सत्यमेव जयते

ADVANCED TRAINING FOR FRONT LINE FUNCTIONARIES OF ONE STOP CENTRE (OSC), WOMEN HELPLINE (WHL), FAMILY COUNSELLING CENTRES (FCC) AND MAHILA SHAKTI KENDRA (MSK) FOR RENDERING QUALITY SERVICES & COORDINATED ASSISTANCE FOR WOMEN AFFECTED WITH VIOLENCE

TAMIL NADU, PUDUCHERRY & ANDAMAN & NICOBAR ISLANDS

DEPARTMENT OF SOCIAL WORK, LOYOLA COLLEGE, CHENNAI.

15TH AND 16TH FEBRUARY 2019

Towards a new dawn

CENTRAL SOCIAL WELFARE BOARD

MINISTRY OF WOMEN AND CHILD DEVELOPMENT

GOVERNMENT OF INDIA

Report of the

Advance training for frontline functionaries of

ONE STOP CENTRE (OSC),

WOMEN HELP LINE (WHL),

FAMILY COUNSELLING CENTRES (FCC) AND

MAHILA SHAKTI KENDRA (MSK)

for rendering quality services and coordinated assistance for women affected with violence.

Organized by Post Graduate and Research Department of Social Work, Loyola College, Chennai in collaboration with Ministry of Women and Child Development, Government of India, Central Social Welfare Board and TamilNadu Social Welfare Board.

at Lawrence Sundaram Hall, Loyola College, Chennai

on 15th and 16th February of 2019

Contents


Ministry of Women & Child Development, Govt. of India
Advanced Training for Frontline Functionaries of One Stop Centre (OSC), Women Helpline (WHL),
Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Services
and Coordinated Assistance for Women Affected with Violence
Loyola College, Nungambakkam, Chennai
15th & 16th February, 2019

Advance training for frontline functionaries of One Stop Centre (OSC), Women Help Line (WHL), Family Counselling Centres (FCC) and Mahila Shakti Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence.

Training Documentation and Page Layout

Prof. Andrew Sesuraj. M, Dept of Social Work, Loyola College

Cover Designs

Mr. Calvin Issac

Still Photography

Mr. Paul Raj, Stella Studios, Chennai 34

C. VIJAYARAJ KUMAR, I.A.S.,
SECRETARY TO GOVERNMENT (FAC)

Social Welfare and Nutritious Meal Programme Department, Secretariat, Chennai -600 009.

Dated: 25.02.2019

Government of Tamil Nadu and the Department of Social Welfare has set high standard for the entire country to emulate through different interventions, schemes, legislations, programmes and models, when it comes to the welfare of women and children.

We were happy that the Central Social Welfare Board and Ministry of Women and Child Development, Government of India has organized on 15th and 16th February, 2019, the Advance level training for front line functionaries of One Stop Centre; (OSC) Women Help Line; (WHL) Family Counselling Centres (FCC) and Mahila Sakthi Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence in Tamil Nadu at Loyola College, Chennai.

I sincerely thank the team from Central Social Welfare Board and Tamil Nadu Social Welfare Board for strenuously ensuring the successful completion of the training in coordination with the Department of Social Work, Loyola College, Chennai.

I sincerely appreciate Mr.G.Perumal Samy, Joint Secretary, Tamil Nadu Social Welfare Board, Mr. Nandresh Nigam, Deputy Director, Central Social Welfare Board and Dr. G. Gladston Xavier, Head, Department of Social Work and his team of faculty members for making it happen.

I wish the report being published, will be useful to desiminate the ideas and information among all the stakeholders working in the field of Women Empowerment.

Regards,

(C. VIJAYARAJ KUMAR)

FOREWORD

Tamil Nadu Government has been a model State in implementing various programmes for the welfare of women through the Department of Social Welfare and NMP.

Systematic and structured State policies have gone a long way in addressing violence and crimes against women and to ensure their rights.

With the Government of India support, the safety measures like Women Help Line, One Stop Centre, Family Counselling Centre, Mahila Sakthi Kendra to create awareness and to turn to when the women are in distress have been set up and is functioning.

I am very happy to be part of all the developments that are taking place and it was a very happy occasion to be in the training programme organized to the staff of the above centres by the Central Social Welfare Board with the Department of Social Work, Loyola College, Chennai at the appropriate time.

I am sure that the training would have enlightened the staff to work with more focus and to facilitate the needs of vulnerable women in a proper way.

I wish the training report will help all the stake holders in the country to work towards the welfare of women in a co-ordinated fashion.

Also I would like to place on record my appreciations to Mr.Nandresh Nigam, Deputy Director, Central Social Welfare Board, Dr. G.Gladston Xavier, Head, Department of Social Work and his team, and Mr. Perumal Samy, Joint Secretary, Tamil Nadu Social Welfare Board for organizing the training programme.

V. AMUTHAVALLI, IAS.,
COMMISSIONER OF SOCIAL WELFARE.
GOVT. OF TAMIL NADU.

Rev. Dr. F. Andrew, SJ
Principal

College of Excellence

LOYOLA COLLEGE
(AUTONOMOUS)
NUNGAMBAKKAM, CHENNAI - 600 034.
TAMIL NADU, INDIA
Tel : +91-44-28178300
Fax : +91-44-28175566
Email : loyolaprincipal@gmail.com
Web : www.loyolacollege.edu

Loyola College is extremely happy to have joined hands with the Ministry of Women and Child Development, Government of India in organizing the Advance level training for front line functionaries of One Stop Center (OSC); Women Help Line (WHL); Family Counselling Centers (FCC) and Mahila Sakthi Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence.

Loyola College, as an institution marching towards its centenary year in training men and women for others has always kept the marginalized and the vulnerable sections of the society in the core of all its interventions. This training, empowering the frontline functionaries One Stop Center (OSC); Women Help Line (WHL); Family Counselling Centers (FCC) and Mahila Sakthi Kendra (MSK) was very much close to our interventions it has helped in enhancing the quality of the services and coordinated assistance for women affected with violence.

I sincerely appreciate Dr. G. Gladston Xavier, the Head, Department of Social Work and his team of faculty members for having grabbed this opportunity to deliver the best in collaboration with Central Social Welfare Board and TamilNadu Social Welfare Board.

May I wish all the participants of the workshop from the different units that render quality services to the women affected with violence that all your interventions are blessed and bears fruit in ensuring anempowering environment for women in the society.

God Bless You

Regards

Rev. Dr. F. Andrew, S.J.
Principal

LOYOLA COLLEGE · CHENNAI 600 034 ·

Dr. G. Gladston Xavier, Ph.D.
Head, Dept. of Social Work

LOYOLA COLLEGE
(AUTONOMOUS)
NUNGAMBAKKAM, CHENNAI - 600 034.
TAMIL NADU, INDIA

Tel : +91-44-28178200, Ext. 480
Fax : +91-44-28175566
Email : gx@loyolacollege.edu
Web : www.loyolacollege.edu

Department of Social Work, Loyola College, Chennai has always been in the forefront in reaching out to the marginalised and vulnerable over the last five decades and more right since the time the department was established in 1957.

Over the years the Department has created stalwarts in the field of social work who have been spreading the message Love, Peace and Justice across the universe.

The department has taken it as a privilege to organize the Advance level training for frontline functionaries of One Stop Center (OSC); Women Help Line (WHL); Family Counselling Centers (FCC) and Mahila Sakthi Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence. The training was held in Loyola Campus on 15th and 16th February 2019.

We have consolidated the proceedings of the training program into a detailed report in order to help in replicating such models across the country reaching out to more women who are in distress.

I sincerely congratulate Prof. Andrew Sesuraj. M and his team members from Loyola Knowledge Hub for Excellence in Child Protection (Loyola KHEChP) along with the students of the department who have coordinated and made the training program successful.

The department stands in gratitude to Ministry of Women and Child Development, Government of India, Central Social Welfare Board and TamilNadu Social Welfare Board for entrusting us with this opportunity.

The Department of Social Work and Loyola College will continue to stand with the government in all its interventions in making this country a SAFE, PEACEFUL AND CONDUCIVE PLACE FOR WOMEN TO GROW AND PROSPER.

Peace

Dr. G. Gladston Xavier
Head, Dept. of Social Work

Name of the Training

Advance training for frontline functionaries of One Stop Centre (OSC), Women Help Line (WHL), Family Counselling Centres (FCC) and Mahila Shakti Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence.

Hosting Institution

Department of Social Work, Loyola College, Chennai in collaboration with Ministry of Women and Child Development, Government of India, Central Social Welfare Board and TamilNadu Social Welfare Board.

Location

Lawrence Sundaram Hall, Loyola College, Chennai

Date:

15th and 16th February of 2019

Introduction

Ministry of Women and Child Development in collaboration with Central Social Welfare Board conducted two day advance training for frontline functionaries of One Stop Centre; (OSC) Women Help Line; (WHL) Family Counselling Centres (FCC) and Mahila Shakti Kendra (MSK) for rendering quality services and coordinated assistance for women affected with violence on 15th and 16th February of 2019 for TamilNadu, Puducherry and Andaman and Nicobar Islands at Loyola College Chennai.

The aim is to strengthen the advance knowledge and approach of staff member of One Stop Centre, Women Helpline, Family Counselling Centre and Mahila Shakti Kendra in handling issues related to women. This training brought together experts from various disciplines such as Social Work, Law, Medical, Psychology and Psychiatry.

Day One

15th February, 2019, Friday

Inaugural Session

Welcome Address

Dr. G. Gladston Xavier,

Head, Department of Social Work, Loyola College, Chennai.

Welcome address was delivered by **Dr. G. Gladston Xavier**, *Head, Department of Social Work, Loyola College, Chennai*.

He recalled the Puratchi Thalaivar Noon meal programme that was initiated in TamilNadu and has become a national level model and he shared that the OSC and FCC becomes a national level model too ensuring empowerment of women.

He thanked Ms. Amuthavalli IAS, Mr. Vijayaraj Kumar IAS and Central Social Welfare Board for having chosen Department of Social Work, Loyola College for implementing this training programme.

Dr. Gladston also assured the audience that the college and the department will always stand with the marginalized and the social welfare department can count on Loyola College for partnership for any interventions aimed at the marginalized sections of the society.

Prof. Mary Jessy Rani, Dean of Women Students, Loyola College felicitated the participants calling them to use the training to hone their counselling and intervention skills in the best interest of strengthening the crisis intervention model. She shared the wishes of Rev. Fr. Rector, Rev. Fr. Secretary and Rev. Fr. Principal for the success of the program.

Special Address

Smt. V. Amudhavalli IAS,

Commissioner, Department of Social Welfare and Noon Meal Programme,
Government of Tamil Nadu

In her special address **Smt. V. Amudhavalli IAS**, Commissioner, Department of Social Welfare and NMP, Government of Tamil Nadu, showed her deep appreciation to Central Social Welfare Board, Ministry of Women and Child Development including other organizers, College Management and the participants for the remarkable workshop.

She recalled how the One Stop Centres are aimed to help the women in distress with legal, psychological, medical, counselling services and linking to the existing social security schemes for their rehabilitation. Already the OSC was established in 6 districts of TamilNadu and is expected to be extended to all the districts soon.

The workshop is to ensure that the participants further sharpen the skills sets already acquired through the experience. The sharing can be success stories or the ones where we failed. We learn from each other. The learning can happen outside the classroom too. She called the participants to explore with fellow participants outside the class.

As per the women helpline data 60 thousand calls were received since December 2018, she shared that she sincerely hopes that at least 20,000 women have received required services.

Ms. Amuthavalli also shared a story explaining the need to hone the skills by taking time to improve the efficiency. She also quoted from *Mahabaratha* where the Arjun's skill of aiming the bow and arrow was discussed. With that example she expressed her intent that the participants keep focused on the objective of the workshop.

'You are in a beautiful campus' acclaimed Ms. Amuthavalli and insisted the participants that this environment should help in learning in a peaceful environment. She wished all the participants for a fruitful workshop

Release of Training Module and Key Note Address

Shri. C. Vijayaraj Kumar, I.A.S.,

Principal Secretary (FAC) Department of Social Welfare and Noon Meal Program, Government of Tamil Nadu

Shri. C. Vijayaraj Kumar, ***I.A.S.,*** *Principal Secretary (FAC) Department of Social Welfare and NMP, Government of Tamil Nadu* in his key note address highlighted on the need to empower women with the practical challenges, by bringing cultural perspective, social differences, gender inequality and quoting through various literature and Puranas.

He thanked the organizers for the honour of being invited as the guest. He recalled the need to look at situations around us in cultural context and based on our traditions. The tradition and culture prescribes reasons and causes for the birth and the problems we face in our lives.

We are living in a society where abusing is seen as a right. Poet Thiruvalluvar says "do good unto the ones who does bad to you so that he feels ashamed". It is impossible to forgive and do good for those who were abusing women. We have to look at Poet Bharathi who says "Bang on those who abuse women". Here Bharathi teaches us to fight it back strongly.

We are in a changing society. Joint family system is no more. From nuclear family we are moving towards single parent families. Migration is changing the scenario. We need to acknowledge the changes that are happening around us.

The society fails to acknowledge the discrimination the girl children are facing today, including the kind of food, dress and other entitlements. We are failing to provide equal access to the girl children and we are not even realizing that we are doing this and considering this as normal and culturally accepted behaviour.

Female feticide is violence against the girl even before she is born. Though it is illegal against the law it still continues.

There are legislations, policies and mechanisms that prohibit the discrimination against girl child and women. But it still continues and we see that as culturally accepted norm and we continue to discriminate.

In an equal opportunity society men and women have to be treated equally. The orientation on how we treat and how we teach our children on gender roles and respect is very important. Men and women are not same but we are equals.

"I have seen the module prepared for the workshop" claimed Mr. Vijayaraj Kumar and congratulated for having put together different dimensions. The module starts from the known to unknown. The module was designed to help in sharpening the skills of the counsellors.

The module speaks about where and how to approach different mechanisms for redressal. The module is well designed and is going to be delivered by Loyola College, the best in the field, added Mr. Vijayaraj Kumar and he invited the participants to make use of the opportunity.

Introducing the Training Module

Dr. Jupaka Madavi,
Senior Consultant, Ministry of Women and Child Development.

Dr. Jupaka Madavi, Senior Consultant MWCD shared about the development of the training module. The module was developed by most experienced in the field with inputs from international organizations.

She also added that the module starts from simple definition to skills required for counsellors since the participants are expected to deliver the best to the women. The module developed to ensure that it carries the basics required for the people who deliver.

The initiative is expected to reach wide range of people in the country. Starting from Kashmir University to Loyola College, the best institutions are lined up and joined hands to address violence against women.

She explained about the preparation of the training module by explaining the aim and the importance that to render a quality services and also to have a better understanding to excel in service. Also, she explained about the initiation and evaluation part of the training module.

Vote of Thanks

Mr. G. Perumal Swamy,
Joint Secretary, TamilNadu Social Welfare Board.

Mr. G. Perumal Swamy, Joint Secretary, TamilNadu Social Welfare Board proposed the vote of thanks. He thanked Mr. Vijayraj Kumar IAS for making the things happen within a short period of time. He also shared his gratitude to Ms. Amuthavalli IAS for having been so proactive in ensuring that the training happens without any delay.

His list of gratitude included the Principal, Loyola College, Dr. Gladston Xavier and Prof. Andrew Sesuraj from the Department of Social Work, Loyola College, Chennai. Dr. Madhavi from MWCD, Mr. Nigam from CSWB and Mr. Lokesh from Puducherry UT SWB.

He also thanked all the participants from One Stop Center; (OSC) Women Help Line; (WHL) Family Counselling Centers (FCC) and Mahila Shakti Kendra (MSK) for having joined the training in a short notice.

Panel Discussion:

Chairperson: Dr. G. Gladston Xavier,

Head, *Department of Social Work, Loyola College Chennai*

Dr. Gladston facilitated the interactive session by calling initiating dialogue with the participants on the issues concerning women in India. He started his facilitation by saying "An empowered woman is not in need of an empowered man, but an empowered man requires an empowered woman"

Issues and Challenges of Women in Tamil Nadu, Puducherry and Andaman & Nicobar Islands.

Prof. Semmalar Selvi,
Department of Social Work, Loyola College, Chennai

There is no need of a workshop to understand the challenges and issues faced by women as we have been experiencing it all through the life claimed Prof. Semmalar Selvi as she started her session. For her question to the participants on what are the reasons behind the challenges and problems faced by women, the participants replied – Patriarchy, the culture and tradition, the social construct about the role of women, the backward thinking about women.

It is important to understand what culture to understand the issues is. The social control on how women should dress should behave and should act. The control of the society on the body of women on how she behaves, how she dresses and what she does. Women are seen as objects to be controlled. Society continuously tries to ensure its control over the physic of women through culture, religion and traditions. Women are seen as objects for satisfying the needs, including the sexual desires, of men.

Victim shaming continues to exist on everyday life. Unless we understand that a woman is an individual apart from the social construct we cannot change anything with the help of our interventions in One Stop Centres or Women Helplines. Gender roles have to be broken. The menial jobs at home like cleaning of home, vessels, dress, toilets etc. are restricted to women while other external roles are a privilege of men.

The caste atrocity killings are manifestation of oppression when a girl tries to assert her right to self-determination, to decide her life partner. Even when the girl is an earning member in the family, she has to carry dowry as a maintenance charge to her in laws house. Unpaid labour never gets recognized at home or in the society. Women are said to be the problem for women. It has to be understood that women carrying the patriarchal ideologies will always try to protect the patriarchy and they are not to be seen as representatives of women.

As Prof. Semmalar progressed through the session she also challenged the participants on the stereo types on women and called the participants to play a vital role in addressing the women in distress who have become the victims of the social constructs.

Counselling Techniques and Theoretical Aspect and Implementations

Prof. Mary Jessy Rani,
Dean of Women Students, Loyola College, Chennai

Prof. Mary Jessy Rani enthralled the audience through examples and real life stories. She listed the taboos that keep women from speaking their issues out and getting help. The audience was taken to confidence through the session as she spelt the skills required for effective counselling.

Personnel in counselling centres are people who extend help to people in need, people in distress. It is important to understand that we do consciously or we do it as a routine. In crisis intervention we need to understand that whether we are responding or reacting.

To her question on what attributes are required for the personnel in counselling centres to face the issues, the participants replied, patience, acceptance, confidentiality, non-judgmental, observation, empathetic, honesty and positive gestures. Prof. Jessy added that to ensure that the attributes are effectively engaged, very important is being in the present, being rooted, remaining as a counsellor without becoming one with the client.

The counsellors don't come from above. We are very much part of the society. Many times we have been part of the problem. We ourselves have become perpetrators.

We need to understand that we can fail. Unless we are open for accepting we'll not be able to equip ourselves to face the challenges.

People come to counsellors after going through a great deal of issues. They have decided to reach us with confidence. They have already manifested their confidence and courage by reaching us. They have come to us with an expectation. The expectation that we will support, we will not be judgmental, we will not victim shame.

We have to accept that we cannot help in every situation. We have our limitations. We need to see and refer to places where the client can get better services.

Sometimes mere listening can bring change. The client does not need solutions; she needs to be attended to as she speaks. But just venting out her feelings or issues, the client gets relieved and gets the support to face the problems on her own.

Acknowledging and encouraging fellow human beings, looking at the best and good things in the victim and helping them to realize and celebrate it will bring great changes in their life.

Counselling is an art of helping the victims to find their own solutions and not forcing our ideas. We need to help and encourage them to face their challenges and find ways in their own lives for themselves.

The session followed by an intensive question answer session

Session 1: Roles and responsibility of One Stop Centre and Women Help Line Staff: Standard operating protocols for inter-coordination among OSC & WHL Functionaries and Counsellors of FCC for Women affected with violence

Dr. Jupaka Madavi,

Senior Consultant MWCD

In her session **Dr. Jupaka Madavi**, *Senior Consultant MWCD*, shared on Roles and responsibility of One Stop Centre and Women HelpLine Staff. She also discussed about the Standard operating protocols for inter- coordination among OSC & WHL Functionaries and Counsellors of FCC for Women affected with violence.

The services have been initiated as the society lacked support mechanism for women who face distress. The first model was piloted in Rajasthan. After the unfortunate Nirbhaya incident, the need for strengthening the protection and support mechanism was very much felt and the government has established Nirbhaya funds for addressing the issues of women.

