. But, violence is a part of the daily lived reality of sex workers; and while we think that brothel keepers, police, pimps are perpetrators of this violence; sex workers often face violence from intimate partners too. No efforts are made to engage with people who perpetrate violence against sex workers, as there is stigma attached and there is an assumption that it is something the sex worker deserves, because of her work.

Another assumption is that Sex work is equated with trafficking. But violence within sex work is often ignored. Recently the Saheli Karyakarta Sangha conducted a program on reproductive and sexual health. While, doing the baseline it was assumed that the violence would be perpetrated by clients, pimps or police. However, 39% sex workers mentioned that intimate partner violence (sexual) was prevalent. In the case of sex workers, the blame for the violence is placed on the sex worker. Further sexual violence is such an integrated part of sex workers lives that they often internalise the violence. There is a dire need to work with sex workers on the issue of intimate partner violence. Within health systems, sex workers' health issues are always discussed in the paradigm of HIV/AIDS or sexually transmitted infections; there is a need to look beyond that and examine issues of violence.

Apart from sexual and physical violence from intimate partners there is also emotional and financial violence. Most women don't want to acknowledge intimate partner violence, or report it. How can intervention be done to address this violence with police, hospitals, counsellors etc. if it is not understood by the organisation. What can be done beyond reporting the case is something that still needs to be understood?

There needs to emerge an understanding about examining Gender Based Violence and its impact on the lives of Sex workers.

Stigma towards sex workers is very high, and this stigma leads to sex workers not being able to access health services, because the stigma translates to those who work with sex workers.

While, so many discussions and laws have come up to address sexual harassment at the workplace, the violence that sex workers experience at their workplace is not a part of the discussion.

There are protocols to test sex workers for Sexually Transmitted Infections (STIs) every four months; but no consent is taken of the sex worker. NGOs are designated to conduct these tests, and these are done without any provision for taking consent of the sex worker. NGOs

do this for the government. But, the act of not taking consent indicates that sex workers are not treated as human beings.

Ms. Sevekari recollected that when she was a student, a case of gang rape had come up in a red light area.... the police said “ye toh randi hai, iske saath kya rape hoga” (She is a sex worker, how can she be raped). The police had an attitude that a sex worker could not be raped. There continues to be no acceptance of police with regards to violence against sex workers. These perceptions are why Domestic Violence experienced by sex workers is kept private, and no one interferes.

There are new trends in sex work, especially because of the strengthening of child rights. Minors are not brought into the red light area, but are kept in outskirts of the city till they get used to sex work. Brothel keeps pressurise sex workers to take on more clients and sex workers have to work against their will.

Where it comes to discussions on intimate partner violence among sex workers, there is no discussion beyond condom usage... there is no discussion about safe abortion, other contraceptives, reproductive care and health.

Since, the health needs of sex workers are not recognised it is even more difficult to bring this into the legal framework. Moreover, no one in the system is even willing to engage about this.

With regards to shelter homes, one needs to question and ask “are safe spaces really safe?” (rescue related). Girls get pregnant in shelters. Girls run away and go back to brothels. They feel safer in brothels than in shelters. These are indicative of the inhuman conditions of shelter homes.

As an NGO, Ms. Sevekari’s organisation has tried to register cases of sexual violence done against sex workers, but this has been extremely challenging.

A big vulnerable group is that of children of sex workers. There is a high prevalence of CSA. A child is not safe in a brothel and is not safe in shelter either. While, there is some work being done, not enough is being done.

Summing up her talk, Ms. Sevekari mentions that there is a need to move from an understanding of “sex worker” to understanding “women in sex work”. All the issues that women experience are also issues of sex workers. This change in perception can help guide and facilitate the development of preventive strategies... which would include but not be restricted to medical response.

Speaker 3: Violence: a Transgender - Hijra perspective

Ms. Gauri Sawant is a Transgender activist and Chairperson of the Sakhi Charchowghi Trust, Mumbai; and

Ms. Lacchi Pune is a Transgender Activist in Pune. The speakers presented a Transgender-Hijra perspective on Gender Based Violence.

Ms. Gauri started speaking by defining "Transgender"(TG), she sharply noted that everyone talks about men and women; but not everyone wants to talk about Transgendered persons when they talk about gender. TG persons' issues are often restricted to HIV and condom usage.

She notes that where it comes to violence against TG's they face violence since birth. She shared her personal experience of being unsure about her sexuality and gender identity, and being subjected to violence because of her gender preference. Transgender persons face violence at the family, they are often asked to leave their homes because the family fears that their sisters/siblings won't find a suitable marriage partner. Ms. Gauri spoke about her personal experiences of when she was in school, and used her birth male gender name of Ganesh, she was constantly asked why do you talk like women, walk like women? She was teased and even threatened. She said that even as a child she knew, just like many other transgendered children, that she will not be accepted in this society. Men won't accept them and yet they won't fit in with women. So, then transgendered children often leave home and go and find women like themselves (Hijra).

In cases of born hermaphrodite children the decision is made by the parents, as to selecting the biological sex of the child and so is the gender identity. The child never has a choice. In some cases, the parents give up these children to the Hijra community.

Ms. Gauri emphasises that she had to go to court for her identity as a transgender person to be acknowledged by the state.

She also spoke about how going to school was difficult, as using washrooms was difficult. The violence in families and the bullying and lack of acceptance at School leads many children to run away.... They run away and come to the Hijra community.

The Hijra community is not free of violence either. There is pressure to conform to the Hijra way of life in the community. Further, there is a hierarchy and dominance of "gurus"(mentor). Draping the saree is considered as a sign of claiming the Hijra identity and is equated to a Kafan (burial cloth), indicating that being a Hijra is a kind of death.

If anyone sexually harasses a Hijra, no one stands up for them. If they are at railway stations, or try to get help from police; they end up being sexually harassed instead of being protected from sexual harassment.

Further, there is violence from the “Guru” as well. Young adults, at the age of 16 or 17 years run away from their homes and reach the Hijra community. There are still evolving in their sexual identity. The guru will pressurise them to get the Nirvana (castration) done. There is no counselling offered. Often they can’t go back to their parents, and they get stuck in a different system of violence. There is also intimate partner violence among Hijras. The perpetual nature of violence often leads Hijras to develop psychological issues and they may slit their wrists.

While several people advocate for sex education, the syllabus of sex-ed does not cover transgender persons.

The lack of livelihood opportunities for TG persons leads them to get to begging and sex work.

Police violence is accepted as normal.

Further, when the Ministry of Women and Child Decided to take into account the concerns of TG as members in WCD, they only invited Male to Female transgender persons. Female to Male transgendered persons were completely ignored.

Ms. Gauri asked an imperative question to the audience. She asked if she was a citizen of India? And if she was then why were her rights denied to her at every level?

Intimate partner violence is not just physical. She cited the example of an ex-partner who said that he loved her, but told her that he could never take me home. She accepted the arrangement, but it hurt her emotionally.

The sexual violence and harassment against transgendered persons permeates to systems and is ingrained in the attitudes of people. When transgendered persons go to the Police Station and if they say that they are hungry, the police will reply asking “kela khatos ka?”(Do you want to eat a banana? Which is indicative of oral sex)

Ms. Gauri emphasised that all the begging behaviour and coming onto people is indicative of an outlet of the anger that TG persons experience.

She said that the prevention of HIV/AIDS discourse paved the way for initiating dialogue and acknowledging the issues of Hijras.

Section 377 says sex between people of the same sex is an unnatural crime, but then Hijras are part of NACO, a government body that gives free condoms to Hijras. The government, acknowledges the identity of transgendered persons where it comes to issues to public health such as HIV/AIDS, but does not transfer this acknowledgment to their sexuality rights and continues to maintain laws that treat them as criminals.