The centres are funded directly through the district collectors in order to ensure the funds are not delayed. The OSC buildings are designed to ensure that there is special space for counselling, toilets and residential facilities

The first Sakhi OSC was launched on 1st April 2015 at Raipur Chattisgarh. 719 OSCs have been approved with at least one OSC in each of 718 districts in the country. Already 314 OSCs are operational in 33 states and UTs. The OSCs and the WHL have become so popular that around 27 lakh women have utilized the services in the short span of time.

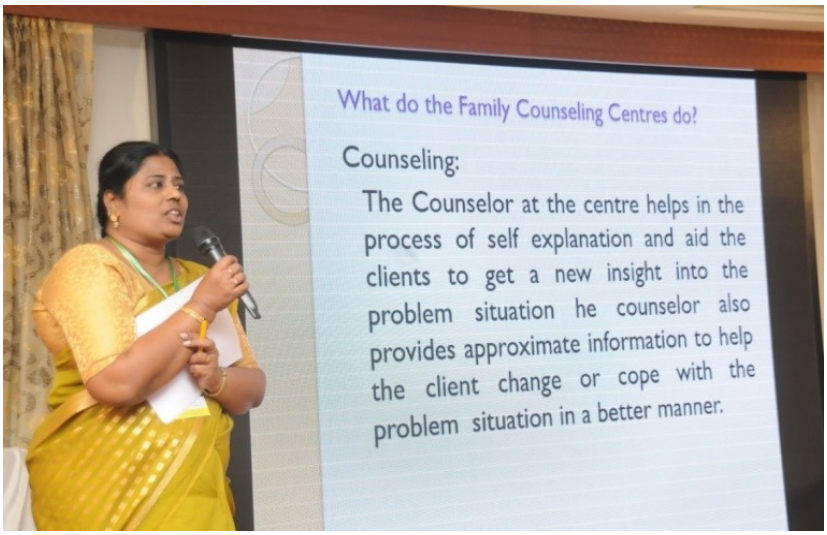
Dr. Jupaka highlighted on the role of social workers, family counsellors, law and medical practitioners in effective functioning of the mechanisms She listed the special features by explaining various initiatives including the preparatory part of training module. Later she pointed out various challenges and issues faced by women across the nation and effective response to violence against women. She maintained that the training curriculum was designed to help, develop knowledge and skills required to respond in an effective and appropriate manner to violence against women.

She also added that the module includes measures to prevent violence against women, ways to respond to and investigate acts of violence and resources to meet the needs of victims during and after an incident.

Session 2: Experiences in Family Counselling Centre

Mrs. K. Bhuvaneshwari,
Family Counsellor, Centre for Action & Rural Education (CARE)

Mrs. K. Bhuvaneshwari from Centre for Action & Rural Education (CARE) made presentation on the history, functions and the services offered by CARE through the Family Counselling Centre. She also listed the challenges and success stories.



Session 3: Orientation of Administrative & Financial Matters regarding One Stop Centre and Women Helpline

Dr. Jupaka Madavi

Dr. Jupaka Madavi explained about the One Stop Centre scheme and its implementation part in details, she covered the following areas in the session.

- Scheme details
- Funding pattern
- Details of operational centre including infrastructures
- Administration
- Various training and capacity building

Nirbhaya Fund and its pattern:

- It has been Announced on 28th February, 2013 and later Approved on 11th September, 2013
- The total corpus available is Rs. 3600 Crores
- Guidelines issued by Ministry of Finance (DEA) to MWCD as Nodal Ministry for appraisal of Proposals on:

  (i) 25th March, 2015

  (ii) 26th October, 2015

  (iii) 6th January, 2016

  (iv) 2018

- Ministry of Women and Child Development is the nodal Ministry to appraise schemes under Nirbhaya Fund and also to review and monitor the progress of sanctioned Schemes in conjunction with the line Ministries/Departments.
- An online dashboard has also been developed to monitor real time data from the Schemes funded under Nirbhaya Fund such as One Stop Centre, Women Helpline & Mahila Police Volunteer etc.
- It has been designed in the following pattern:

Ministries, UTs & Districts	: 100 %
States	: 60:40
Difficult terrain States	: 90: 10

Objectives of OSC:

- To provide integrated support and assistance to women affected by violence, under one roof
- To facilitate immediate, emergency and non-emergency access to a range of services including medical, legal, psychological and counselling support to aggrieved women

Following are the services provided in OSC

- Emergency/Response to the needy situation or to the women seeking help.
- Legal aid and counselling
- Psycho Social- counselling support to mentally depressed women
- Short Homes- Temporary shelter
- Medical assistance to physical abuse and injuries
- Video conference and police assistance for further legal and judicial proceedings

OSC Scheme Provisions for Infrastructure and administration:

- The OSC building should be a suitable space with having at least 5 rooms and carpet area of 132 sq. m. within a hospital / medical facility which may be prominently visible and easily accessible to the women affected by violence.
- Building Construction should limit with Total area of 300 sq. m. or Temporary Existing building with the above mentioned facilities. the budget allocation of Rs.10 Lakh for refurbishment where land is not available and Rs. 1 lakh for refurbishment where land is available and building construction is in process
- It should be integrated with 181 and other existing helplines.
- Training and Capacity building conducted in National, State and Regional level, Over 1560 functionaries trained from December, 2017 to October, 2018

One Stop Centre Scheme Modalities

OSC Staff

- Centre Administrator – The First Point of Contact
- Case Worker
- Police Facilitation Officer (PFO)
- Para Legal Personnel/ Lawyer
- Para Medical Personnel
- Counsellor
- IT Staff
- Multi- purpose Helper
- Security Guard/ Night Guard

Monitoring of OSC

- Implemented at the District Level
- Task Force to be set up at :
  National Level: Secretary, MWCD is the Chairperson
  State Level: Principal Secretary of women & Child development is the Chairperson
  District Level: District Collector is the Chairperson

Session 4: Strengthening Health Sector Response to ensure quality service for women affected with violence at One Stop Centre - adapting Global standards

Dr. A. R. Shanthi,
Gandhi Hospital, Corporation of Chennai

During her interaction **Dr. A. R. Shanthi,** *Gandhi Hospital, Corporation of Chennai share on the medico legal context of extending support to women in distress.* This session was most interesting and eye opening for the participants in both medical and legal stream. She also explained about the various standard operating protocols and importance of guidelines related to sexual violence case.

She shared definition of Sexual Assault by WHO as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work." (WHO, 2003)

Sexual assault, a form of sexual violence, is a term often used synonymously with rape. However, sexual assault could include anything from touching another person's body in a sexual way without the person's consent to forced sexual intercourse - oral and anal sexual acts, child molestation, fondling and attempted rape.

She listed the following forms of sexual assault

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

While explaining the health consequence of sexual assault, she added

- In addition to violation of human rights, sexual assault may lead to several direct and indirect health consequences.
- In absence of history of sexual assault, these signs and symptoms may prompt one to suspect the possibility of sexual abuse/assault.

- Both the doctor and survivor agrees sexual assault
- Only survivor accepts sexual complaints (absolutely no evidence, correlation, threatening)
- Only doctor suspects sexual assault denied

While asserting the need for a guideline and training she said that there is lack of uniformity in protocols and gaps in existing provision of medico legal care to survivors/victims of sexual violence.

She dealt on the Guidelines and Protocols of Medico Legal care for survivors and victims of sexual violence in detail.

She added that Survivors of sexual violence should receive all services completely free of cost. This includes OPD/inpatient registration, lab and radiology investigations, Urine Pregnancy Test (UPT) and medicines.

The casualty medical officer must label the case papers for any sexual violence case as "free" so that free treatment is ensured. Medicines should be prescribed from those available in the hospital. If certain investigations or medicines are not available, the social worker at the hospital should ensure that the survivor is compensated for investigations/ medicines from outside. A copy of all documentation (including that pertaining to medico-legal examination and treatment) must be provided to the survivor free of cost.

Medico- legal Protocols:

Definition of sexual violence by World Health Organisation (WHO),

- as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work." (WHO, 2003)
- Sexual assault, a form of sexual violence, is a term often used synonymously with rape. However, sexual assault could include anything from touching another person's body in a sexual way without the person's consent to forced sexual intercourse --- oral and anal sexual acts, child molestation, fondling and attempted rape.

Different Forms of Sexual Violence:

- Coerced/forced sex in marriage or live in relationships or dating relationships.
- Rape by strangers.
- Systematic rape during armed conflict, sexual slavery.
- Unwanted sexual advances or sexual harassment.
- Sexual abuse of children.
- Sexual abuse of people with mental and physical disabilities.
- Forced prostitution and trafficking for the purpose of sexual exploitation.

- Child and forced marriage.
- Denial of the right to use contraception or to adopt other measures to protect against STIs.
- Forced abortion and forced sterilization.
- Female genital cutting.
- Inspections for virginity.
- Forced exposure to pornography.
- Forcibly disrobing and parading naked any person.

HEALTH CONSEQUENCES OF SEXUAL ASSAULT:

In addition to violation of human rights, sexual assault may lead to several direct and indirect health consequences. There are signs and symptoms may prompt one to suspect the possibility of sexual abuse/assault and the history of the incident. The victim may undergo both Physical and Psychological Health Consequences in shorter and longer term effects; hence it is very important to understand the victim state of reaction and response according to that.

List of Health Consequences

Physical Health Consequences	Psychological Health Consequences-	
Severe abdominal pain	Short term effects	Long term effects
Burning micturition	Fear and shock	Depression and chronic anxiety.
Urinary tract infections.	Physical and emotional pain	Feelings of vulnerability
Exposure to sexually transmitted infections (including HIV/AIDS).	Worthlessness	Loss of control/loss of self-esteem
Pelvic inflammatory disease.	Intense self-disgust	Emotional distress.
Infertility.	powerlessness Apathy	Impaired sense of self.
Sexual dysfunction.	Denial	Nightmares.
Dyspareunia.	Numbness	Self-blame
Menstrual disorders.	Withdrawal	Mistrust.
Miscarriage of an existing fetus.	An inability to function normally in their daily lives.	Avoidance and post-traumatic stress disorder.
Unsafe abortion.		Chronic mental disorders.
Mutilated genitalia.		Committing suicide or endangering their lives.(self-immolation)
Self-mutilation as a result of psychological trauma.		

Guidelines and Protocols of Medico-legal care for survivors/victims of sexual violence.

The Criminal Law Amendment Act (CLA) 2013 has expanded the definition of rape to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/fingers and non-penetrative (touching, fondling, stalking, etc.) and recognized right to treatment for all survivors/victims /victims of sexual violence by the public and private health care facilities. Failure to treat is now an offence under the law and it a punishable offence. Denial of medical care to survivors/victims of sexual violence and acid attack amounts to an offence under Section 166 B IPC with imprisonment for a term which may extend to one year or with fine or with both. The law further disallows any reference to past sexual practices of the survivor. The Criminal Law Amendment Act 2013, in Section 357C Cr. P C says that both private and public health professionals are obligated to provide treatment.

The right to health care:

The Ministry of Health and Family Welfare proposes to provide clear directives to all health facilities to ensure that all survivors of all forms of sexual violence, rape and incest including people that face marginalization based on disability, sexual orientation, caste, religion, class, have

the state to ensure that appropriate physical and mental health services are available without discrimination and are accessible, acceptable and of good quality

To realize the right to health care of survivors/victims, health professionals must be trained to respond appropriately to their needs, in a sensitive and non-discriminatory manner respectful of the privacy, dignity and autonomy of each survivor. Health workers cannot refuse treatment or discriminate on the basis of gender, sexual orientation, disability, caste, religion, tribe, language, marital status, occupation, political belief, or other status.

Health care services:

- Medical treatment for physical injuries,
- Prophylaxis and testing for sexually transmitted infections,
- Psychosocial support.
- Recognizing the right of all persons to health, health care workers must obtain informed consent of the survivors/victims of sexual violence prior to conducting medical examinations or initiating medico-legal investigations.
- All medico-legal examinations and procedures must respect the privacy and dignity of the survivor.
- Immediate and follow up treatment,
- Post rape care including emergency contraception,
- Post exposure prophylaxis for HIV prevention and access to safe abortion services,
- Police protection,
- Emergency shelter,

- Documentation of cases,
- Forensic services and
- Referrals for legal aid and other services.

Role of the health facility and components of comprehensive health care response:

- Health professionals play a dual role in responding to the survivors of sexual assault.
- The first is to provide the required medical treatment and psychological support.
- The second is to assist survivors in their medico-legal proceedings by collecting evidence and ensuring good quality documentation.
- After making an assessment regarding the severity of sexual violence, the first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs.
- While doing so it is pertinent to remember that the sites of treatment would also be examined for evidence collection later.
- Section 164 (A) of the Criminal Procedure Code-lays out following legal obligations of the health worker in cases of sexual violence:
    - Examination of a case of rape shall be conducted by a registered medical practitioner (RMP) employed in a hospital run by the government or a local authority and in the absence of such a practitioner, by any other RMP.
    - Examination to be conducted without delay and a reasoned report to be prepared by the RMP.
    - Record consent obtained specifically for this examination.
    - Exact time of start and close of examination to be recorded.
    - RMP to forward report without delay to Investigating Officer (IO), and in turn IO to Magistrate
    - Health professionals need to respond comprehensively to the needs of survivors. The components of a comprehensive response include:
    - Providing necessary medical support to the survivor of sexual violence.
    - Establishing a uniform method of examination and evidence collection by following the protocols. [in the Sexual Assault Forensic Evidence (SAFE) kit]
    - Informed consent for examination, evidence collection and informing the police.
    - First contact psychological support and validation.
    - Maintaining a clear and fool-proof chain of custody of medical evidence collected.
    - Referring to appropriate agencies for further assistance (eg. Legal support services, shelter services, etc)

Guidelines are to help establish rapport:

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

Facilitating procedures:

- The health worker should explain to the survivor in simple and understandable language the rationale for various procedures and details of how they will be performed.
- Specific steps when dealing with a survivor from marginalized groups such as children, persons with disability, LGBTI persons, sex workers or persons from minority community, may be required.
- Ensure confidentiality and explain to the survivor that she/he must reveal the entire history to health professional without fear. The survivor may be persuaded not to hide anything
- The fact that genital examination may be uncomfortable but is necessary for legal purposes should be explained to the survivor.
- The survivor should be informed about the need to carry out additional procedures such as x-rays, etc which may require him/her to visit to others departments

While performing the examination, the purpose of forensic medical examination is to form an opinion on the following:

1. Whether a sexual act has been attempted or completed.
2. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching.
3. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen.
4. Whether such a sexual act is recent, and whether any harm has been caused to the survivor's body. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused. However, the absence of signs of struggle does not imply consent.
5. The age of the survivor needs to be verified in the case of adolescent girls/boys. Whether alcohol or drugs have been administered to the survivor needs to be ascertained.

GUIDELINES FOR RESPONDING TO SPECIAL GROUPS

Marginalized groups are defined as

1. Individuals who face discrimination because their gender identity is not based on physiological appearance or where an individual's body doesn't fall in the rigid binary of male and female genitalia.
2. Individuals who face discrimination based on the sexual orientation they practice.
3. Individuals who face discrimination because they are involved in sex work.
4. Individuals with physical, psycho social and/or intellectual disability.
5. Individuals from religious minorities, castes or tribes.

Guiding principles for health professionals while working with special groups

1. Complete medical treatment and health care must be offered right at the outset at all health facilities. Health professionals should ensure that they are not biased against people belonging to marginalized groups and must treat them with respect.
2. Health professionals must steer clear from demonstrating shock, disbelief, ridicule and ensure that such a conduct does not seep into the doctor- patient relationship.
3. Health professionals must acknowledge challenges and obstacles faced by marginalised groups in accessing health services and create an enabling atmosphere for them in the health facility.
4. Health professionals must enable survivors to feel at ease to be able to reveal the abuse that they have faced.
5. There must be cultural sensitivity while carrying out medical procedures. Cultural sensitivity refers to recognition of the caste, class, community, religion-determined behaviour and perceptions of the patient, without any bias/prejudice.
6. Individuals belonging to marginalized communities are often mistreated and ridiculed.

    a. In many instances, complaints from marginalized communities do not even get recorded. Therefore efforts must be made by health professionals to dialogue with the allied agencies such as the police, to record the complaint at the health facility if survivors express such a desire.

    b. Doing so at health institutions would be useful for survivors from marginalised groups as health institutions are perceived as less intimidating compared to police stations.

7. Health professionals must ensure that information on referral institutions providing good quality services for marginalised groups is available at the health facility.
8. Transgender and intersex persons

9. Medical practitioners must recognize that transgender and intersex people (TG/IS) are vulnerable to sexual violence due to the marginalization and discrimination they face.
10. Under such circumstances, it is all the more essential that sexual violence faced by TG/IS people is recognized as such by health professionals who often serve as the first point of approach for a survivor of sexual violence.
11. It is not uncommon for TG and IS persons to experience ridicule in the health facilities.
12. Health professionals often ignorant of the variations in biology and gender identity and also tend to 'pathologize' them.

Guidelines for examination: Transgender / Intersex

1. Gender identity is not constituted by anatomy, especially appearance of genitals. Primacy should be given in the record to the survivor's stated gender identity and appropriate names and pronouns used.
2. Intake forms and other documents that ask about gender or sex should have options as male/female/others.
3. Genital anatomical variations of transgender and intersex people must be included in the examination proforma.
4. Transgender and intersex people may be unwilling to report the case to law enforcement for fear of being exposed to inappropriate questions and abuse, therefore adequate care should be provided for those who do approach health institutions.
5. Information on the intersex variations or transgender status of the survivor must be treated as confidential and not to be revealed without the survivor's consent.
6. The inadvertent discovery during examination or history taking that a person is transgender or intersex must not be treated with ridicule, hostility, surprise, shock, or dismay. Such reactions convey that the person is being judged and is likely to make them uncomfortable in the health care setting.

Persons of alternate sexual orientation.

- Sexual orientation refers to a person's sense of identity based on sexual attractions, related behaviour, and membership in a community of others who share those attractions.
- The 'normative' sexual orientation in our society is 'heterosexual', meaning that persons are expected to be attracted to others of the opposite sex. However, people may have various other sexual orientations.
- A person identifying with a homosexual identity for instance, is sexually attracted to a person of the same sex.

- There is widespread belief that homosexuality is a 'disease'; generally a 'mental illness' that needs to be cured or that homosexuality is a 'sin'. These ideas have no basis in fact and are responsible for deep seated prejudices in society against lesbian, gay and bisexual people which often lead to a number of violent acts against them, including sexual violence.

Guidelines for examination - Persons of alternate sexual orientation

- Even though the examination of a lesbian, gay or bisexual individual is not physically any different from that of a heterosexual person, a doctor should be especially sensitive to the former group's anxieties and concerns when it comes to such examinations.
- There should be no judgment on the person's sexual orientation in general or as a cause of the assault.
- Confidentiality of their sexual orientation should be maintained. One should not discuss or mention it to the other staff members unless needed for treatment reasons.
- The health professional should not express shock, wonder, or any other negative emotions when a person reveals their sexual orientation. The speech and behaviour of the health professional should remain inclusive.
    - Old injuries or fact that a person is 'habituated to anal sex' should NOT be recorded.
    - Treatment should NOT be denied to any person based on/due to their sexual orientation
    - The doctor and hospital staff should be understanding towards the survivor and should provide care and treatment with sensitivity.
    - The doctor or the hospital staff should not give any advice or 'offer solutions' to 'cure' them of their sexual orientation.
    - Lesbian, gay, bisexual and transgender persons are likely to be targets of hate crimes and may want to talk about the role their sexual orientation played in making them vulnerable to sexual violence.
    - Their experience should be given a sincere hearing and validated. The survivors should be assured that it was not their fault that they were sexually assaulted

Sex workers

- While women remain the largest group involved in sex work, the numbers of men acknowledged to be involved is growing.
- Although far less numerous, transgender individuals - both transvestites and trans-sexuals - are also active in sex work. It is important to bear in mind that just because sex workers exchange sexual acts for money or goods, does not mean that they cannot be sexually assaulted.
- The Supreme Court of India has acknowledged that a woman who is a sex worker has the right to decide with whom she will have sex, and so any non-consensual intercourse with her would therefore amount to rape. Sexual abuse by clients, police, pimps, brothel owners and others is commonly encountered by sex workers.
- Coercion to perform sexual acts by use of verbal threats, physical force and forced unwanted sexual acts by clients have been reported by sex workers as some of the types of sexual violence that they face.