Transgendered persons further have issues, such as they can’t get a house on rent or travel. Traveling in public transport is difficult as no one wants to sit next to them. Ms. Gauri spoke

about how at the workshop venue, the watchman didn't let her come in. During lunch, a conference participant didn't sit next to her for lunch.

Violence has become so normal in the lives of Hijras that they have started ignoring it.

India has a Hijra system, but the guru gets the younger Hijras into alcoholism, smoking, sex work, begging etc. Transgendered persons are a vulnerable high risk group where the Hijra herself has an attitude that she should just die..

Hijras lack basic citizenship rights in India. They have been unable to get a ration card.

Many transgendered persons are born as a man, and first come out as effeminate gay, they are often forced to get married.

Ms. Gauri emphasised that there exist several myths regarding transgendered persons that needs to be dispelled. Stigma needs to be dispelled.

Stigma in hospital settings, means that transgendered persons are not given proper medical care. If they have to be hospitalised there is a dilemma as hospitals don't have special wards for transgendered persons. In a particular government hospital, a Hijra person was put on a mattress on the floor in a corridor near a toilet. Doctors are themselves not sensitive to the needs of transgendered persons, so much less can be expected from other medical personnel. Steps to eliminate discrimination need to be initiated in hospital settings. Within health systems Hijra are only included within AIDS Control. Doctor's syllabus also doesn't include how to provide medical care to transgendered persons. They are unaware as to which catheter is to be used. They don't learn how to perform a castration.

Government programs focus on condom dumping to transgendered persons, and do nothing more than that. Transgendered persons don't have jobs, housing, citizenship rights and these issues get ignored.

Among Hijras there is the existence of a panchayat. This panchayat does not recognise intimate partner violence. If a Hijra does go to the police to file a complaint the panchayat will penalise them with a fine of Rs. 1,50,000/- because of which they don't have any recourse to the law either. The community has oppressive practices.

Open Discussion on session 3:

The session was opened for discussion and the following questions emerged. The speakers answered the questions and also encouraged a discussion.

Questions:

- In Child Welfare Committee (CWC), there are no Transgendered Children who have gone through violence. But, in work with NGOs there are TG children who come

forward to talk about the violence they experience. Where do these children go? These children are not safe, so what happens to them?

- There are babies who are surrendered by parents to the Hijra community because they are Hermaphrodites. If they are children in need of care and protection, can these children be brought in front of CWC?

Below we will look at the discussions that emerged through these questions and comments:

- Parents give away their hermaphrodite children. Hijras raise these children and educate them till they finish primary school. These children are raised by the Hijra community as girls. They are put into sex work very early. Some people from the Hijra community want a hostel for such children. But children are not safe, within the Hijra community too. Ms. Gauri was answering this question and mentioned that she used to work with Don Bosco, when she was a gay man, but there was no provision for such children within their work with underprivileged children.
  The transgender welfare board is not set up yet, but there is no provisions for children who are transgender.
  Children are especially vulnerable within the Hijra community. The guru's get them into sex work and begging early on. They are exposed to alcoholism and smoking. Sometimes, Guru's will tell them that they have not used a condom and even at the age of 60 years they don't have AIDS. These youngsters end up getting infected by the time they are 16 or 17 years old.

- The babies that parents give up, and are brought into the HIjra community are raised by a Hijra. This baby will grow up to become a support for the Hijra who raised her. In old age there is no option for livelihood for a Hijra. But say a Hijra has 10 Chelas (younger hijras), each chela will give her Rs.10,000 per month. Hijra's are also bought and sold by the Guru's. There is a lot of violence within the community.
- Ms. Gauri mentioned that the community is quite closed, so when she went to the court to get rights for TG persons, not everyone from the community was pleased. There are several debates and contestations within the domain of what TG's want. Some want to maintain the structures.
- Prof. Lakshmi Lingam, mentioned that transgendered persons voices are full of power and representation. The voices are also full of humour, dressing, clapping, resisting hierarchy... but through all this the arguments and voices get sharper and further solidified. She spoke about her previous discomfort and worry around Hijras, but she had a Ph.D. student who was transgendered and this changed her mind about the issue. But there is no clear solution that is emerging... the violence continues... and we are unable to bring change in personal lives too. We need to bring about changes in our personal lives... address TG issues beyond HIV.
- Another discussion point was that in work and sex work... there is ageism. Similarly ageing affects Transgendered persons too.

- Ms. Lacchi Pune made a very crucial point. She said that the government has now taken note of Hijras because of HIV, and this has provided Hijras with the scope to document their problems. But the government does nothing beyond HIV/AIDS. There is a need to look at a Hijra as a citizen and not a risky citizen.
- Manisha Gupte made an extremely poignant contribution to the discussion. She said that often issues of Hijras and other Transgendered persons are not given any importance. These spaces need to be created by learning through the experiences of people and from ongoing issues. She mentioned that she works with cis-women, and claims to work with women... but realises that she is limited in the way she works with women.

Session 4: Deliberating on future strategies

The fourth session is a Panel Conversation that elicits the comments on the current situation from representatives of various government offices and /or machinery.

Anchor: Prof. Lakshmi Lingam

Panel Members:

- Sushma Chavan, ACP, Pune, MH, India
- Jayant Pawanikar, WCD, Pune, MH, India
- Dr. Seema Malik, Former Superintendent, K.B. Bhabha Hospital (Secretary), Mumbai, MH, India & former Project Director, Dilaasa, Mumbai, MH, India

Each of the Panel members spoke about Gender Based Violence and the need to reflect on this within their work.

Panelist 1: Sushma Chavan, ACP, Pune, MH, India

Sushma Chavan, ACP, Pune was the first panelist to speak. She spoke about the Police system. She started her discussion by referencing the discussion about POCSO and Violence against women from the previous sessions, and commented that the Police have been mentioned frequently while talking about these issues. NGOs come to the police when cases of child sexual abuse and violence come into their notice. It was only after 2012, when POCSO was passed, that the police has gained awareness about the issue. Police had a different perspective of looking at society, were not aware of some issues, and were not serious about these issues. However, the police have grown a lot following the awareness that has come from the new laws.

Implementing POCSO, is not the sole responsibility of the Police or NGOs, it is the shared collectively responsibility of everyone. She cited her experience of working on cases of Child

Sexual Abuse and rape. She was posted with the CID in 2006, and the Nagar Sex Scandal came to light. In that case, 2 minor girls were raped. They were trafficked across villages and made to indulge in sex work. When this case came forth, and local police got the case and an NGO named Snehalaya took this case. The case received media and NGO attention. The local police were blamed for shortcomings in handling the case and the then Home Minister R. R. Patil gave the case to CID. Those two girls- one was 13 years old and the other was 15 years old had been raped by multiple people. 22 people had raped the 13 year old. She used to wear a frock, she was a child. Her family situation was bad and this was misused by the perpetrators. Between December 2005 to February 2006 she was taken to many villages and raped. When her father realised that she was missing he went to Snehalaya, asking them to help. The child's mother had passed away. When the case came to the CID, the CID did a lot of work. For about 1-1/2 year the CID worked on the case, gathered evidence, counselled the child, helped her develop faith on police and society. A Case was registered. The child was placed in the rescue home, from where she was kidnapped. Ms. Sushma said that she was scared when the girl was kidnapped because it was her responsibility to keep the child safe. However, because she had developed a good rapport with the child, the child phoned her and contacted her and thus the police found the child and presented her to the court. The case was supported by the police and all 22 perpetrators were convicted in the Sessions Court and in the High Court, the case now is with the Supreme Court.

Snehalaya (NGO) and police worked together and helped in getting witnesses, help in rehab, etc. Ms. Sushma feels that if we work collaboratively, we can really make a positive difference.