Guidelines for examination While examining sex workers

- They face a number of challenges due to the nature of their work
- They have already faced a significant amount of discrimination from various agencies of society at every stage and hence their decision to approach a health care facility for treatment or examination should be considered a courageous one.
- A sex worker has a right to receive treatment and not providing it for any reason is punishable by law.
- Do not make assumptions about the person's health. Myths such as, "Sex workers are all addicts/HIV positive" are only myths. These propagate an unhealthy assumption of this group which may lead to further marginalization.
- Sex workers can be of any gender. No statements blaming the survivor or his/her profession for the violence faced should be made.
- Only information of the current episode of violence that the survivor is reporting must be documented. Any information of past sexual encounters is irrelevant to the current incident of sexual violence and should not be noted.

Persons with Disability

- It includes those who have long term physical, mental, intellectual or sensory impairments
- which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.
- Women and children with disability are particularly vulnerable to violence, discrimination, stigma and neglect. In fact, persons with disabilities may be repeatedly victimized, especially by caretakers. Some reports suggest that women and girls with disabilities are three times more likely to be victims of physical and sexual abuse as compared to other women and girls.(COMA PATIENT DELIVERED,HYSTRECTOMY CONTROVERSY)
- Women and girls with disabilities who are institutionalized are at risk of abuse in shelters and hospitals. This has now been recognized as 'custodial rape' in the revised Indian Penal Code (Criminal Law Amendment Act, 2013).
- Women with disabilities are often unable to report sexual abuse because of the obvious barriers to communication, as well as their dependency on carers who may also be abusers.
- When they do report, their complaints are not taken seriously and the challenges they face in expressing themselves in a system that does not create an enabling environment to allow for such expression, complicates matters further.
- India has ratified the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) which mandates that country must make specific provisions to end discrimination and violence faced by persons with disabilities.

- It also mandates that healthcare systems must make necessary provisions to ensure access to health care to persons with disabilities. However, our health systems in general are not friendly to persons with disabilities.

Guidelines for examination -Persons with disability

- Be aware of the nature and extent of disability that the person has and make necessary accommodations in the space where the examination is carried out.
- Do not make assumptions about the survivor's disability and ask about it before providing any assistance.
- Do not assume that a person with disability cannot give history of sexual violence himself/herself. Because abuse by near and dear ones is common, it is important to not let the history be dictated by the caretaker or person accompanying the survivor. History must be sought independently, directly from the survivor herself/himself. Let the person decide who can be present in the room while history is being sought and examination conducted.
- Make arrangements for interpreters or special educators in case the person has a speech/hearing or cognitive disability. Maintain a resource list with names, addresses and other contact details of interpreters, translators and special educators in and around your hospital, who could be contacted for assistance.
- Even while using the services of an interpreter, communicate with the person directly as much as possible, and be present while the interpreter or special educator is with the person.
- Understand that an examination in the case of a disabled person may take longer. Do not rush through things as it may distress the survivor. Take time to make the survivor comfortable and establish trust, in order to conduct a thorough examination.
- Recognize that the person may not have been through an internal examination before. The procedure should be explained in a language they can understand. They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Ensure that adequate and appropriate counselling services are provided to the survivors. If required, the services of an expert may be required in this regard, which should be made available.
- Consent: All persons are ordinarily able to give or refuse to give informed consent, including persons with mental illness and intellectual disabilities, and their informed consent should be sought and obtained before any medical examination. Some specific steps may be required when taking informed consent from persons with mental illness or those with intellectual disabilities.

- If it is deemed necessary, such persons should
    a) be provided the necessary information (what the procedure involves, the reason for doing the procedure, the potential risks and discomforts) in a simple language and in a form that makes it easy for them to understand the information;
    b) be given adequate time to arrive at a decision;
    c) be provided the assistance of a friend/colleague/care-giver in making the informed consent decision and in conveying their decision to medical personnel. The decision of the person to either give consent or refuse consent with the above supports, to the medical examination, should be respected.

People facing caste, class or religion based discrimination

- Sexual violence is mostly perpetrated by those in a position of power upon those who are relatively vulnerable. This position of power may be a function of a person's gender, class, caste, religion, ethnicity, sexual orientation and/or other factors.
- In India, the caste or religion that a person belongs to impacts on the power and influence that they exercise.
- Women are seen as symbols of honour of their social community.
- Violating the bodily integrity of women is equated with violating the honour of the entire community and bringing disgrace to it. Health professionals should be aware that while women and girls are specifically targeted during communal or caste conflicts, other members of the targeted community (including young boys) may also be subjected to sexual violence

Guidelines for examination

- Do not pass any explicit or implicit comments, or in any other way communicate your personal opinion, about the person's caste or religion while medically treating them.
- Do not ask the person who is being given medical treatment any questions about her religion/caste, except those that are relevant to the nature of violence she has faced or the kind of treatment she requires

Guidelines for responding to children:

- In case the child is under 12 years of age, consent for examination needs to be sought from the parent or guardian.
- Children may be accompanied by the abuser when they come for medical treatment, so be aware and screen when you suspect abuse. In such situations, a female person appointed by the head of the hospital/institution may be called in to be present during the examination.
- Do not assume that because the child is young he/she will not be able to provide a history. History seeking can be facilitated by use of dolls and body charts.

- Believe what is being reported by the child. There are misconceptions that children lie or that they are tutored by parents to make false complaints against others. Do not let such myths affect the manner in which you respond to cases of child sexual abuse.
- Specific needs of children must be kept in mind while providing care to child survivors. Doses of treatment will have to be adjusted as required in terms of medical treatment. For psychological support, it is imperative to speak with the carer/s of the survivor in addition the survivor themselves.
- Health professionals must make a note of the following aspects while screening for sexual abuse. Assurance of confidentiality and provision of privacy are keys to enabling children to speak about the abuse.
- Section 11: Sexual Harassment of the Child-With sexual intent
  - Utters any word or makes any sound, or makes any gesture or exhibits any object or part of body with the intention that such.
  - word or sound shall be heard, or such gesture or object or part of body shall be seen by the child; or
  - makes a child exhibit his body or any part of his body so as it is seen by such person or any other person; or
  - shows any object to a child in any form or media for pornographic purposes; or repeatedly or constantly follows or watches or contacts a child either directly or through electronic, digital or any other means; or
  - threatens to use, in any form of media, a real or fabricated depiction through electronic, film or digital or any other mode, of any part of the body of the child or the involvement of the child in a sexual act; or entices a child for pornographic purposes or gives gratification therefore.
  - Section 12: Up to three years of imprisonment and liable to fine.

Dealing with adolescents

- Important to communicate that she was not at fault,
- Need to encourage her to share feelings, fears and concerns.
- For an adolescent, acceptance by family and peers becomes a critical aspect in healing.
- Parents and friends should encourage survivor to seek counselling and crisis intervention support as adolescence is an age of turbulence and the survivor may not be comfortable talking about several issues with parents / carers such as “contraception”, “health sexual relationships”, fears of contracting infections such as STI/HIV, anxiety about how they are perceived by others in the school/ college.
- Carers should exercise caution and not become over protective and restrictive in their approach.
- This could occur due to fear of recurrence of the assault and fear for survivor's safety. These concerns need to be discussed openly with the survivor and encourage her to make informed decisions.

SOP

- The SOP must be printed and available to all staff of the hospital.
- Any registered medical practitioner can conduct the examination and it is not mandatory for a gynaecologist to examine such a case.
- In case of a girl or woman, every possible effort should be made to find a female doctor
- but absence of availability of lady doctor should not deny or delay the treatment and examination
- In case a female doctor is not available for the examination of a female survivor, a male doctor should conduct the examination in the presence of a female attendant.
- In case of a minor/person with disability, his/her parent/guardian/any other person with whom the survivor is comfortable may be present.
- In the case of a transgender/intersex person, the survivor should be given a choice as to whether she/he wants to be examined by a female doctor, or a male doctor. In case a female doctor is not available, a male doctor may conduct the examination in the presence of a female attendant.
- Police personnel must not be allowed in the examination room during the consultation with the survivor. If the survivor requests, her relative may be present while the examination is done.
- There must be no delay in conducting an examination and collecting evidence.
- Providing treatment and necessary medical investigations is the prime responsibility of the examining doctor. Admission, evidence collection or filing a police complaint is not mandatory for providing treatment.
- The history taking & examination should be carried out in complete privacy in the special room set up in the hospital for examination of sexual violence survivor.
- The room should have adequate space, sufficient lighting, a comfortable examination table, all the equipment required for a thorough examination, and the sexual assault forensic OPERATIONAL ISSUES 20 evidence (SAFE) kit containing the following items for collecting and preserving physical evidence following a sexual violence:

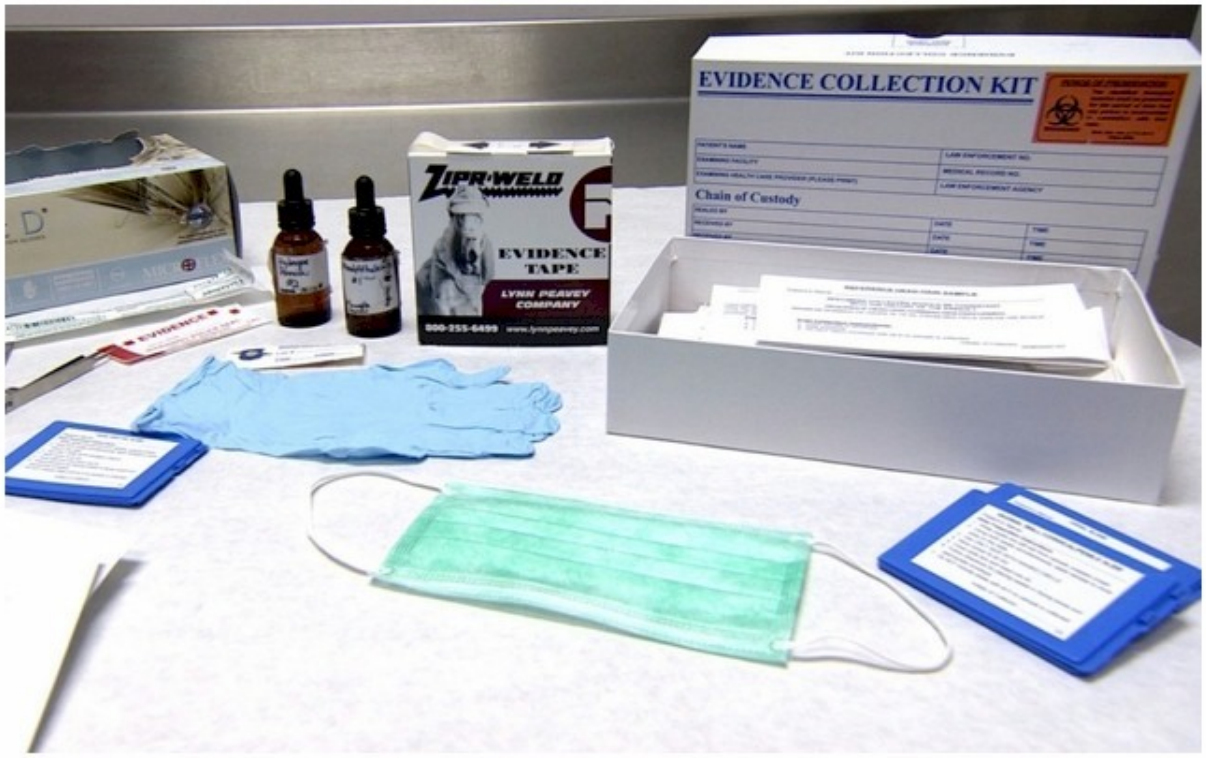
Sexual Assault Forensic Evidence -SAFE

Below are the materials supposed to be kept ready and safe for further forensic evidence report

- Forms for documentation
- Large sheet of paper to undress over
- Paper bags for clothing collection
- Catchment Paper
- Sterile cotton swabs and swab guards for biological evidence collection
- Comb , Nail Cutter , Wooden stick for finger nail scrapings • Small scissors , Urine sample container

- Tubes/ vials/ vacutainers for blood samples [Ethylenediaminetetraacetic acid (EDTA), Plain, Sodium fluoride] ,Syringes and needle for drawing blood, Distilled water , Disposable gloves ,Glass slides
- Envelopes or boxes for individual evidence samples ,Labels ,Lac(sealing wax) Stick for sealing ,Clean clothing, shower/hygiene items for survivors use after the examination

Sexual Assault Forensic Evidence -SAFE KIT



Other items for a forensic/medical examination and treatment that may be included are:

- Woods lamp/Good torch
- Vaginal speculums
- Drying rack for wet swabs &/or clothing
- Patient gown, cover sheet, blanket, pillow
- Post-It notes to collect trace evidence
- Camera (35mm, digital with colour printer)
- Microscope
- Colposcopy/ Magnifying glass
- Toluidine blue dye
- 1% Acetic acid diluted spray
- Urine Pregnancy test kit
- Medication

- The collected samples for evidence may be preserved in the hospital till such time that police are able to complete their paper work for dispatch to forensic lab test including DNA.

- After the examination is complete the survivor should be permitted to wash up, using the toiletries and the clothing provided by the hospital if her own clothing is taken as evidence.
- Admission should not be insisted upon unless the survivor requires indoor stay for observation/treatment.

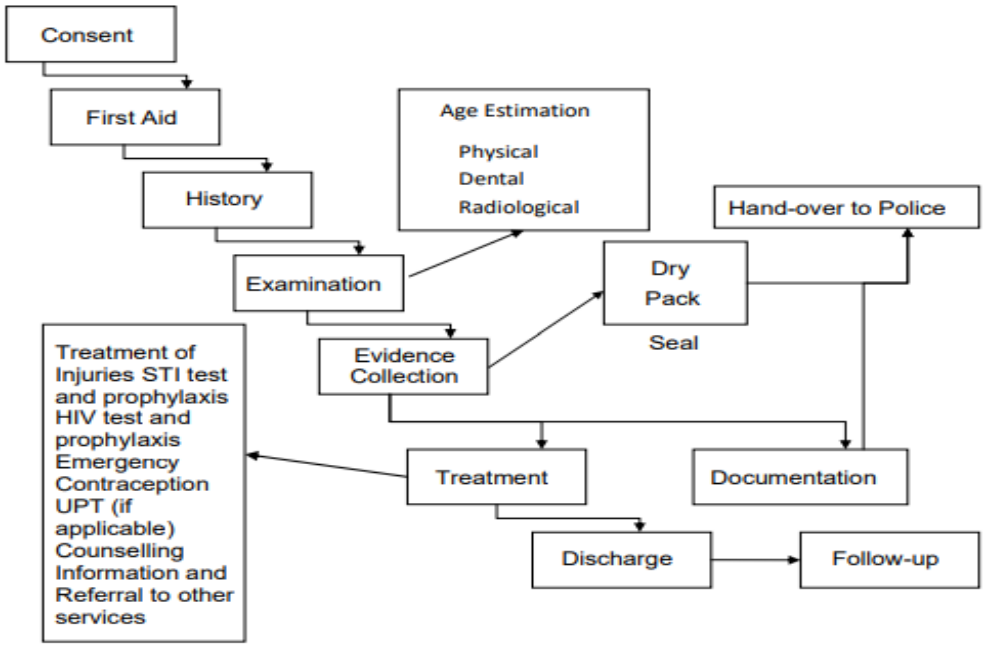
Complete free treatment

- Survivors of sexual violence should receive all services completely free of cost. This includes OPD/inpatient registration, lab and radiology investigations, Urine Pregnancy Test (UPT) and medicines.
- The casualty medical officer must label the case papers for any sexual violence case as "free" so that free treatment is ensured.
- Medicines should be prescribed from those available in the hospital. If certain investigations or medicines are not available, the social worker at the hospital should ensure that the survivor is compensated for investigations/ medicines from outside.
- A copy of all documentation (including that pertaining to medico-legal examination and treatment) must be provided to the survivor free of cost.

MEDICAL EXAMINATION AND REPORTING FOR SEXUAL VIOLENCE
Guidelines - stepwise approach- comprehensive response

- Initial resuscitation/ first Aid
- Informed consent for examination, evidence collection, police procedures
- Detailed History taking
- Medical Examination

The following are the components of a comprehensive health care response to sexual violence and must be carried out in all cases:



- Age Estimation (physical/dental/radiological) – if requested by the investigating agency.
- Evidence Collection as per the protocol
- Documentation
- Packing, sealing and handing over the collected evidence to police
- Treatment of Injuries
- Testing/prophylaxis for STIs, HIV, Hepatitis B and Pregnancy
- Psychological support & counselling xii. Referral for further help (shelter, legal support)
- Record the name of hospital where the survivor is being examined followed by the following:
- 2-5. Name, address, age and sex (male/female/other) of the survivor 6-7.Date and time of receiving the patient in the hospital and commencement of examination
- 8. Name of the person who brought the survivor and relationship to accompanying persons.
- Informed consent: A survivor may approach a health facility under three circumstances:

  a) on his/her own only for treatment for effects of assault;

  b) with a police requisition after police complaint; or

  c) with a court directive.

MLC

a) If a person has come directly to the hospital without the police requisition, the hospital is bound to provide treatment and conduct a medical examination with consent of the survivor/parent/guardian (depending on age). A police requisition is not required for this. •

b) If a person has come on his/her own without FIR, s/he may or may not want to lodge a Complaint but requires a medical examination and treatment. Even in such cases the doctor is bound to inform the police as per law. However neither court nor police can force the survivor to undergo medical examination. It has to be with the informed consent of the survivor/ parent/ guardian (depending on the age).

c) In case the survivor does not want to pursue a police case, a MLC must be made and she must be informed that she has the right to refuse to file FIR. An informed refusal must be documented in such cases.

d) If the person has come with a police requisition or wishes to lodge a complaint later, the information about medico-legal case (MLC) no. & police station should be recorded.

e) Doctors are legally bound to examine and provide treatment to survivors of sexual violence. The timely reporting, documentation and collection of forensic evidence may assist the investigation of this crime.

f) In all three circumstances, it is mandatory to seek an Informed Consent/refusal for examination and evidence collection. Consent should be taken for the following purposes: examination, sample collection for clinical and forensic examination, treatment and police intimation.

g) The consent form must be signed by the person him/herself if s/he is above 12 yrs. of age.
h) Consent must be taken from the guardian/ parent if the survivor is under the age of 12 years.
i) In case of persons with mental disability, please refer to section on "Persons with Disabilities"
j) The consent form must be signed by the survivor, a witness and the examining doctor.
k) Any major 'disinterested', person may be considered a witness
l) Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/ or a person in whom the child reposes trust. Include

- The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum as necessary depending on the particular circumstances.

- To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.

- The survivor or in case of child, the parent/guardian/or a person in whom the child reposes trust, has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.

- As per the law, the hospital/ examining doctor is required/duty bound to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it should not result in denial of treatment for sexual violence.