When a Child Sexual Abuse case comes to police, everyone is upset, there are several delays in reporting and the parents get stressed because of delay and then they start complaining. If a Police Constable or someone doesn't take case, the person should go to the in-charge, go to Police Inspector, Assistant Commissioner of Police, Deputy Commissioner of Police or even the Commissioner. She requests everyone to be a little positive in their attitude towards police, as this can help easy delivery of justice.

Ms. Sushma then highlighted the challenges that Police may experience. Police also face barriers in working. Police also don't get response from medical faculty and have to guard the victim when they are hospitalised. A police constable has to put on duty for 3-4 days in the hospital when sexual assualt cases come forth. The Police force is understaffed and this causes several problems. Police have issues in gathering proof. The samples don't get collected in time by the hospital, and this destroys evidence. But these issues can be made better through creating awareness. She mentioned that a workshop was conducted in Sasoon Hospital, and this improved the response of the hospital. In cases of CSA, a statement should be collected as soon as possible because the memory is fresh and it should be recorded while the incident is still fresh. Video recording for statements is not possible due to lack of infrastructure, but because of the law police do it in their limited

means. But there are technical problems with this. If child is small, a statement of the mother is taken, and then a statement of the child is taken, but often there are contradictions in these statements. Rarely are there witnesses in cases of CSA. Families in these cases are usually quite non cooperative and this evidence doesn't come forth.

The Police department is doing much better now than they were doing previously. If court says that a Police officer didn't do a proper investigation, then court can make an enquiry into the police officer which could jeopardise their career. Police is now scrutinising cases better because it goes to the court, and if any gaps are found in the scrutiny it goes back for investigation.

Ms. Sushma appeals that people come to the police with doubt, but this doubt can be dispelled. The Police's role is to maintain law and order and it is not the judiciary. She mentioned that if you speak to the Police well, you may get better cooperation. May be not 100%, but it will be better.

Panelist 2: Jayant Pawanikar (WCD)

Jayant Pawanikar, (Women and Child Department, Pune) was the second panellist. He initiated his talk by mentioning that when it comes to speaking of WCD and Gender violence, the first question that is posed is "What is WCD doing?" He feels that before that laws need to be examined, and we need to realise that there are several stakeholders in upholding these laws, such as Society, NGOs, Police, WCD etc. The roles of all these stakeholders need to be aligned, such that all the stakeholders come together. However, he posited that checking if everyone does their role well is extremely difficult; and when it comes to social Acts apart from those who draft it no one knows what to do. There exists no provision for a Nodal agency to ensure the law is enforced, implemented. While, the WCD, make laws and protocols the WCD does not have any provisions to ensure the implementation. The lack of a Nodal agency means that if the WCD gives directions to the police, the police will ask "who are you to tell us"? In the process "justice to the victim" is left out.

Mr. Jayant posits that there is a need for "convergence" between various stakeholders, such that they can exchange ideas and frame laws that can be implemented more effectively.

He highlights the following issues that arise due to the lack of convergence:

- Different departments conduct different trainings on the same topic, and have different messages on the same subject. There is no clear module on implementation, and people receive different messages which create problems in implementing laws.

- Reporting is also an issue, as victims don't report. It is a matter of social change of perspective. This will take time, and Mr. Jayant was of the opinion that this time should be given.

- Further, Infrastructure and manpower are big challenges in implementing the law.

He shared his experience of working on POCSO, mentioning that even though he works on POCSO, he is unaware about how many children courts are there in Pune. The info stays limited till the Judiciary. The information doesn't reach implementers. Mr. Jayant posited that this can only be done when there is a discussion on "convergence". He elaborated on the issue of convergence, by sharing a case of POCSO. In Panvel, there were mentally challenged children who were being sexually abused. The team investigating the matter had a psychiatrist who was able to investigate and uncover the abuse. The psychiatrist saw that a child would start spitting every time a particular man came into the room, the psychiatrist deciphered this as sign of something undesirable, which led to asking questions that brought for the incident.

The lack of psychological services anywhere, be it in the police, hospital, trauma, WCD is a big hurdle in working on issues of Gender Based Violence. Mr. Jayant felt that without these facilities, there will always be gaps in implementing laws.

He also identified stigma as a big hurdle mentioning that even implementers' perspective can be flawed... and presently there aren't strong steps to address this.

He also felt that if the infrastructure isn't strong then the implementation will not be strong. There will be limitations, but if we converge we can move forward and bring about change.

Conviction rate at every stage is different, and sometimes a judgement under the PWDVA takes 2-3 years. The lack of convergence sometimes becomes bigger hurdles.

Within departments, when there are gender sensitisation programs junior officers are sent for the training, thus, the trainings don't result in any change. These trainings should be made mandatory for the officers implementing the Act and efforts should be made to extend it beyond the classroom.

Summing up this arguments, Mr. Jayant identifies 3 main areas to improve implementation of laws and protocols addressing Gender based violence: Sensitisation- convergence-infrastructure.

Panelist 3: Dr. Seema Malik

Dr. Seema Mallik is the Former Superintendent, K.B. Bhabha Hospital (Secretary), Mumbai, and the former Project Director, Dilaasa, Mumbai. She was the third panellist of the session. Dr. Seema highlights that Gender based violence is prevalent in all stages of life, from womb to tomb; but not everyone from medical field knows how to address it. She is a gynaecologist who turned administrator and often found that despite being sensitive to the issue, there was not much she could do. She used to run away from patient, and her boss used to tell her to just make a medico-legal case. If any lady would come in for a Medical Termination of Pregnancy, the medical personnel would scold her and somehow try to convince her to get a copper-T. It was after her training with TISS, and then her involvement with CEHAT (through their Dilasa Centre and hospital trainings to sensitise staff) that she was able to gain a perspective on working on issues of gender based violence. This led to an examination of the medico-legal case register, and it was realised that the register was strong but the hospital was not filling the paper work for addressing Gender Based Violence.

Dr. Seema talks about how she worked in a BMC hospital, where the patient was telling that they had been victims of domestic violence, but the case would be written as stove burn accident, accident poisoning etc. Since, she was in administration; she used to send people in places of power for gender trainings and this brought several positive changes. Somehow, she was able to get everyone on board.

She asserted that when government and non-government bodies collaborate, a lot can be achieved together. The support from CEHAT and Bandra Police Station was key in helping the hospital bring about positive changes in dealing with Gender Based Violence. The Dilasa centre was initiated at Bhabha Hospital and now there are 11 more centres.

Dr. Seema states that the government often doesn't have a perspective for social change... they don't have resources for research and training. But these collaborations can bridge that gap.

She recollected her experience of being part of a research process with CEHAT that was undertaken when the Protection of Women from Domestic Violence Act was being formulated. The research focussed on understanding what is currently being done in such cases. It was found that the junior most doctor would look at an assault case, no senior doctor wanted to take on such a case because they didn't want to go to court. Then after trainings positive changes occurred. But the willingness of the hospital to give this data, helped bridge the gap.

Where it comes to POCSO, there are several loopholes, but conducting robust research and getting data to validate these loopholes can help bring about the necessary amendments to the law.

She mentioned that, while there have been many changes within the response of hospitals to Gender Based Violence, things are still falling short... there is still no understanding on how to address issues of transgendered persons. She mentioned that it is probably high time to start thinking and ask as to why Transgendered persons are not being included?

Dr. Seema concluded her talk by stating that Doctor's trainings should include ways in which they can implement the laws. These trainings can be part of the process to renew their licenses. If these trainings are affiliated with Medical council, nursing council and regular refresher trainings are held, then several issues in dealing with medical response to Gender Based Violence can be addressed.