Informed refusal for police intimation

a) The survivor or guardian may refuse to give consent for any part of examination. In this case the doctor should explain the importance of examination and evidence collection. However the refusal should be respected. It should also be explained that refusal for such examination will not affect/compromise treatment. Such informed refusal for examination and evidence collection must be documented.

b) In case there is informed refusal for police intimation, then that should be documented. At the time of MLC intimation being sent to the police, a clear note stating "informed refusal for police intimation" should be made.

c) Only in situations, where it is life threatening the doctor may initiate treatment without consent as per section 92 of IPC. (NIRBAYA)
Two marks of identification such as moles, scars, tattoos etc., preferably from the exposed parts of the body should be documented. While describing identification mark emphasis should be on size, site, surface, shape, colour, fixity to underlying structures. Left Thumb impression is to be taken in the space provided.

d) **Menstrual history** (Cycle length and duration, Date of last menstrual period).If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly. Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/examination

e) **Vaccination history** is important with regard to tetanus and hepatitis B, so as to ascertain if prophylaxis is required

Sexual violence history

a) Be sensitive to the survivor as she has experienced a traumatic episode and s/he may not be able to provide all the details.
b) Explain to him/her that the process of history taking is important for further treatment and for filing a case if needed.
c) Create an environment of trust so that the survivor is able to speak out. Do not pass judgmental remarks.
d) A relative could be present with the consent of the survivor, if s/he is comfortable.
e) Details of the date, time and location of incident of sexual violence should be recorded.
f) In case of more than one assailant, their number should be recorded along with the names and relation if known.
g) One must note who is narrating the incident- survivor or an informant. If history is narrated by a person other than the survivor herself, his/her name should be noted. Especially if the identity of assailants is revealed it is better to also have a countersignature of the informant.
h) The doctor should record the complete history of the incident, in survivor's own words as it has evidentiary value in the court of law.
i) Use of any Physical violence during assault must be recorded with detailed description of the type of violence and its location on the body (eg. Beating on the legs, biting cheeks, pulling hair, kicking the abdomen etc.).
j) Note history of injury marks that the survivor may state to have left on the assailant's body as it can be matched eventually with the findings of the assailant's examination. • If any weapon(s) were used such as sticks, acid burns, gun shots, knife attacks etc.; if the use of drugs/alcohol was involved. Verbal threats should be recorded in survivor's words, eg. harming her or her near and dear ones.

k) Information regarding attempted or completed penetration by penis/ finger/ object in vagina/ anus/ mouth should be properly recorded. There could also be other acts such as masturbation of the assailant by the survivor, masturbation of the survivor by the assailant, oral sex by the assailant on the survivor or sucking, licking, kissing of body parts.

l) Information about emission of semen, use of condom, sucking or spitting along with the location should be clearly stated. Information about emission of semen outside the orifices should be elicited as swabs taken from such sites can have evidentiary value. Information regarding use of condom during the assault is relevant because in such cases, vaginal swabs and smears would be negative for sperm/semen

m) While recording history of sexual violence, it is important to enquire and record in simple language whether these acts occurred or not.

n) A clear differentiation should be made between a 'negative' and 'not sure' history. If the survivor does not know if a particular act occurred, it should be recorded as "did not know"'. • One should not feel awkward in asking for history of the sexual act. If details are not entered it may weaken the survivor's testimony. The details of history are what will also guide the examination, treatment and evidence collection and therefore seeking a complete history is critical to the medical examination process, sample collection for clinical & forensic examination, treatment and police intimation.

o) In case of children, illustrative books, body charts or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.

p) Details of clothing worn at the time of assault should be recorded.

q) Post assault Information should be collected on activities like changed clothes, cleaned clothes, bathed/ urinated/ defecated/ showered/ washed genitals (in all cases) and rinsing mouth, drinking, eating (in oral sexual violence)/ had sexual intercourse after the incident of sexual violence. This would have a bearing on the trace evidence collected from these sites.

r) If vaginal swabs for detection of semen are being taken then record history of last consensual sexual intercourse in the week preceding the examination.

s) It should be recorded because detection of sperm/semen is a valuable evidence. While seeking such history, explain to the survivor why this information is being sought, because the survivor may not want to disclose such history as it may seem invasive.

t) Information related to past abuse (physical/sexual/emotional) should be recorded in order to understand if there is any health consequence related to the assault. This information should be kept in mind during examination & interpretation of findings.

u) Relevant surgical history

- Relevant medical history in relation to sexually transmitted infections (gonorrhea, HIV, HBV etc.) can be elicited by asking about discharge per-urethra/per-anus, warts, ulcers, burning micturition, lower abdominal pain etc.

- Based on this information re-examination/ investigations can be done after incubation period of that disease.
- If there is vaginal discharge, record its type, i.e., texture, colour, odour, etc. · Relevant surgical history in relation to treatment of fissures/injuries/scars of anogenital area should be noted.

General physical examination:

a) Record if the person is oriented in space and time and is able to respond to all the questions asked by the doctor.
b) Any signs of intoxication by ingestion or injection of drug/alcohol must be noted.
c) Pulse. B.P., respiration, temperature and state of pupils is recorded.
d) A note is made of the state of clothing if it is the same as that worn at the time of assault. If it is freshly torn or has stains of blood/ semen/ mud etc.; the site, size, and colour of stains should be described.

PROFORMA FOR MEDICO-LEGAL EXAMINATION OF SURVIVORS/VICTIMS OF SEXUAL VIOLENCE. GOI - ONE PAGE INSTRUCTIONS FOR DOCTORS

1. Informed consent: (include information)

   Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/person in whom the child reposes trust.

   a) The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum.
   b) To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.
   c) The survivor or in case of child, the parent/guardian/person in whom the child reposes trust, has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.
   d) As per the law, the hospital/ examining doctor is required to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it will not result in denial of treatment for sexual violence. Informed refusal will be documented in such cases.

2. Per vaginum examination, commonly referred to by lay persons as 'two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introitus, elasticity of the vagina or hymen or about past sexual experience or habituation to sexual intercourse should be made as it has no bearing on a case of sexual violence.

No comment on shape, size, and/or elasticity of the anal opening or about previous sexual experience or habituation to anal intercourse should be made.

3. Injury documentation:
   a) Examine the body parts for sexual violence related findings (such as injuries, bleeding, swelling, tenderness, discharge). This includes both micro mucosal injuries which may heal within short period to that of severe injuries which would take longer to heal.
   b) Injuries must be recorded with details - size, site, shape, colour.
   c) If a past history of sexual violence is reported, then record relevant findings. Sexual violence is largely perpetrated against females, but it can also be perpetrated against males, transgender and intersex persons.
4. The nature of forensic evidence collected will be determined by three main factors nature of sexual violence, time lapsed between incident of sexual violence and examination and whether survivor has bathed or washed herself.
5. Opinion: The issue of whether an incident of rape/sexual assault occurred is a legal issue and not a medical diagnosis.
   a) Consequently, doctors should not, on the basis of the medical examination conclude whether rape/sexual assault had occurred or not. Only findings in relation to medical findings should be recorded in the medical report.
   b) Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor.
   c) It should be always kept in mind that normal examination findings neither refute nor confirm sexual violence. Hence circumstantial/other evidence may please be taken into consideration.
   d) Absence of injuries may be due to inability of survivor to offer resistance to the assailant because of intoxication or threats or Delay in reporting for examination

Examination for injuries

a) Presence of injuries is only observed in one third cases of forced sexual intercourse. Absence of injuries does not mean the survivor has consented to sexual activity. As per law, if resistance was not offered that does not mean the person has consented.
b) The entire body surface should be inspected carefully for signs of bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks
c) Describe all the injuries. Describe the type of injury (abrasion, laceration, incised, contusion etc.), site, size, shape, colour, swelling, signs of healing, simple/grievous, dimensions. Mention possible weapon of infliction such as - hard, blunt, rough, sharp, etc. Refer to Annexure 2 for noting time of injury
d) Injuries are best represented when marked on body charts. They must be numbered on the body charts and each must be described in detail. Describe any stains seen on the body - the type of stain (blood, semen,

lubricant, etc.) its actual site, size and colour. Mention the number of swabs collected and their sites.

e) Lacerations: Clean with antiseptic or soap and water. If the survivor is already immunized with Tetanus Toxoid or if no injuries, TT not required. If there are injuries and survivor is not immunized, administer ½ cc TT IM.
f) If lacerations require repair and suturing, which is often the case in minor girls, refer to the nearest centre offering surgical treatment. Post Exposure Prophylaxis (PEP) for HIV should be given if a survivor reports within 72 hours of the assault. Before PEP is prescribed, HIV risk should be assessed.

Follow-up :re-examination important

a) 2 days after the assault to note the development of bruises and other injuries; thereafter at 3 and6 weeks.
b) All follow ups should be documented.
c) Repeat test for gonorrhea if possible.
d) Test for pregnancy.
e) Repeat after six weeks for VDRL.
f) Assess for psychological sequelae and re-iterate need for psychological support as per section 5 of the guidelines. Psychosocial care: All survivors should be provided the first line support.
g) The health professional must provide this support himself/herself or ensure that there is someone trained at the facility to provide this.

Local examination of genital parts/other orifices

a) External genital area and Perineum is observed carefully for evidence of injury, seminal stains and stray pubic hair. Pubic hair is examined for any seminal deposits/ stray hair. Combing is done to pick up any stray hair or foreign material, and sample of pubic hair, and matted pubic hair is taken and preserved. If pubic hair is shaven, a note is made.
b) In case of female survivors, the vulva is inspected systematically for any signs of recent injury such as bleeding, tears, bruises, abrasions, swelling, or discharge and infection involving urethral meatus & vestibule, labia majora and minora, fourchette, introitus and hymen

Genital and anal evidence

a) In the case of any suspected seminal deposits on the pubic hair of the woman, clip matted portion of the pubic hair; allow drying in the shade and placing in an envelope.
b) Pubic hair of the survivor is then combed for specimens of the offender's pubic hair. A comb must be used for this purpose and a catchment paper must be used to collect and preserve the specimens. Cuttings of the pubic hair are also taken for the purpose of comparison or to serve as control samples. If pubic hair has been shaved, do not fail to make a mention of it in the records.
c) Take two swabs from the vulva, vagina, anal opening for ano-genital evidence. Swabs must be collected depending on the history and examination. Swabs from orifices must be collected only if there is a history of penetration.

d) Two vaginal smears are to be prepared on the glass slide provided, air-dried in the shade and sent for seminal fluid/ spermatozoa examination.

Examination of the vagina

a) a sterile speculum lubricated with warm saline/ sterile water.
b) Gentle retraction allows for inspection of the vaginal canal
c) Look for bruises, redness, bleeding and tears, which may even extend onto the perineum, especially in the case of very young girls.
d) In case injuries are not visible but suspected; look for micro injuries using good light and a magnifying glass/ colposcopy whatever is available
e) If 1% Toluidine blue is available it is sprayed and excess is wiped out. Micro injuries will stand out in blue. Care should be taken that all these tests are done only after swabs for trace evidence are collected.
f) Per speculum examination is not a must in the case of children/young girls when there is no history of penetration and no visible injuries.
g) The examination and treatment as needed may have to be performed under general anaesthesia in case of minors and when injuries inflicted are severe. If there is vaginal discharge, note its texture, colour, odour.
h) Per-Vaginum examination commonly referred to by lay persons as 'two-finger test', must not be conducted for establishing rape/sexual violence and the size of the vaginal introitus has no bearing on a case of sexual violence.
i) Per vaginum examination can be done only in adult women when medically indicated.

The status of hymen

a) It is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things.
b) An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse.
c) Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual violence. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented.
d) Genital findings must also be marked on body charts and numbered accordingly.
e) Bleeding/swelling/tears/discharge/stains/warts around the anus and anal orifice must be documented.
f) Per-rectal examination to detect tears/stains/fissures/hemorrhoids in the anal canal must be carried out and relevant swabs from these sites should be collected.
g) Oral cavity should also be examined for any evidence of bleeding, discharge, tear, odema, tenderness.

CLOTHES

a) Clothes that the survivor was wearing at the time of the incident of sexual violence are of evidentiary value if there is any stains/tears/trace evidence on them. Hence they must be preserved.
b) Please describe each piece of clothing separately with proper labelling. Presence of stains - semen, blood, foreign material etc - should be properly noted.
c) Also note if there are any tears or other marks on the clothes. If clothes are already changed then the survivor must be asked for the clothes that were worn at the time of assault and these must be preserved.
d) Always ensure that the clothes and samples are air dried before storing them in their respective packets. Ensure that clothing is folded in such a manner that the stained parts are not in contact with unstained parts of the clothing. Pack each piece of clothing in a separate bag, seal and label it duly.

Body evidence

a. Swabs are used to collect bloodstains on the body, foreign material on the body surfaces seminal stains on the skin surfaces and other stains. Detection of scalp hair and pubic hair of the accused on the survivor's body (and vice-versa) has evidentiary value.
b. Collect loose scalp and pubic hair by combing. Intact scalp and pubic hair is also collected from the survivor so that it can be matched with loose hair collected from the accused. All hair must be collected in the catchment paper which is then folded and sealed. If there is struggle during the sexual violence, with accused and survivor scratching each other, then epithelial cells of one may be present under the nails of the other that can be used for DNA detection. Nail clippings and scrapings must be taken for both hands and packed separately. Ensure that there is no underlying tissue contamination while clipping nails. Blood is collected for grouping and also helps in comparing and matching blood stains at the scene of crime.
c. Collect blood and urine for detection of drugs/alcohol as the influence of drugs/ alcohol has a bearing on the outcome of the entire investigation. If such substances are found in the blood, the validity of consent is called into question. In a given case, for instance, there may not be any physical or genital injuries.
d. In such a situation, ascertaining the presence of drug/alcohol in the blood or urine is important since this may have affected the survivor's ability to offer resistance. Urine sample may be collected in a container to test for drugs and alcohol levels as required.
e. Venous blood is collected with the sterile syringe and needle provided and transferred to 3 sterile vials/ vaccutainers for the following purposes:
f. Plain Vial/Vaccutainer - Blood grouping and drug estimation, Sodium Fluoride - Alcohol estimation, EDTA - DNA Analysis. · Collect oral swab for detection of semen and spermatozoa.

g. Oral swabs should be taken from the posterior parts of the buccal cavity, behind the last molars where the chances of finding any evidence are highest.

SWABS

a) Often lubricants are used in penetration with finger or object, so relevant swabs must be taken for detection of lubricant. Other pieces of evidence such as tampons (may be available as well), which should be preserved.
b) Swab sticks for collecting samples should be moistened with distilled water provided. • Swabs must be air dried, but not dried in direct sunlight. Drying of swabs is absolutely mandatory as there may be decomposition/degradation of evidence which can render it un-usable.
c) Vaginal washing is collected using a syringe and a small rubber catheter. 2-3 ml of saline is instilled in the vagina and fluid is aspirated. Fluid filled syringe is sent to FSL laboratory after putting a knot over the rubber catheter.
d) While handing over the samples, a requisition letter addressed to the FSL, stating what all samples are being sent and what each sample needs to be tested for should be stated. For example, "Vaginal swab to be tested for semen". This form must be signed by the examining doctor as well as the officer to whom the evidence is handed over.
e) Please ensure that the numbering of individual packets is in consonance with the numbering on the requisition form. Specimens sent to the Forensic Science laboratory will not be received unless they are packed separately, sealed, labeled and handed over

Sample collection/investigations

a) Hospital laboratory/ Clinical laboratory
   1. Blood for HIV, VDRL, HbsAg
   2. Urine test for Pregnancy
   3. Ultrasound for pregnancy/internal injury
   4. X-ray for Injury
b) Central/ State Forensic Science Laboratory
   1) Debris collection paper
   2) Clothing evidence where available – (to be packed in separate paper bags after air drying)
   3) List and Details of clothing worn by the survivor at time of sexual violence incident
c) Collection of samples for central/ State forensic science laboratory
d) After assessment of the case, determine what evidence needs to be collected. It would depend upon nature of assault, time elapsed between assault and examination and if the person has bathed/washed herself since the assault.
e) If a woman reports within 96 hours (4 days) of the assault, all evidence including swabs must be collected, based on the nature of assault that has occurred. The likelihood of finding evidence after 72 hours (3 days) is greatly reduced; however it is better to collect evidence up to 96 hours in case the survivor may be unsure of the number of hours lapsed since the assault.

f) The spermatozoa can be identified only for 72 hours after assault. So if a survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent for tests for identifying semen.
g) Evidence on the outside of the body and on materials such as clothing can be collected even after 96 hours.
h) The nature of swabs taken is determined to a large extent by the history and nature of assault and time lapse between incident and examination. For example, if the survivor is certain that there is no anal intercourse; anal swabs need not be taken.
i) Request the survivor to stand on a large sheet of paper, so as to collect any specimens of foreign material e.g. grass, mud, pubic or scalp hair etc. which may have been left on her person from the site of assault/ from the accused. This sheet of paper is folded carefully and preserved in a bag to be sent to the FSL for trace evidence detection.
j) Absence of injuries or negative laboratory results may be due to:
k) Inability of survivor to offer resistance to the assailant because of intoxication or threats
l) b. Delay in reporting for examination
m) Activities such as urinating, washing, bathing, changing clothes or douching which may lead to loss of evidence
n) Use of condom/vasectomy or diseases of vase

Provisional clinical opinion

a) Drafting of provisional opinion should be done immediately after examination of the survivor on the basis of history and findings of detailed clinical examination of the survivor.
b) The provisional opinion must, in brief, mention relevant aspects of the history of sexual violence, clinical findings and samples which are sent for analysis to FSL.
c) An inference must be drawn in the opinion, correlating the history and clinical findings.
d) The following section offers some scenarios about ways to draft a provisional and final opinion. However, this list is not exhaustive and readers are advised to form provisional opinions based on the examples given below.
e) It should be always kept in mind that normal examination findings neither refute nor confirm the forceful sexual intercourse. Hence circumstantial/other evidence may please be taken into consideration.

Sample of Medico- Legal examination report of sexual Violence

CONFIDENTIAL

Medico-legal Examination Report of Sexual Violence

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

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

12. Informed Consent/refusal

I.....D/o or S/o.....

hereby give my consent for:

a) medical examination for treatment Yes ☐ No ☐

b) this medico legal examination Yes ☐ No ☐

c) sample collection for clinical & forensic examination Yes ☐ No ☐

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

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

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

Product of conception –DNA kit important

If a woman reports with a pregnancy resulting from an assault,

a) She is to be given the option of undergoing an abortion, and protocols for MTP are to be followed.
b) The products of conception (PoC) may be sent as evidence to the forensic lab (FSL) for establishing paternity / identifying the accused.
c) The examining doctor/AMO/CMO is to contact the respective police station, ask them to collect the DNA Kit from the FSL and bring it to the hospital to coincide with the time of MTP.
d) The DNA Kit is used to collect the blood sample of the survivor. The accompanying DNA Kit forms are to be filled by the examining doctor. A photograph of the survivor is required for this form, and should be arranged for prior to the MTP.
e) The products of conception (PoC) are to be rinsed with normal saline (NOT completely soaked in saline) and collected in a wide-mouthed container with a lid.
f) This sample is to be handed over immediately to the police along with the DNA Kit, or preserved at 4 degree Celsius. It is to be transported by the police in an ice-box, maintaining the temperature at around 4 degree Celsius (2 to 8 degree Celsius) at all times.
g) Signature and seal After the examination the medical practitioner should document the report,
h) Formulate opinion,
i) Sign the report and handover the report and sealed samples to police under due acknowledgement.
j) On the last sheet, mention how many pages are attached.
k) Each page of the report should be signed to avoid tampering.
l) It is important that one copy of all documents be given to the survivor as it is his/her right to have this information.
m) One copy to be given to the police and
n) One copy must be kept for hospital records.
o) All evidence needs to be packed and sealed properly in separate envelopes.
p) The responsibility for this lies with the examining doctor. All blood samples must be refrigerated until handed over to next in chain of custody. The hospital has the responsibility of properly preserving samples till handed over to police.

Psycho- Social Care for survivors/Victims

Treat sexually transmitted infections:

a) If clinical signs are suggestive of STD, collect relevant swabs and start PEP. If there are no clinical signs, wait for lab results.
b) For non-pregnant women,
c) the preferred choice is Azithromycin 1gm stat or Doxycycline 100mg bd for 7days, with Metronidazole 400 mg for 7days with antacid.

d) For pregnant women, Amoxycillin /Azithromycin with Metronidazole is preferred. Metronidazole should NOT to be given in the 1st trimester of pregnancy.
e) Hepatitis B. Draw a sample of blood for HBsAg and administer 0.06 ml/kg HB immune globulin immediately (anytime upto 72 hours after sexual act). Pregnancy Prophylaxis (Emergency contraception)
f) The preferred choice of treatment is 2 tablets of Levonorgestrel 750 ìg, within 72 hours. If vomiting occurs, repeat within 3 hours. OR 2 tablets COCs Mala D - 2 tablets stat repeated 12 hours within 72 hours
g) Although emergency contraception is most efficacious if given within the first 72 hours, it can be given for up to 5 days after the assault.
h) Pregnancy assessment must be done on follow up and the survivor must be advised to get tested for pregnancy in case she misses her next period.