Open Discussion:

Prof. Lakshmi, the Chair of the session invited questions and comments. The discussion which ensured was extremely interesting.

Ms. Gauri, a transgender rights activist, posed the first question to Mr. Jayant Pawanikar from the WCD. She said that the WCD has not been meeting with Transgendered persons to discuss the Transgender Bill, and the WCD is withholding any work related to setting up the Transgender Welfare Board. When transgendered persons go to the WCD, they are asked to keep waiting for hours and in the end no one meets with them. She directly confronted Mr.Jayant to say that the WCD keeps giving excuses, but when the government has allocated money why is it not being utilised for the welfare of transgendered persons.

Mr. Jayant has requested Ms. Gauri to send him an email regarding this so that he can try to do something.

Ms. Tejasvi Sevekari, Director, Saheli Karyakarta Sangha, Pune also commented, focussing on Mr. Jayant's talk. She said that the WCD's perspective needs changing, but nothing is being done to change it and make WCD more inclusive for marginalised groups such as sex workers. She recalled a meeting at WCD, where some officer came in and started talking about rehabilitation without making an attempt to understand the needs of sex workers. One sex worker got upset and told him that rehabilitation does not work. In such cases, while the WCD wants to do something good, much of the effort is selective and doesn't address the needs of the groups. Mr. Jayant said that it was his responsibility to sensitise his department, he has made efforts to sensitise himself and he does his best to bring about changes in his department.

A question was posed to Ms. Sushma, ACP, Pune; asking that in some remote incidents, some male members of police are perpetrators of violence, what can be done to address this?

Ms. Sushma said that not all people are alike. She clarified to say that not everyone is good or bad. In such cases, a complaint must be made to a higher police official. These cases should not be neglected or kept silent.

Prof. Lingam elaborated that the system is very complex and there is no black and white answers where it comes to individual behaviours of the police. But the system cannot be dumped, and more effective ways to work with the system needs to be developed. When efforts are made to engage with the police, democracy is deepened and people understand their rights. She said that one police officer (Ms. Sushma) cannot give answers for all of the system.

Closing and wrap up: Deliberating on future strategies

The concluding session elicited a round of comments from the participants and opened discussion on way forward and wrapped up the workshop.

Co-chairs:

Prof. Lakshmi Lingam, TISS, Mumbai

Ms. Manisha Gupte, Founding Trustee and Co-convener, MASUM, Pune

The chairs thanked the speakers and the audience for the active participation in the workshop. They then went on to sum up the key discussions from each session, to make connections and draw learning from each session.

Below is a topic wise summary of the wrap up:

- Paved a way for understanding issues of Gender Based Violence

The first session in particular laid out a framework for understanding Gender Based Violence that is rooted in patriarchal gender roles. These affect men and women, as well as any person who is a deviant from gendered binary roles such as transgendered persons, sex workers and other LGBTQ persons.

The sessions highlighted that gender plays out in different ways and the key concern is on understanding means by which it can be demystified. NGOs, while handling cases are not unanimous in their opinion on how do we understand consent and force within issues of Gender Based Violence. Consent takes away victimhood from a woman, and gives her a position of benevolence and power. But 70s feminism saw women as victims and women can do no wrong, this understanding was shattered as “the myth of sisterhood” as intersectionality came into discussions.

The sessions also brought forth issues of identity based politics. Asking questions about, “How do we deal with issues when difficult situations come forward and how we can deal with it?”

It helped us highlight that social hierarchies and structures of caste operate in the way Gender Based Violence gets addressed. Hypergamous marriages are not accepted and this may lead to violence. The family is a site that purports gender based violence and usually women and girls retract their statements under family pressure.

The chairs highlighted that feminist practice doesn’t work on the basis of an individual. Highlighting that it is necessary to reflect on larger issues and arguments within this. As right-wing groups unleash “Love Jihad” and separate young couples, it pushes people into closed rooms- where they get into physical intimacy much faster and also closed spaces become invisible spaces for violence. However, as feminists, we need to reflect on who is allying with us on an issue- so, if right wingers are agreeing with us, we need to reflect on our stand and inspect it better, as there may be issues in our stand. Feminism must be about fairness and justice. So, while there are several internal issues, a common strategy is to look at structures of oppression and challenge it strongly. So we have to learn good things from these strategies.

- Laws and the constraints

The chairs also highlighted that several sessions looked at the way in which several laws, that may be framed to address issues of Gender Based Violence fall short in implementation due to infrastructural issues, issues in gender perspective and lack of collaboration among various systems such as Police, Hospitals, Courts, Shelter homes etc.

- POCSO and its implementation

The Chairs looked at the sessions that discussed Child Sexual Abuse and the POCSO Act. The session highlighted that there is a need to look at Child Sexual Abuse related issues from the perspective of the child and thus rethink POCSO. There needs to be provisions for psychological support to children. Further, there are several infrastructural and legal constraints that affect the implementation of the Act.

Some of these constraints are:

- Child Welfare Committee (CWC) is not conversant with POCSO. Chairpersons of CWC’s don’t get protection, though they are quasi judiciary. They burn out- losing people who are amplifying
- Section 40 of POCSO seeks the consent of a parent for medical exam. But this may be a problem, as parents may not give consent.
- Mandatory reporting means that often cases of CSA may not seek the medical care they need, because they do not want to report the case.

A few possible solutions are:

- A SOP (Standard Operating Procedures) and manuals need to be put in place for CWC to know their role.
- Re-think the stand on mandatory reporting
- Develop a checklist of implementation of POCSO

- Looking beyond gender binaries

The sessions also highlighted the need to understand new forms of gender relations, and also take into account the specific issues of LGBTQ persons while framing legislation and implementing processes to address issues of Gender Based Violence.

The lives of Transgendered persons are linked with violence at every stage, and they further lack systems of support. They experience violence internally and externally. The way we look at Gender Based Violence needs to grow. Gender needs to be seen as a structure and there needs to be an understanding of gender beyond the category of women. Spaces have to be created to make gender more inclusive. There is dire need then to work further on this and move beyond lip service.

While, there are loopholes within institutions (health, police, and judiciary) and now we need to look beyond that, understand the underlying biases in society that pertain to gender. It is also necessary to build relationships with NGOs to identify how work can be done.

- Some strategies to undertake

The sessions of the workshop also suggested strategies to bring about a better understanding of Gender Based Violence and inform interventions.

- A feminist and rights based perspective of working at the village level, can provide a strong base for combating violence as a human rights issue, public health issue and a local governance issue. Especially, since NGOs work cannot last forever, developing the capacities of the village communities is necessary. This could be done through mobilising the communities and create spaces for transformation.

- A strong local opinion needs to be strategically developed in favour of gender based equality and violence.

- On the level of strategy, building collectives can be long term response to addressing issues of Gender Based Violence at the community level. This is something that needs investing (mobilising, building collective strengths), especially in the context of violence.

- Efforts can be made to connect with marginalised groups in addressing issues of Gender Based Violence, especially where it comes to denial of service/difficulty in accessing services. For example, methods need to be devised on ways in which systems respond to a transgendered person seeking medical services.

- There also needs to be a re-examination of the biases that become barriers in providing medical care to survivors of Gender Based Violence. The medical system is laden with biases; and innovative ways need to be sought to make space for violence survivors within the medical system, such that they can get the care they need. This should be done from the perspective of the survivors of violence.

- Transgendered persons are not safe in a male ward. There is continuous structural violence against Transgendered persons because of their identity. One stop centres have provided an opportunity to weave issues of LGBTQ into addressing Gender Based Violence, especially among the government.

- Trainings are an important step in bringing about changes in mindset. Even if few people change their perspective about working on gender based violence, it impacts the life of every patient who they come across.