A set of guidelines

a) Creating an enabling atmosphere and establishing trust The health professional should
b) Speak to survivor in a private space
c) Recognize her courage in reaching you as she has overcome several barriers
d) Recognise the dilemma faced by survivor in reporting violence. Do not label non-reporting to police as false case.
e) Assure the survivor that her treatment will not be compromised
f) Inform survivor of available resources, referrals, legal rights so that she can take an informed decision.
    a. Sexual violence is known to cause physical, emotional social and economic consequences which can jeopardize the well-being of survivors and their families. Fear of police investigation procedures, shame related to the sexual violence, lack of support from the community, fear that nobody will believe them and lack of information about negative health consequences may lead survivors to hide such incidents.
    b. Reasons for not wanting to report to police could range from fear about community reactions, fear that nobody would believe them, feelings of shame, threats from perpetrators. With children there could also be a possibility that survivor has not disclosed the assault to parents/guardians.

Facilitation and demystification of medical procedures

The health professional should:

1. Prepare the survivor for an internal examination.
2. Explain the various stages of the examination.
3. Communicate the rationale for referral for X-ray, USG, age estimation amongst others.
    a. Any incident of sexual violence leads to a feeling of powerlessness amongst survivors. It is therefore important to recognize such covert feelings and explain the purpose of medical examination. Explaining the purpose of internal examination and steps in conducting it can help survivors to make sense of what is happening to them. This can help in regaining control over the situation.

b. Currently each health setting may not have all the infrastructure for additional services such as age estimation, laboratory for assessing infections, sonography machines to detect internal injuries/ pregnancy and so on.

4. While making referrals providers must ensure confidentiality and privacy of survivors so that they are not embarrassed due to being identified as a "survivor of sexual violence".

Addressing survivor's emotional well-being

The health professional should:

a) Recognized that survivors may present varied emotions.
b) Encourage the survivor to express her feelings.
c) Encourage survivors to seek crisis counselling.
d) Assess for suicidal ideation.
e) Make a safety assessment and safety plan.
f) Involve family and friends in healing process of survivor.

a. Each survivor copes with the assault differently. Coping is also dependent on whether survivors have parental/ spousal support, community support, job security, economic wherewithal for litigation and several such factors.
b. Most survivors may not openly express their feelings. A good starting point is to explain range of feelings that survivors may experience such as sleeplessness, anxiety, nervousness, crying spells, feelings of ending one's life, anger and flash backs (RTS, emotional reactions post rape) after an assault. It must also be discussed that such reactions are normal after a traumatic episode.
c. Crisis counselling can help in overcoming trauma. Providers must explain to the survivors that:
d. "rape" is a violation of bodily integrity and not a loss of honour.
e. Assault is an abuse of power and not an act of lust.
f. Positive messaging such as "you are not responsible for rape", "It is not about the clothes you wear"
g. This would enable the survivor to discard feelings of self-blame as it is the perpetrator who should feel ashamed about the act and help in rebuilding survivor's confidence in self.
h. Safety assessment must be done:

g) If assessment reveals that she is unsafe and fears reoccurrence of sexual violence health professional must offer her alternate arrangements for stay such as temporary admission in the hospital or referral to shelter services. However some survivors may want to go home particularly if there are children or other dependents.
h) A safety plan must be made which may include suggestions such as making a police complaint about threats received, building support strategy with neighbours/ community and temporary relocation from the old residence.

a. where a parent is the perpetrator of sexual abuse:

i) Survivors under 18 years, are likely to be accompanied by parents / guardians. If a health professional finds out that the perpetrator is the parent, it is critical to involve social worker/counsellor from the hospital to

discuss safety of the child. As per POCSCO Act, 2012 social worker would have to speak with the child to assess whom the child trusts and can be called upon in the hospital itself.

j) Simultaneously social worker would also have to contact police, who in communication with social worker should assess whether the child is in need of protection and care. Likewise the child may be admitted to the hospital for a period of 24 hours till a long term strategy for shelter or child welfare home is made.

Role of family, friends and community

a) Recovery from sexual violence is dependent on the extent of support received from family, friends and community.
b) Health professionals are best suited to engage with family and discuss ways of promoting survivors' well-being. It must be discussed with all care givers that survivor should not be held responsible for the assault. Judgments such as; "she should have been careful", "she should have resisted" make the survivors journey to recovery more difficult. In situations of child sexual abuse: Parents may experience anger, confusion, and guilt. Some may also blame themselves for not having taken adequate care or paid attention to the child. Reiterate that it is the perpetrator who misused their position.
c) Messages such as:
d) Believe that recovery from abuse is possible
e) Strategies such as good touch and bad touch can be taught to the child from a very young age, so that if the child is touched inappropriately, she should raise an alarm.
f) Restricting child's mobility such as not being allowed to play with friends, not allowed to go to school, not allowed to visit friends, may be perceived by the child as punishment for something the child had no control on.
g) Encourage the child to carry on with his/ her daily routine.
h) Follow up with crisis counselling so that the child is able to deal with negative feelings and also heal from the abuse.

Interface of health systems with police

a) A standard operating procedure outlining the interface between the police and health systems is critical. Whenever a survivor reports to the police, the police must take her/ him to the nearest health facility for medical examination, treatment and care. Delays related to the medical examination and treatment can jeopardize the health of the survivor.
b) Health professionals should also ask survivors whether they were examined elsewhere before reaching the current health set up and if survivors are carrying documentation of the same.
c) If this is the case , health professionals must refrain from carrying out an examination just because the police have brought a requisition and also explain the same to them
d) The health sector has a therapeutic role and confidentiality of information and privacy in the entire course of examination and treatment must be ensured. The police should not be allowed to be present while details of the incident of

sexual violence, examination, evidence collection and treatment are being sought from the survivor.

e) The police cannot interfere with the duties of a health professional. They cannot take away the survivor immediately after evidence collection but must wait until treatment and care is provided.
f) In the case of unaccompanied survivors brought by the police for sexual violence examination, police should not be asked to sign as witness in the medico legal form. In such situations, a senior medical officer or any health professional should sign as witness in the best interest of the survivor.
g) Health professionals must not entertain questions from the police such as "whether rape occurred", "whether survivor is capable of sexual intercourse", "whether the person is capable of having sexual intercourse". They should explain the nature of medico legal evidence, its limitations as well as the role of examining doctors as expert witnesses.

GUIDELINES FOR INTERFACE WITH OTHER AGENCIES SUCH AS POLICE AND JUDICIARY 41 1CLA, 2013 and POCSCO Act, 2012 both recognize that any registered medical practitioner can carry out a medico legal examination and provide treatment and records of that health provider will stand in the court of law(164A CRPC).

Interface of health systems and public prosecutors

a) The doctor must review the notes of the case to equip him/herself with the history that has been provided by the survivor to the doctor, the police and the magistrate. In case there is a difference in the histories, the same should be clarified in advance with the public prosecutor. It is possible that a survivor revealed additional information to the doctor based on her comfort, than the police or the magistrate.
b) Examining doctors should prepare themselves well in time with the case documents before reaching the court. Efforts must be made by doctors to dialogue with the public prosecutor and also ask them about the role that they need to play. This would help them to be well prepared and respond to questions asked in the court.

Interface of health systems and the judiciary

a) Doctors are termed as "expert witness" by Law. As per 164 A, Cr.P.C., an examining doctor has to prepare a reasoned medical opinion without delay.
b) A medical opinion has to be provided on the following aspects –
c) Evidence that survivor was administered drugs/psychotropic substance/alcohol, etc; -
d) Evidence that the survivor has an intellectual, or mental disability; -
e) Evidence of physical health consequences such as bruises, contusions, contused lacerated; wounds, tenderness, swelling, pain in micturition, pain in defecation, pregnancy, etc. –
f) Age of the survivor if she / he does not have a birth certificate or if mandated by the court.

g) Absence of injuries on the survivor has to be interpreted by the examining doctor in the courtroom based on medical knowledge and details of the episode provided by survivor to the doctor.
h) Lack of injuries have to be based on the time lapse between the incident and reporting to hospitals, information pertaining to luring the child or adult survivor, or factors such as fear, shock and surprise or other circumstances that rendered the child or adult survivor unable to resist the perpetrator.
i) The examining doctor will also have to provide a medical opinion on negative findings related to forensic lab analysis.
j) Absence of negative laboratory results may be due to: -
k) Delay in reaching a hospital / health centre for examination and treatment; -
l) Activities undertaken by the survivor after the incident of sexual violence such as urinating, washing, bathing, changing clothes or douching which leads to loss of evidence; -
m) Use of condom/vasectomy or diseases of vas of the perpetrator, or
    - Perpetrator did not emit semen if it was a penile penetrative sexual act.
n) The examining doctor should clarify in the court that normal examination findings neither refute nor confirm whether the sexual offence occurred or not. They must ensure that a medical opinion cannot be given on whether 'rape' occurred because 'rape' is a legal term.

Interface of the health system with the child welfare committee

a) Health professionals should communicate to the child the need for her/him (health professional) to disclose the abuse to the child welfare committee (CWC) so that the latter can take immediate steps to protect the child from abuse.
b) Children may be referred for examination by the child welfare committees (CWC). Health professionals may have to orient the CWC about the health consequences of sexual abuse and the importance of provision of complete health care. At the same time they must explain the limitations of medical evidence, thus even if medical evidence of sexual violence is not found, this in no way should be construed as a child lying about sexual abuse.
c) Mobile care units (MCUs) must include indicators for assessing whether a child has been subjected to sexual violence. Such an enquiry must be included as a component of routine medical check-ups.
d) A standard operating procedure for routine medical examination, care and management must be adopted by all child welfare homes and they must be asked to provide reports of these assessments to the child welfare committee. Health professionals may be called upon for doing this.

Session 5: Medico Legal Protocols and Guidelines for women affected with violence – Revised MLC for Form as per 2014 Guidelines of ministry of Health and family Welfare

Adv. Adhilakshmi Logamurthy,

Secretary, *Women Lawyers Association, Madras High Court*.

Adv. Adhilakshmi Logamurthy, Secretary, *Women Lawyers Association, Madras High Court*, shared a session on legal services authority and on cases related to women issues. The session gained applause of audience as information was conveyed in both hilarious and informative manner. Following are the subjects covered.

- The constitutional rights of women
- Functioning of legal aid
- Forms of Sexual Violence
- Physical Health Consequences
- Psychological Health Consequences
- Laws and criminal amendments related to women

The inspiring lawyer discussed about the nature of job of the counsellors and the challenges they have to face in their day to day life. She recommended not taking the problems of their clients personally and sympathizing with them. She rather asked them to empathize with the clients and help them find solutions on their own. At many times the counsellors start speaking for the client forgetting the Principles of Individuality and Non Judgmental attitude. This kind of attitude will affect the lives of the counsellors.

The next stage of discussion was on the provision of Free- Legal Aid. It is applicable for all women, children, Differently abled, Transgender, Minor and people below poverty line.

She added that the counsellors at the OSC, WHL should do the basic ground work for the clients as the advocates in the legal aid cell will depend on the ground work done by the counsellors.

The speaker stated that National, State, District level legal services are available in India. More light was thrown on various provisions, characteristic features of free legal aid.

The difference of Lok Adalat and Free legal aid was explained. The concerns related to bank are addressed by the Lok Adalat and not in free legal aid.

The next major part of the session was on the laws benefiting the women and children. The various acts present for women and children were discussed and how to relate with cases was also briefly explained.

Ms. Adhilakshmi requested the counsellors to be more updated about all the acts available for family, women and children. She also suggested them to follow a structure for counselling, strategies while giving counselling. It is important to make the couples live their sweet memories. The common mistake which counsellors make is giving leading questions just like lawyers do in court. Listening to the client is very important as it would help the counsellor to analyse and situations. The problems can be somewhere else too than what the client considers as a problem.

When children are invited for counselling it will be better if the counselling is not present in office atmosphere. In most cases of domestic violence in family and divorce the testimony given by the children has more value. With the new educated and empowered generation, understanding the gender roles becomes more vital. The counsellors have to understand this trend, acknowledge that change and support the clients in accepting the new roles. The speaker also shared the essence of marital life and how it can be maintained with all the pros and cons.

Listening to the client is very important and see how you can help the client in speaking up the issue. The problems can be somewhere else too.

With the new educated and empowered generation, understanding the gender roles becomes more vital. The counsellors have to understand this trend, acknowledge that change and support the clients in accepting the new roles.

After the session the speaker took up questions from the counsellors. There were numerous questions pertaining to the cases dealt by the counsellors.

Overall it was a very lively and interactive session though “Law is dry” as stated by the speaker herself. She made Law sound very simple and understandable.

Session 6: 112 Mobile App with SHOUT under emergency response and support system project (ERSS) MHA, GOI

Mr. Suveen Jose,

CDAC Trivandrum

Mr. Suveen Jose, *CDAC Trivandrum* presented an orientation on panic button in Mobile phones through 112 mobile App with SHOUT under emergency response and support system project (ERSS) MHA,GOI. It was a live demo session on new panic button app. He also oriented the participants to install the app and explained the special feature and user guide as live demo.

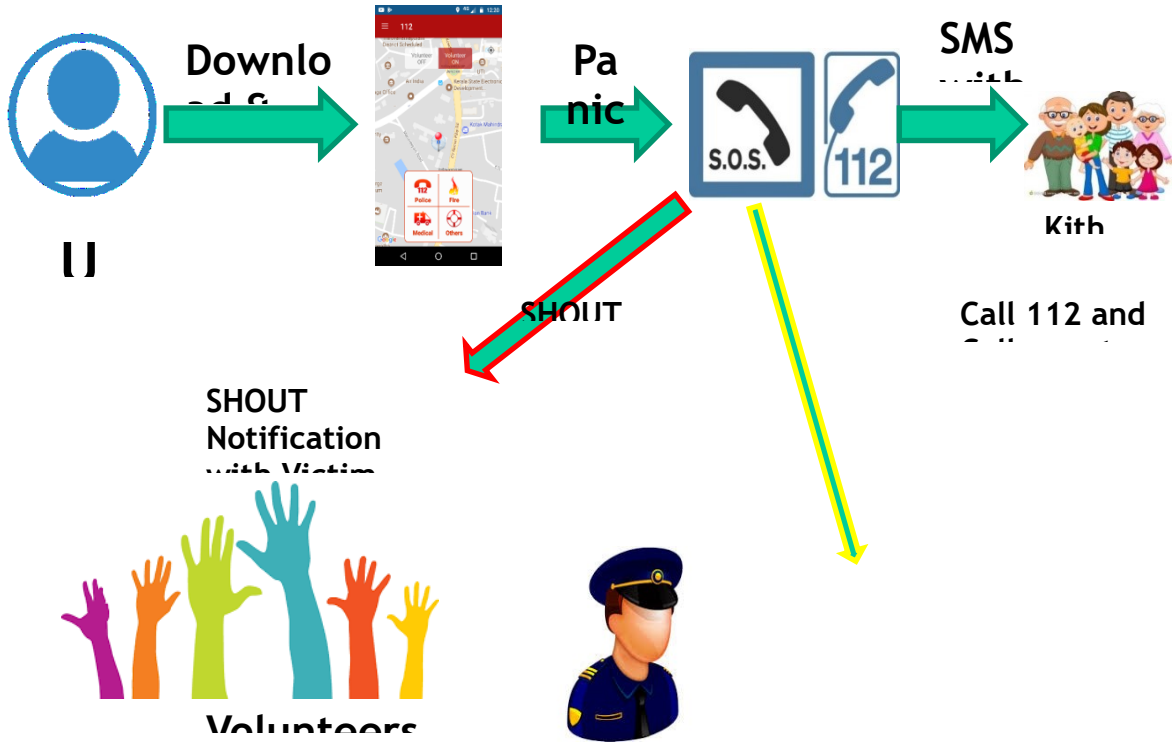
Introduction of 112 Mobile App

An App that helps you to raise an panic signal seeking services of police, ambulance, fire force etc. on a common platform.

Major Features

- Can be triggered using power button of the Mobile
- Directly dials the emergency number (in older phones where power button functionality is not there)
- Victim location sends as a SMS to 112 response centre.
- Emergency information send to 5 or more Kith & Kin
- Periodic location updates

112 App & Web portal Image

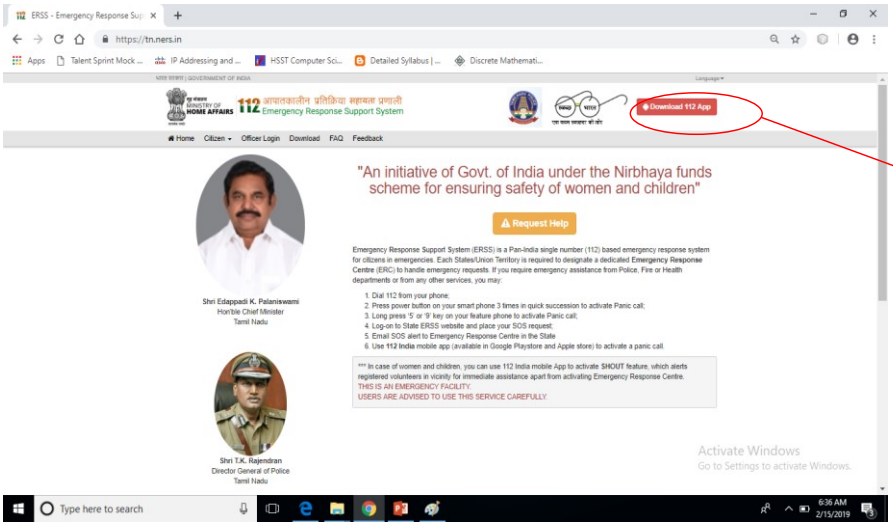


Instruction on How to Download and function of 112 App.

A User Guide

How to Download the 112 App? - Android

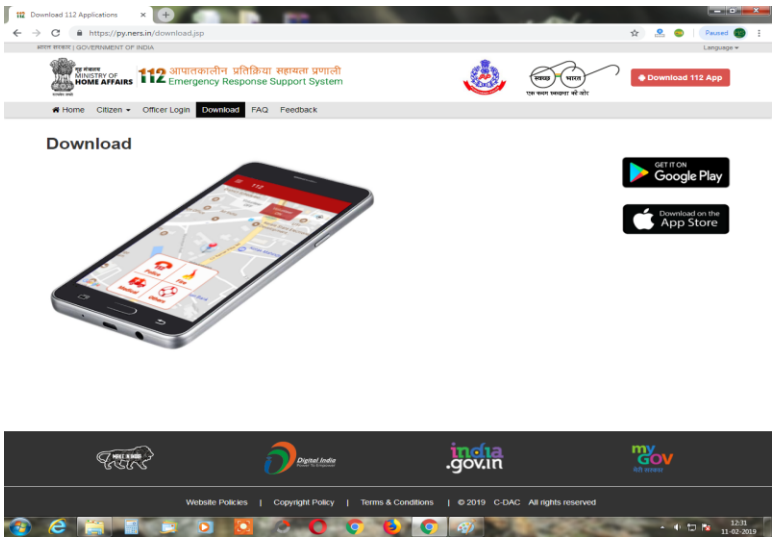
Open Website – https://www.tn.ners.in



Click this option?

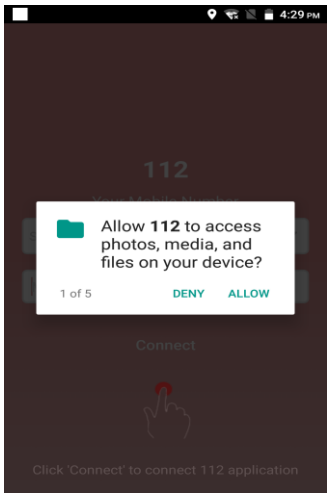
4

How to Download the 112 App?



"112.apk" will be downloaded on your phone/computer

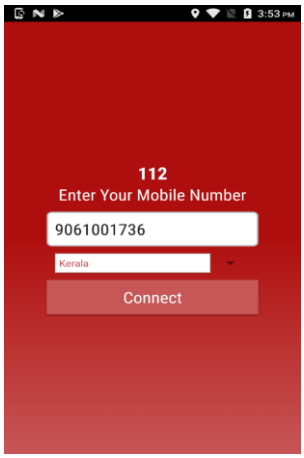
5



- You have to provide permission for the app to access information on your device

112 App – One time Registration

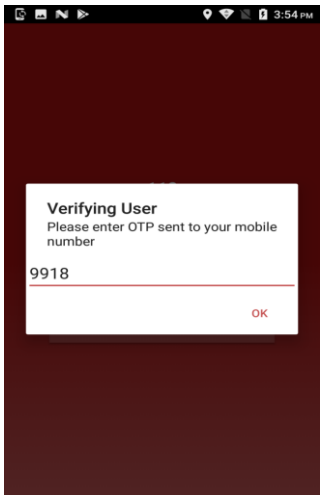
Intialization Page



- Enter your mobile number
- Select your State - Puduchery
- Press Connect

112 App – One time Registration

OTP Confirmation

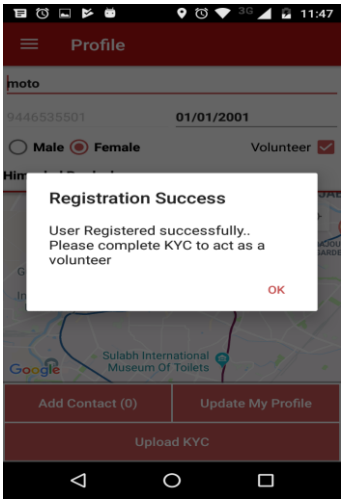


- One time password message is send to your mobile

10

112 App

Profile Page Registration Success

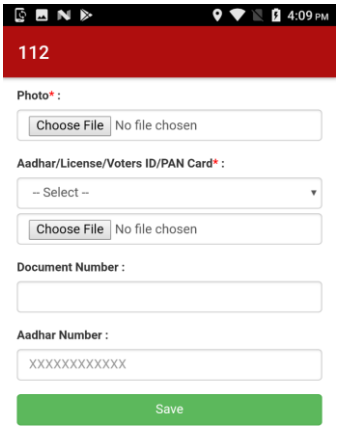


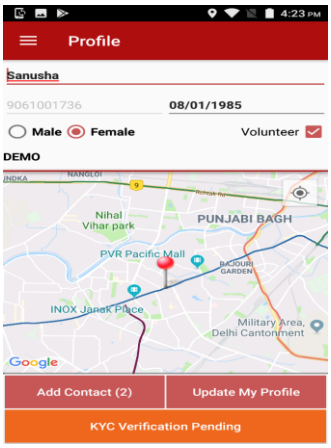
- Once Profile Registration is complete get this message

12

112 App – For Volunteers

Upload KYC

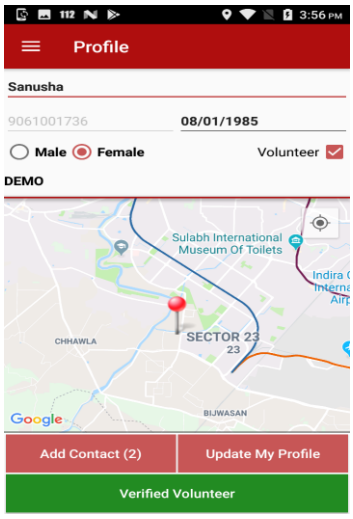




- Give KYC details and save
- KYC Verification will shown pending until the admin approval

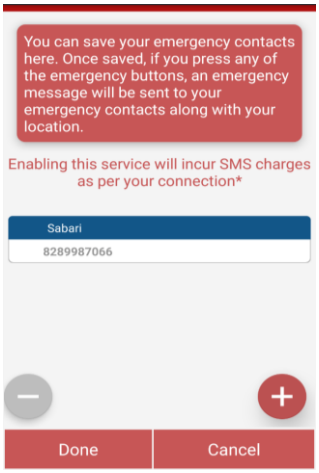
112 App

Verified Volunteer



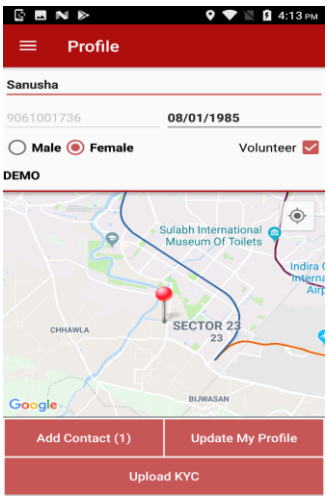
- After approving the KYC admin then show the satus verified Volunteer

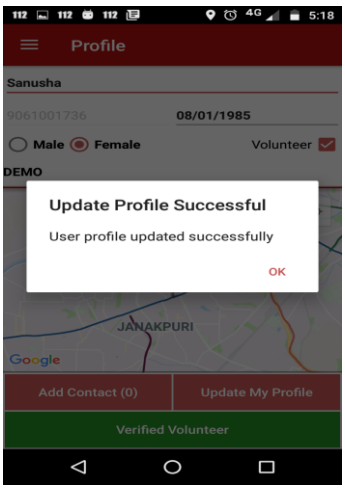
Add Contacts



- Add the Urgent contacts
- While pressing the panic button the panic message is get by these contact also

Update Profile

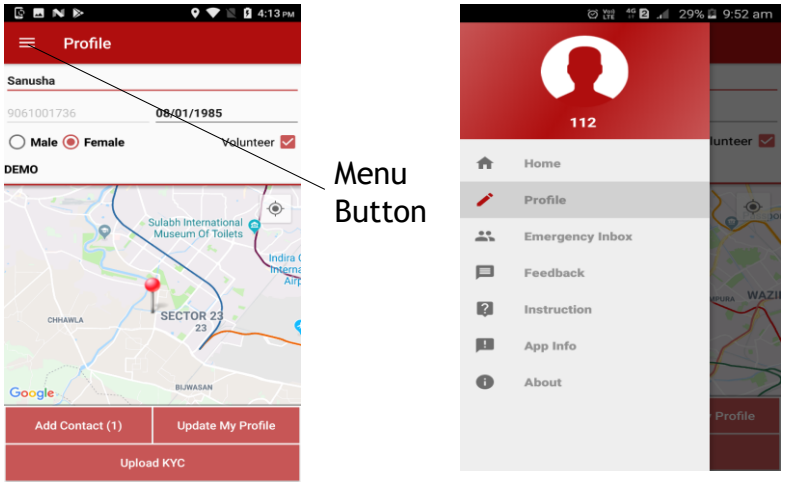




- To edit the profile press update profile

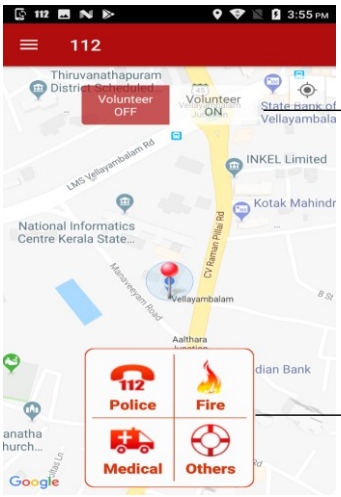
112 App

Menu



112 App

Home Page



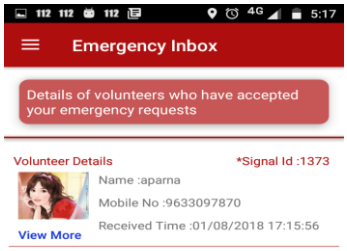
Volunteer ON OF flag

- Click on the panic button emergency will send

Panic Button

112 App

Emergency Inbox

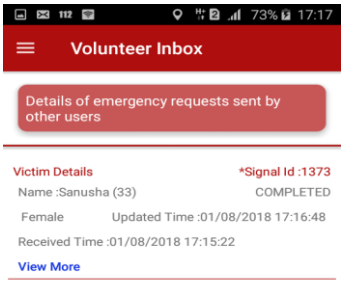


- Volunteer details displayed here

19

112 App

Volunteer Inbox

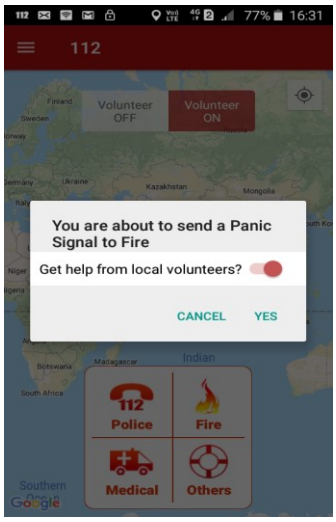


- Volunteer inbox victim details displayed

20

112 App

Alert When Press The Emergency



- One alert message will shown
- After four seconds emergency send automatically

21

112 App - Volunteer

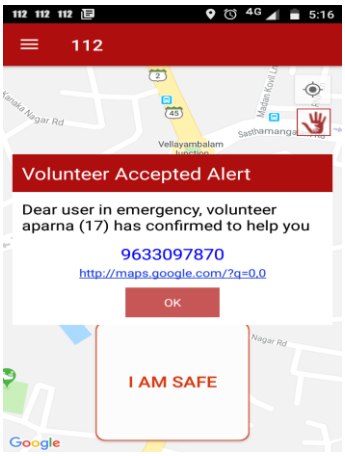
Emergency Alert to Volunteer

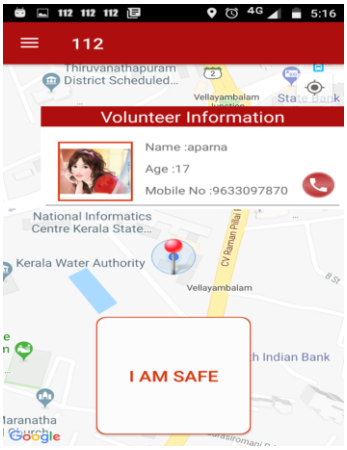
- Once victim press panic button nearby volunteer get the alert message

22

112 App

Volunteer Accept Alert





- Volunteer accepts emergency then victim get volunteer information

23

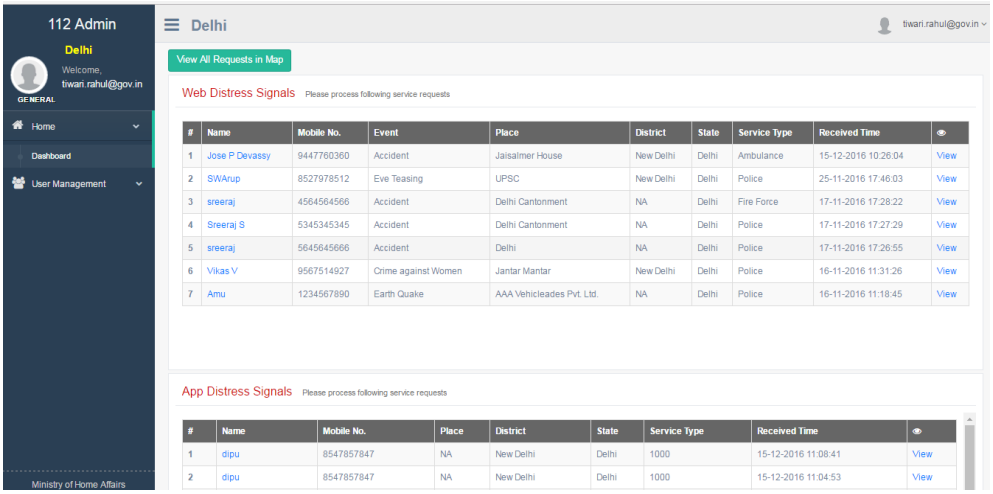
112 App

After Press The Emergency

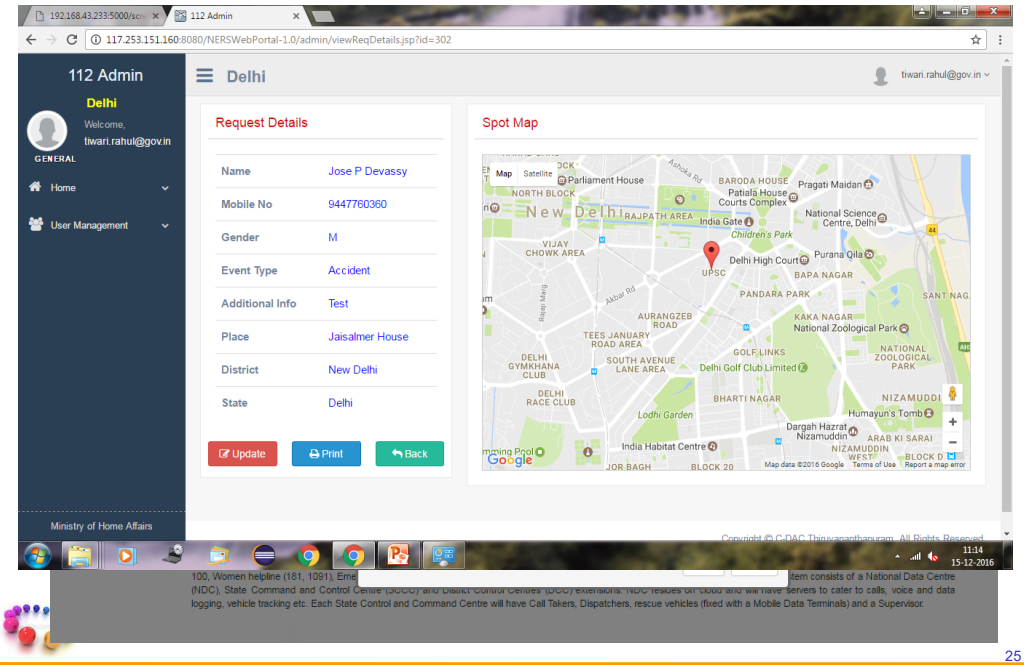
- Victim is safe then press Iam safe

22

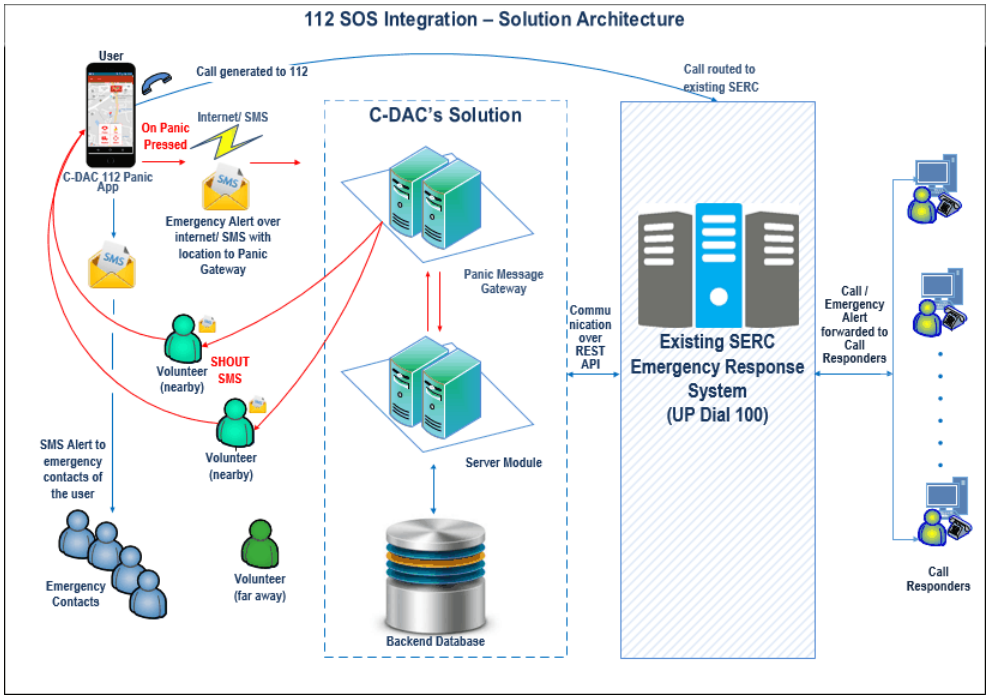
112 Web Portal – Officer View – Pending Events



112 Web Portal – Event Details View



112 Integration with Existing SERC



Day Two

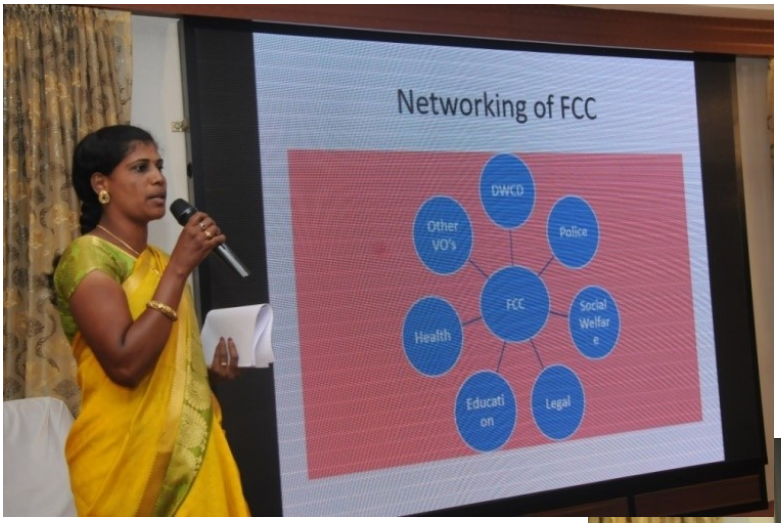
16th February, 2019, Saturday

Session 1:

Presentation on Functioning of Family Counselling Centres.

The participants from the following family counselling centres shared their organization profile and the range of services delivered to women in distress and the local networking with different organisations/departments. Meanwhile they also shared their experiences in collaboration with other programmes and schemes where they have convergence with the services of family counselling centre.

- GOOD HOPE, Madurai
- Centre for Social Action and Women's Development, Pondicherry
- YWCA, Thirupur
- YWCA, Coimbatore
- Sureksha- Nagarkoil, Kanyakumari Dist
- BAJSS- Pondicherry
- TMSSS,Thanjavur



Session 2: Crisis Intervention- Roleplay on Counselling Rehabilitation

Dr. R. Jayalakshmi,

Medical Social Worker-UHC, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER),

Dr. R. Jayalakshmi, *Medical Social Worker-UHC, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER),*shared her insights on crisis intervention with live examples. She started with definition and importance of crisis invention, later explained the different form of violence against women and its coping mechanism in order to handle the crisis situation.

She added that Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms.

Crisis intervention is emergency first aid for mental health & domestic violence. It requires that the person experiencing the crisis receive timely and skillful support to help cope with his/her situation before physical or emotional deterioration occurs. A stressful event alone does not constitute a crisis; rather, crisis is determined by the individual's view of the event and response to it.

While speaking about the objectives of crisis intervention she listed the following

- To identify the problems generated by stressors and the difficulties posed by the need for change
- To list alternatives and strategies for action
- To build a decision-making model and develop steps for implementing it
- To operationalize alternatives
- To apply the steps and feedback on results

She also covered the following areas in crisis intervention.

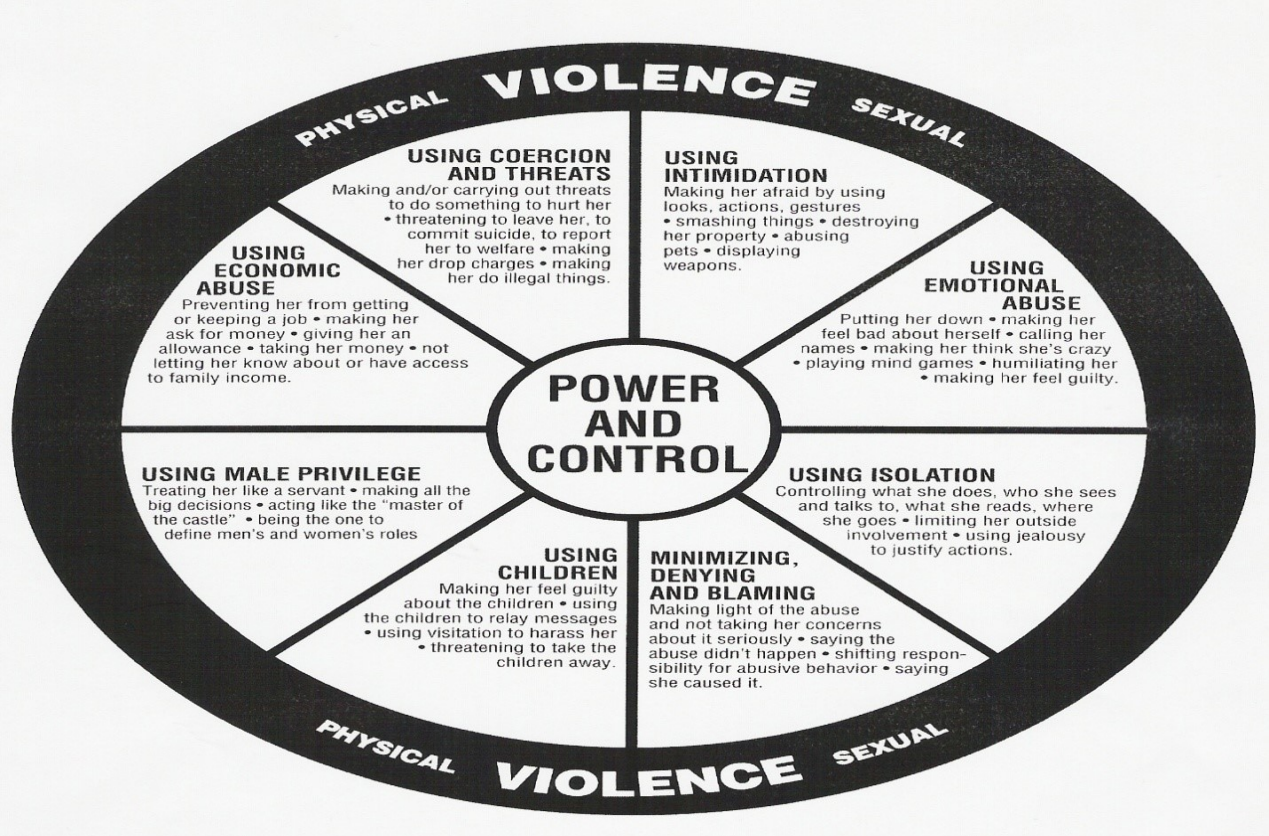
- ❖ Strategy to handle crisis situation
- ❖ Techniques in crisis intervention
- ❖ Stages of response
- ❖ Past experiences
- ❖ Laws for women
- ❖ Integration
- ❖ Assessment
- ❖ Risk factors
- ❖ Special consideration including record keeping.

Participants were engaged during sessions through interactions and role play by three different groups on three topics through which she explained the effective response to the crisis situation. They played alcohol addiction, suspicious case and missing case. Here group of audience were given an observation as activity to observe and analysis of different roles like response of counsellor, victim, attendee etc.

CRISIS INTERVENTION

Definition:

- Crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms.(James & Gilliland, 2001)
- Crisis intervention is emergency first aid for mental health & domestic violence. It requires that the person experiencing the crisis receive timely and skillful support to help cope with his/her situation before physical or emotional deterioration occurs.
- A stressful event alone does not constitute a crisis; rather, crisis is determined by the individual's view of the event and response to it. (Smead, 1988).



Objectives:

- To identify the problems generated by stressors and the difficulties posed by the need for change
- To list alternatives and strategies for action
- To build a decision-making model and develop steps for implementing it
- To operationalize alternatives
- To apply the steps and feedback on results

Techniques in Crisis Intervention:

Guidance should be task-oriented and it should focus on the "here and now" which is being with client in current situation. Communications is more important where in it should hold concern for the person, and build hope and confidence about the probability of an eventual successful outcome.

Stages of response:

There are three main stages to crisis Situation. ACUTE CRISIS- 24 to 48 hours, OUTWARD ASSESSMENT and INTEGRATION

- **1: ACUTE CRISIS**

  In this stage, it is very important intervene the victims of marital violence within 24 to 48 hours, as they will be in some loss, confusion and imbalance state of mind.

- **2:OUTWARD ADJUSTMENT**

  It occurs within 24 hours and last for many months or years. Reclaiming one's own life events offers opportunities for mastery over one's environment again, too to be with people who have the potential to be safe, caring, and supportive. Hence it is importance to rebuilding some interpersonal trust

- **3:INTEGRATION**

  The integration process means developing and incorporating new aspects to their personal identity having enough distance from the actual danger to reflect on its meaning in their life on both a personal and interpersonal level

Risk Factors:

- Threat of murder or suicide: extreme danger
- Fantasies of murder or suicide
- Access to weapons
- Obsession with one's partner
- Isolation of the aggressor and centralization of the victim
- Rage
- Depression
- Drugs and/or alcohol
- History of violent crime
- Access to the abused woman
- Separation
- N.B.: The absence of risk factors does not guarantee safety. Certain factors are serious on their own; the more risk factors present, the higher the level of danger

Intervention:

- It should be based on Planning occurs simultaneously as assessment is made about how much time has elapsed between the occurrence of the stressor event and this initial interview. It should be based on how much the crisis has interrupted the person's life; we need to Understand. The effect of this disruption on others in the family; and Level of functioning prior to crisis and what resources can be mobilized.

- Physical & emotional – ensure about SAFETY , and analysis on RISK PLANNING
- Ventilation & validation -Whom to ventilate , providing Support, we should benon judgmental and ensure the Reassurance to client- normal reaction
- Education and information - Common reaction to crime/risk behaviours, sense of control over life
- Mobilize Resources – need to IDENTIFY COPING MECHANISM

Special Consideration:

- Proper CLOSURE of the case is very important
- Providing Cognitive reorientation if its required
- Ensuring Any others concerns
- Need to be clear on what Questions to ask
- Ensuring Reassurance and coping mechanism
- Regular FOLLOW-UP
- Write down when /time etc.
- Reminder for next meeting
- RECORD KEEPING
- Patient with Ongoing Psychiatric illness
- Understanding than analysis of Ongoing Danger

Session 3 : Roleplay on Family Counselling Centres

Dr. R. Jayalakshmi,

Medical Social Worker-UHC, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER),

The training programme was made more interesting with role plays performed by the participants of the training. It was directed by *Dr. R. Jayalakshmi, Medical Social Worker-UHC, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER).*The central idea of the role play was to highlight the role of counsellors in one stop centres, Family counselling centres. The involvement of various other departments while helping a woman in distress was narrated very well.

The outline of the play was how a police officer rescues a woman from a railway station and contacts the nearby one stop centre to offer help. In the one stop centre the client is given initial first aid, post which the details of the client is collected. The client stated that she had been chased by four men and was forced to get into the train. Language stands as a barrier as the clients speaks only Hindi. After attaining the primary details of the client, a legal officer is called for advice and a women police officer to restore the client with her family. The women police officer promises the client that she will take her safely to her hometown.

Thus this plot was narrated very beautifully by the participants of the training programme. Dr. R. Jayalakshmi explained how the counsellors should handle such cases.

Another role play was on how the counsellor deals with the problem of a married woman who comes along with her mother stating that she has issues with her husband.

The strategies for offering family counselling were briefed by the speaker and suggestions from the participants were also considered. The participants shared their views on the cases portrayed in the role play.

Overall the role play kept the participants more involved in the training programme.

Session 4: Data Updation & MIS at One Stop Centre and 181 Women Helpline of Tamil Nadu

Ms. Vidya Viswanathan,

Consultant, MWCD

Ms. Vidya Viswanathan, *Consultant, MWCD,* explained about the women helpline 181, She covered general instruction, Implementation Status of Women Helpline, administration part (both National and State level), funding, emergency situation, type of services.

Objective of Women helpline:

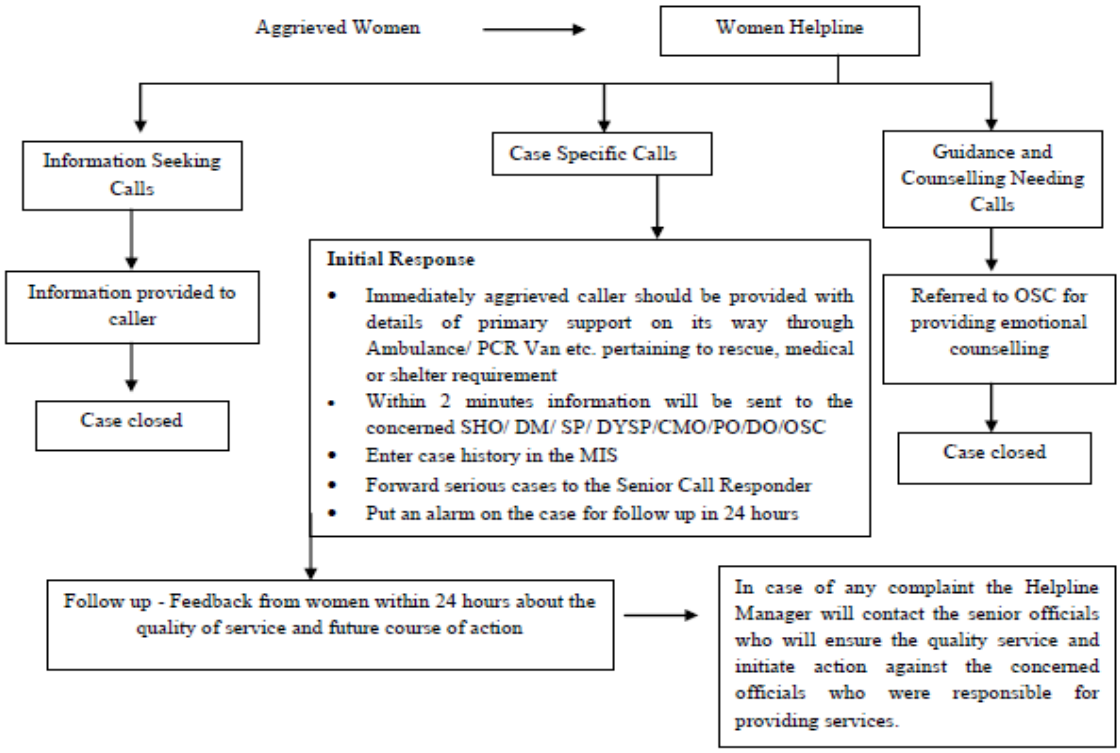
- To provide 24 Hours telecom services to women affected by violence seeking support and information.
- To facilitate Emergency and non-emergency intervention through referral to the appropriate agencies –police, ambulance, DLSA, Protection Officer, OSC etc
- To Provide Information about the appropriate support services, government schemes and programmes available for women
- To provide back office to One Stop Centres by maintaining the data base of all the cases registered at OSC and the services provided in each case with regular follow-ups

She said 181 Women Helpline is a helpline for Women and girls facing violence within public or private sphere of life or seeking information about women related

programmes or schemes. It is operational across 31 States/UT Over and over 20 Lakh Women have got assistance through Women Helpline across India

At the national level MWCD is responsible for budgetary control and administration of the Scheme and at the state level MWCD is responsible for budgetary control and administration of the Scheme.

Helpline Response and Type of Services



On the Standard Operating Procedures,

- The helpline staff shall at all times be extremely polite and give a patient hearing to the caller
- The helpline staff should reassure the caller that help is on its way
- The helpline staff shall not insist on the caller to disclose her identity unless the caller so agrees
- A confidential record including identity, contact details of the caller, personal case details and the name of the officer/department to which the case was referred will be fed into a system (MIS) with a Unique ID
- The call responder shall take all possible information about the grievance of the caller (i.e. type of problem/grievance, his/her present location, type of help/assistance he/she required etc.), including the details of the caller (whatever he/she discloses at that point of time without insisting too much on this aspect)
- The information shall be immediately passed to the local police, nearest PCR Van/Ambulance etc.
- Information of the caller, call details, action taken, follow-ups should be fed into the software
- The call responder will encourage the caller to keep patience and not loose her temper/composure

- The concerned officer should reach the caller with all the required/necessary equipment i.e. First aid kit etc.
- Keeping the mental and physical condition of the caller in mind, maximum possible aid should be provided immediately

Session 5: Protocols to be followed while handling the cases and during the rescue and intervention

Mrs. Malathy,
Deputy Director, Social Welfare Department

Mrs. Malathy, Deputy Director, Social Welfare Department shared her insights with the participants on the rules, regulations, protocols to be followed while handling the cases and during the rescue and intervention.

Session 5: Convergent Action at One Stop Centre(OSC)

Dr. Jupaka Madavi,

Consultant, MWCD

Strengthening the Role of OSCs for coordinated response and Convergence of Schemes and programmes of women safety, security and empowerment for women affected with violence and sexual harassment. She also trained about Media Protocols for one stop centers and documentation of success stories for all forms of Media.

Launch of One Stop Centre – SAKHI Logo and Training Module in Tamil

Shri. Ashish Srivastava IAS,

Joint Secretary, Ministry of Women and Child Development, Government of India

Shri. Ashish Srivastava IAS, *Joint Secretary, Ministry of Women and Child Development, Government of India* Launched the Training Module in Tamil and introduced the logo of OSC with positive and motivational notes.

On a positive note he shared his happiness over the presence of almost all the units in the state for the training.

Mr. Srivastava reviewed the existing operations of One Stop Center,181 Women HelpLine, Mahila Police Volunteers, Implementation of Sexual Harassment Act, Child's Adoption, etc. in all the 32 districts of Tamil Nadu.

He insisted that the training manual should remain in the minds of all the personnel working in One Stop Centres, Women Helpline, Mahila Shakti Kendra and Family Counselling Centres as we will not have time to read it when a woman in distress comes to you for help.

Without protection we cannot speak about empowerment. If we want our sisters and daughters to be empowered then we need to ensure a protective environment.

No one should be living in fear of someone trailing, someone abusing or someone violating

The Centre, after the unfortunate Nirbhaya incident, has set up nirbhaya funds to ensure mechanisms for protection of women in place.

He listed the actions to be taken immediately

- Ensure that the construction work for the OSC commences within a week's time, if not started already to ensure the buildings are ready before rains.
- Those districts who have not submitted the land details are to do it immediately.
- Ensure that each OSC, WHL, FCC and MSK has full staff strength. Complete the recruitment immediately and ensure that the centres start functioning.
- For every OSC create a directory with all details
- In every village and ward, start identifying Mahila Police Volunteer to link with the 181 call centre.
- Ensure that we reach out to every nook and corner of the state with the help of volunteers to help the women in distress

While speaking on the logo of SAKHI, he claimed that the logo was designed in such a way that it can be easily displayed on walls using stencils. Popularizing the programme is all about ensuring more women use these services at the time of need.

He also elucidated on effective response, quality services, budget analysis, record keeping, popularizing the logos and scheme among people and follow-up activities.

Vote of Thanks

Prof. Andrew Sesuraj. M,
Faculty, Department of Social Work. Loyola College.

The programme came to a close with Vote of Thanks proposed by Prof. Andrew Sesuraj. M, Faculty, Department of Social Work. He thanked the Ministry of Women and Child Development and Central Social Welfare Board for having chosen the Department of Social Work to implement this training.

He also thanked Mr. Perumal Swamy, Joint secretary, TamilNadu Social Welfare Board for tirelessly working to make the workshop happen. He also thanked the Mr. Nandresh Nigam, Assistant Director, Central Social Welfare Board for his guidance and support. He also thanked Rev. Dr. Andrew, the Principal of Loyola College and Dr. Gladston Xavier the head of the department.

As he concluded his vote of thanks, Prof. Andrew Sesuraj. M requested the participants to share the gratitude of the Ministry, the Central and State Social Welfare boards and Loyola College to all heads of the institutions for having sent the participants to this training in a short notice.

A copy of the Training Module in Tamil was shared with all the participants.

Profile of Speakers

Dr. G. Gladston Xavier Ph.D
Head, Dept. of Social Work, Loyola College, Chennai

Dr. G. Gladston Xavier is currently the Head of the Social Work Department, in Loyola College, Chennai. Prior to this he was Dean of Arts Faculties. Since 2000, he has been teaching forced displacement, community organization, social action, peace building, social research methodology and human rights related subjects.

In 2003 Dr. Gladston Xavier was instrumental in constituting a specialization called Human Rights consisting of eight distinct papers. In addition to teaching, he co-founded the Loyola Under-Graduate Outreach Program in 2001. All the sophomores who are in college participate in a 120 hour neighbourhoods outreach in one year. Till 2013, he was the deputy director of the program. In this role I worked with 8 full time social workers and 25 professors who supervised their respective classes. He was given the responsibility of strategizing, planning and training the staff and the student leaders. In the area of research he was part of the founding core group of Loyola Institute for Social Science Training and Research (LISSTAR) the official social science research organ of the college. He played a pivotal role in restructuring the institute.

Dr. Gladston Xavier is the co-director of the Caux Scholars Program at Asia Plateau, Panchgani, India. It is a peace-building program that brings together scholars from 20 countries for an intensive experiential process. In 2018 he was elected as the deputy chairperson of the Asia Pacific Refugee Rights Network (APRRN). He has lectured/presented papers/visited/conducted workshops/ in over 45 universities in 60 countries. These include, Oxford, Harvard, Colombia, Hasselt, Leuven, Sophia, Mahidol, Coventry and Fatima Jinnah University.

Apart from the regular academic activities, Dr. Gladston Xavier has been practicing Social Work and conflict transformation at the national and the international levels. The specific areas of work have been in Forced Migration, Community development and Conflict transformation.

In the capacity of a consultant, I have undertaken several monitoring, evaluation and research projects for organizations such as: OXFAM, Dan Church Aid, Christian Aid, DANIDA, GTZ/FLICT, UNAIDS, UNICEF and UNDP. Most of these evaluations were on development, sustainable livelihoods, disaster relief and Peace Building. Currently he is chair of the South Asia Working Group of the Asia Pacific Refugee Rights Network, a member based organization with 450 members of the Asia Pacific region.

The creative contributions to the field of Social Work and Peace building have been: Developing a case analysis framework to understand communities, evolving Social Work interventions for human rights, understanding the community

through the community wheel, establishing people oriented management systems human resources management, asset based community development, using theatre for social transformation, community confidence building strategies, measuring livelihoods and research for empowerment.

Prof. P. Mary Jessy Rani
Dean of Women Students, Loyola College, Chennai

Prof. Prof. P. Mary Jessy Rani is currently the Assistant Professor at the Department of Social Work and Dean of Women Students, Loyola College, Chennai. She did her graduation from Stella Maris, M. Phil at Loyola College and Ph. D at Madras School of Social Work. Ms. Mary Jessy Rani, driven by her social consciousness indulged herself in activities targeted at the progress of marginalized sections.

Prof. Mary Jessy Rani has over twenty years of work experience in the field of social work. She started her career as a freelance project evaluator for the Adult Literacy Programmes of the State Resource Centre. She moved on to become the Senior Welfare Officer of an International Adoption Organisation and has vast expertise in the field of child adoption involving both in-country and inter-country. Currently she teaches at the department of Social Work, Loyola College and has extensive experience in teaching, undertaking research and designing curriculum in Social Work. She is also the Dean of Women Students at the college and spear heads initiatives for holistic development of women students on the campus.

She has extensive experience of organizing and conducting training programmes, workshops and conferences related to the field of social work. She was the Core-organising member of the South Zone Social Work Educators Meet, which was first of its kind to be executed. She has been a trainer on child psychology for Child Welfare Committee Members, Public- Prosecutors and Newly Recruited Additional Public Prosecutors through the Ministry of Social Defence and Department of Prosecution.

Prof. Semmalar Selvi

Assistant Professor, Dept of Social Work, Loyola College, Chennai.

Semmalar is a Women Rights activist from Chennai. She has been defending for the rights of the marginalized especially the dalit women. After completing her Masters in Social Work in the year 2004 she began monitoring the human rights violations and other atrocities encountered by dalit women in various parts of Tamil Nadu. She conducts fact-finding of various incidents and cases of atrocities against Dalits which includes brutal Killings, Violence and sexual harassments against Dalit women, Custodial torture and deaths.

She has also trained representatives from grassroots organizations and other field based human rights defenders on legal instruments such as Scheduled caste/Scheduled tribe prevention of atrocities act. Later in her career she has worked in ensuring Dalits access to Relief and Rehabilitation measures of Government and other Non-government bodies during disaster (Tsumani). This

was crucial since Dalits were denied of these entitlements due to caste based discrimination in the communities. She was part of organising Public Hearing in coastal areas and followed it up with further advocacy to ensure Dalits access to Justice during in the time of disaster.

As part of her doctoral research she conducted research on difficulties faced by Dalit students' in accessing higher education. The main contention of her thesis is how the privatization of Higher Education sector in India is sharply eliminating the first generation Dalit students who are aspiring to access professional education.

She has also actively engaged in establishing Educational resource centres in the rural villages in order to prevent Dalit students' school dropout rate and enable their access to higher education. These centres also address challenges faced by Dalit students in their schools in terms of exclusion and discriminations by the school authorities.

Apart from this she is been engaged in sensitising students, Dalit women groups, youth groups and other organisations on the issues of caste based discrimination and exclusion with an aim to build an egalitarian society. She also organises public meetings, campaigns and rallies in response to untouchability issues of Dalits. She promotes Dalit women leadership by organising various meetings to strengthen Dalit women Leadership in Tamil Nadu.

Received awards from Indian Council for Social Science Research to present paper Presented a paper titled "Access to Higher Education: The Situation of Untouchables in India" in Canada International Conference on Education (CICE) at University of Toronto, Canada (June 24-26, 2013). Received Ministry of Social Justice and Empowerment, Government of India scholarship (meant for Dalit Scholars) to visit Columbia University in the year 2015. At present she is teaching Human Rights and Community development papers at Department of Social Work, Loyola College, Chennai.

Adv. Adhilakshmi Logamurthy

Advocate / Legal Consultant

Adv. Adhilakshmi Logamurthy is a bright, dynamic and talented legal practitioner with a proven track record of providing indispensable advice to the clients and delivering positive outcome for them. She can communicate clearly and effectively both in legal profession and to the public at large. She constantly focused on resolving various legal and social issues.

Adv. Adhilakshmi Logamurthy completed her B.L., (5 Year Integrated Course) (1988-1993) from Dr. Ambedkar Government Law College, Chennai (University of Madras) and P. G. Diploma in Industrial Relations & Personnel Management (1995 -1996) Bharatiya Vidya Bhavan, Chennai. Enrolled as an **ADVOCATE** on the rolls of the Bar Council of Tamil Nadu in the year 1993

Adv. Adhilakshmi Logamurthy is now practicing in almost all fields of law with special interest towards Family laws and Issues relating to Women and Children in particular (Domestic Violence, Dowry Harassment, Divorce, Maintenance of Children and Elders, Adoption, Harassment of Women at Workplace) also involved in Industrial Employee Counselling, Domestic Enquiry etc., Appearing before Family Courts, Mahila Courts, Appellate Courts, State and District Women's commission, Juvenile Justice Board etc.,

- The Present Elected **Secretary of Women Lawyers' Association,** High Court, Madras
- **Former Vice-President of Women Lawyers Association,** High Court, Madras
- Senior Panel Lawyer of Tamil Nadu State Legal Services Authority.
- Panelist in imparting legal literacy - programme organized by **State Resource Centre** for the benefit of District Nodal Officers.
- Trainer / Guest Faculty, Police Academy - Tamil Nadu
- Vice Chairman National Institute of Personnel Management (**NIPM**) Madras Chapter

DR. R. JAYALAKSHMI, M.S.W., M.Phil, Ph.D. (SOCIAL WORK)

MEDICAL SOCIAL WORKER Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER), PUDUCHERRY

DR. R. JAYALAKSHMI, currently working as medical social worker at the Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER) , PUDUCHERRY since July 2013

She is a Trainer of Trainers (ToT)

- Master Trainer in HIV/AIDS trained under (NACO) for TANSACS/PSACS
- Master Trainer – Parenting – Rajiv Gandhi National Institute of Youth Development (RGNIYD), Sri Perumbudur , Tamil Nadu

She received

- JEEVA RAKSHA AWARD (Excellence Services in Hospital Setting) Brevity's Achievement Awards Committee & IBC India Advisory Board,Bengaluru7th November , 2015

She has presented papers at International Conferences on

1. A Cross Sectional Study to Assess the Patient Satisfaction among the Coronary Artery Disease Patient's attending the Dept. of Cardiology, JIPMER. International Conference on Community Mental Health: Trends and Challenges. St. Joseph's College, Bangalore, India, Dec 2015.
2. Influence of Parental Handling and Bonding among Adolescence School Students, International Conference on Innovative Research & Solutions, Puducherry, April 2014.
3. Influence of Parental Handling on Adolescence School Students - International Conference Of Child and Adolescent Mental Health, Department of Social Work, Bharathidasan University,Tiruchirappalli,Jan2013.
4. Effect of Parental Belief's And Handling on the Childs Development and the need for Parental Education and Intervention in Indian Scenario - International Conference on Student's Mental Health Issues and Challenges, Dept. of Applied Psychology, Pondicherry University, Jul 2011.
5. Marital Adjustment among the parents of C.P Children, International Rehab Conference on ChannellingThe Challenges Disability, Tiruchrappalli,Dec - 2006.

Dr. A. R. Shanthi M.B.B.S.,D.G.O,DNB(OG),BGL,(PGMLE)
Consultant Gynaecologist

Dr. A. R. Shanthi is currently a practicing consultant Gynaecologist at Gandhi Hospital, Alandur, Chennai Corporation. She retired as Chief Medical Officer of the Dept of Obstetrics and Gynaecology from ESIC, PGIMSR and Medical College, Chennai where she worked for more than two decades.

Dr. A. R. Shanthi completed her M.B.B.S in 1986-1992 from Thanjavur Medical College and did her DGO from Madras Medical College from 2003 to 2005. She proceeded to complete her DNB (OG) in 2011-2013 at VHS, Chennai. MOHFW-GOI.

Apart from being a practicing consultant Gynaecologist she is also an active feminist, social and health activist who has extensive written articles in Tamil newspapers. She is the State co convener, National Council member, All India Working Women Forum, and is also associated with Doctors' organization for Social Equality and Peace.

Annexures

- Programme Schedule
- Attendance Sheet

Programme Schedule

Day	Time	Session	Resource Person
Day One 15th February 2019, Friday	**9.00 am Registration**		
	10. 30 am	**Inaugural Session** **Welcome Address : Dr. Gladston Xavier**, Head, Department of Social Work, Loyola College, Chennai. **Felicitation : Prof. Mary Jessy Rani**, Dean of Women Students, Loyola College. **Special Address : Smt. V. Amudhavalli IAS**, Commissioner, Department of Social Welfare and Noon Meal Programme, Government of Tamil Nadu **Release of Training Module and Key Note Address** **Shri. C. Vijayaraj Kumar, I.A.S.,** Principal Secretary (FAC) Department of Social Welfare and Noon Meal Program, Government of Tamil Nadu **Introducing the Training Module Dr. Jupaka Madavi**, Senior Consultant, Ministry of Women and Child Development. **Vote of Thanks : Mr. G. Perumal Samy,** Joint Secretary, TamilNadu Social Welfare Board.	
	11.30 am Tea Break		
	12.00 noon	Panel Discussion Chairperson : Dr. Gladston Xavier, Head, Department of Social Work, Loyola College, Chennai	
		Issues and Challenges of Women in Tamil Nadu, Puducherry and Andaman & Nicobar Islands	Prof. Semmalar Selvi, *Department of Social Work, Loyola College, Chennai*
		Counselling Techniques and Theoretical Aspect and Implementations	Prof. Mary Jessy Rani, *Dean of Women Students, Loyola College, Chennai*
	1.00 pm	Session 1 : Roles and responsibility of One Stop Centre and Women Help Line Staff: Standard operating protocols for inter-coordination	Dr. Jupaka Madavi, *Senior Consultant MWCD*
	1.30 pm Lunch Break		
	2.30 pm	Session 2: Experiences in Family Counselling Centre	Mrs. K. Bhuvaneshwari, Family Counsellor, Centre for Action & Rural Education
	3.00 pm	Session 3: Orientation of Administrative & Financial Matters regarding One Stop Centre and Women Helpline	Dr. Jupaka Madavi
	3.20 pm	Session 4: Strengthening Health Sector Response to ensure quality service for women affected with violence at One Stop Centre - adapting Global standards	Dr. A. R. Shanthi, *Gandhi Hospital, Corporation of Chennai*

	4.00 pm	Session 5: Medico Legal Protocols and Guidelines for women affected with violence – Revised MLC for Form as per 2014 Guidelines of ministry of Health and family Welfare	Adv. Adhilakshmi Logamurthy, Secretary, *Women Lawyers Association, Madras High Court*
	5.00 pm **Tea Break**		
	5.30 pm	Session 6: 112 Mobile App with SHOUT under emergency response and support system project (ERSS) MHA, GOI	Mr. Suveen Jose, *CDAC Trivandrum*
Day Two – 16th February 2019, Saturday	9.30 am	Session 1: Presentation on Functioning of Family Counselling Centres	Implementing Partner Organizaitons
	10.30 am	Session 2: Crisis Intervention- Roleplay on Counselling Rehabilitation	Dr. R. Jayalakshmi, Medical Social Worker-UHC, Jawaharlal Institute of Postgraduate Medical Education and Research (JIPMER),
	11.30 am Tea Break		
	12.00 noon	Session 3 : Roleplay on Family Counselling Centres	Dr. R. Jayalakshmi, Medical Social Worker-UHC, JIPMER.
	12.30 pm	Session 4: Data Updation & MIS at One Stop Centre and 181 Women Helpline of Tamil Nadu	Ms. Vidya Viswanathan, Consultant, MWCD
	1.00 pm	Session 5: Protocols to be followed while handling the cases and during the rescue and intervention	Mrs. Malathy, Deputy Director, Social Welfare Department
	1.30 pm **Lunch Break**		
	2.30 pm	Session 6: Convergent Action at One Stop Centre(OSC)	Dr. Jupaka Madavi, Consultant, MWCD
	3.30 pm	**Launch of One Stop Centre – SAKHI Logo and Training Module in Tamil**	**Shri. Ashish Srivastava IAS, Joint Secretary, Ministry of Women and Child Development, Government of India**
	4.30 pm	Vote of Thanks	Prof. Andrew Sesuraj. M, Department of Social Work. Loyola College.

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

Family Counselling Centre — Pondicherry

Total S.No	S.No	Name	Desig nation	Name of Organization	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	1	1.Th.Ragunathan	Counsellor	Association for Social Health in India,	9786577329	ragukarthik20@gmail.com	
2		2. Tmt.Kamatchi	Counsellor		9791280438	kamatchim8@gmail.com	
3	2	Mrs.Kalaivani	Counsellor	Bharathiya AdimJati Sevak Sangh	9943742347	kalaivanifccbajss1010@gmail.com	
4		Ms.Gomathy.G	Counsellor		8778227893		
5	3	Ms.Thamizharasi.	Counsellor	Centre for Social Action and Women's Development	8189957618	tamilpomsw@gmail.com	

6		Ms.P.Vijaya,	Counsellor	Centre for Social Action and Women's Development	9500704275	vijayaroshan23@gmail.com	
7	4	Tmt.Padmavathi,.	Counsellor	Community Seva Centre	8220636370	balmavadyfcc2018@gmail.com	
8		Th.Ilayarasan	Counsellor		8754617415	ilayarasanfcc@gmail.com	
9	5	Tmt.Kalaithamizh	Counsellor	Peoples Social Development Foundation (PSDF)	9626883131	kalainagappan@gmail.com	
10		Ms.Akila,	Counsellor		9789280785	akila.pondy@gmail.com	
11	6	Th.Kannan	Counsellor	Pondicherry Women's Conference,	9245755727	agasthiyakannan@gmail.com	
12		. Claris Emily Josephine J	Counsellor		9994259656	emilyjosepsine3103@gmail.com	
13		Th.Vignesh,	Counsellor		9791941181	vigneshromeo89@gmail.com	
14	7	B.Suganya	Counsellor	Karunalayam Rural Welfare Society (KRWS)	9677957226	b.suganyabala95@gmail.com	
15		Ms.Abirami	Counsellor		9455422267	abi.msw12@gmail.com	

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

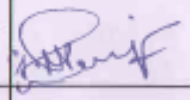
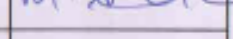
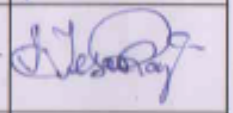
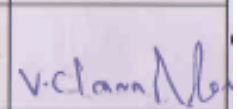
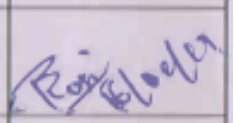
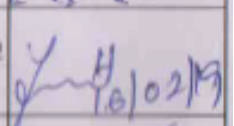
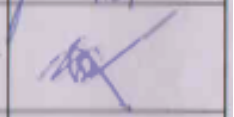
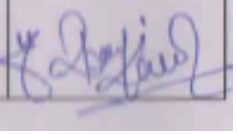
Family Counselling Centre

Total S.No	S.No	Name	Desig nation	Name of Organization	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	1	Ms.P.Karthikaa	Counsellor	Indian Red Cross Society, Tamilnadu Branch, Chennai 08	9962572506	karthikaa.prakaash@gmail.com	P. Karthikaa
2	2	Ms.Poonkodi	Counsellor	Annai Fathima Trust, Chennai -02	7010892003	kodiprakash@gmail.com	Poonkodi
3		Ms.Idamahizh kumari	Counsellor		9176181379	boazlloyd37@gmail.com	Idamahizh
4	3	Ms.P.Ponmuthu	Counsellor	Kalaiselvi Karunalaya Social Welfare Society	917615781	ppponmuthu1@gmail.com	P Ponmuthu

5		Ms.G.Sandhiya ms.G.Sandhiya	Counsellor	Chennai -37	8667348421	info@kkssindia.org	
6	4	Ms.X.Mercy Genibha	Counsellor	Guild of Service, Egmore, Chennai – 8.	7401112936	mercyjenimsw@gmail.com	
7		Ms.M.Sangeetha M	Counsellor		9994654471	m.sangee1989@gmail.com	
8	5	Ms.Lini Mathew	Counsellor	Guild of Service, Egmore, Chennai – 8.	9962828292	linijoshi77@gmail.com	
9		Ms.Sharmila	Counsellor		9940472371	sharmila1710@yahoo.com	
10	6	Ms.Mani Megalai	Counsellor	Guild of Service, Egmore, Chennai – 8.	9952925176	manimegalai6424@gmail.com	
11		Ms.Sathiya bama	Counsellor		9840522699	goscentral@yahoo.co.in	
12	7	Ms.K.Jaya	Counsellor	People Awareness Social Welfare Trust, Chennai, Tambaram	9843280244	asokanjaya@gmail.com	
13		Ms.A.E.Anushiya Rency Mabel	Counsellor		9940149974	shiya.anu8@gmail.com	
14	8	Ms.W.Sebasti Lourd mary Anusha	Counsellor	Young Women's Christian Association of	8056151722	jesus.manushal@gmail.com	

15		Ms.M.Yuvapriya	Counsellor	Madras	9884321845	jayayuva22@gmail.com	
16	9	Ms.G.Selvarani	Counsellor	Women's Indian Association, Chennai 28	8056275477	selvarani6889@gmail.com	
17		Ms.T.Jamuna	Counsellor	Women's Indian Association, Chennai 28	9840587184	jamunathiruvenkadam@gmail.com	
18	10	Ms.Joanna	Counsellor	Madras Christian Council of Social Service, Chennai	9566347992	mccss@mccss.org	
19	11	Ms.B.Murugeswari	Counsellor	Literates Welfare Association, Theni	8870680671	murugeswarib1987@rediffmail.com	
20	12	Ms.R.Theivajothi	Counsellor	Centre For Development & Communication Trust , Theni	9585225858	cendect@gmail.com	
21	13	Ms.R.Prasanna	Counsellor	The Society Organised for Promotion of Rural Tribal and Downtrodden, Theni.	9791466634	jackprasannamsw@gmail.com	
22		Ms.M.Maria Jenifer Kulandai Jesu	Counsellor	The Society Organised for Promotion of Rural Tribal and Downtrodden, Theni.	9788099464	augustujeni@gmail.com	

23	14	Ms.K.Parthasarathy	Counsellor	Virutcham Magalir Munnetra Kalzangiam, Virudhunagar	9489557611	vmmk2000@yahoo.co.in	
24		Ms.P.Ponnumari	Counsellor	Virutcham Magalir Munnetra Kalzangiam, Virudhunagar		vmmk2000@yahoo.co.in	
25	15	Ms.B.Beemasri	Counsellor	Centre for Rural Education and Economic Development Society , Cuddalore			
26		Mr.C. Subbaian	Counsellor		8525849462	creed.ngo@gmail.com	
27	16	Mr.P.Koteeswaran	Counsellor	Society for Awareness Kowledge and Training Integration (Sakti), Cuddalore	9443957483	newsaktifcccudd@gmail.com	
28		Ms.O.Shanmugapriya	Counsellor		7397062467	saktifcc@gmail.com	
29	17	Ms.S. Brindha	Counsellor	Thanjavur Multi-Purpose Social Service Society, Thanajavur	9042541930	tajmsss1@yahoo.co.in	
30		Mr.P. Pulavendiram	Counsellor		9790354563	tajmsss1@yahoo.co.in	
31	18	Ms.Suganya	Counsellor	Indian Development Organisation Trust, Perambalur	8760606635	director@indotrust.org	
32	19	Mr.C. Govindan	Counsellor	Avvai Village Welfare	8608703546	avvaikk@yahoo.com	

33		Ms.Y.M. Rajeshwari	Counsellor	Society , Nagapattinam	9787592326	avvaikk@yahoo.com	
34	20	Ms.M. Amudhavalli	Counsellor	Gramiya Social Welfare Society , Nagapattinam	9442933580	gswsgsws@gmail.com	
35		Ms.P.Rani Diana	Counsellor		8098744351	gswsgsws@gmail.com	
36	21	Mr.I.Jesuraj	Counsellor	Dindigul Multi-Purpose Social Service Society, Dindigul	9442939901	jesurajirudhayam719@gmail.com	
37		Ms.V.Claramargret	Counsellor		8220649143	jesurajirudhayam719@gmail.com	
38	22	Ms.Rajamaheswari	Counsellor	Khajamalai Ladies Association, Trichy	9944914325	rajimaheswari19@yahoo.co.in	
39		Ms.T.Rosi	Counsellor		9597318099	thanishlausrose@gmail.com	
40	23	Ms.N.Yasodhai	Counsellor	Congregation of the Sisters of the Cross of Chavanod (SOC SEAD),, Trichy	9095625646	yasomsw@gmail.com	
41		Mr.C.Sasi	Counsellor		0431-2700923	sasiyoga18@gmail.com	
42	24	Mr.Ravikumar	Counsellor	Health Education and Development Society	9043985698 9585589785	headsrs@gmail.com	

43		Ms.Divya	Counsellor	Development Society (HEADS), Karur	9043985698	headsrs@gmail.com	
44	25	Ms.C.Rajammal	Counsellor	Arasan Rural Development Society, (ARDS), Tirunelveli	6382099557	arasankalakad@yahoo.com	
45		Ms.G.Punitha	Counsellor		8489592009	arasankalakad@yahoo.com	
46	26	Ms.V.Uma	Counsellor	Suraksha Community Centre for Family Health, Kaniyakumari	9487417127	umamsw88@gmail.com	
47		Ms.P.Jayalakshmi	Counsellor		8220618524	jayamsw90@gmail.com	
48	27	Ms.G.Selvi Victor	Counsellor	Centre for Rural Development of Inida, Kaniyakumari	7010639963	crdofindia@yahoo.com	
49	28	R.Rajesh	Counsellor	Kaniyakumari	8144681973	rajesh09msw@gmail.com	
50	29	Ms.R.Simondevid	Counsellor	Integrate Women Development Institute (IWDI) , Chennai 49	9944234419	simondevisr@gmail.com	
51		Ms.Amala.A	Counsellor		7708668920	amalaannadurai@gmail.com	
52	29	Ms.C.T.RenukaDevi	Counsellor	Saras Trust, Nilgiris	9442601250	sarastrustooty@yahoo.co.in	

53		Ms.B.Sujatha	Counsellor	Saras Trust, Nilgiris	9787914125	sarastrustooty@yahoo.co.in	
54	30	Ms.Babyreeta	Counsellor	Gandhi Peace Centre , Nilgiris	9843194674	gpcngo1985@gmail.com	
55		Mr.D.Nandesu	Counsellor		9150104868	sumathigpc@gmail.com	
56	31	Ms.E.Ranjitha	Counsellor	Sadayandai Illanger Narpani Mandram (SINAM), Thiruvannamalai	8110029813	sinamtn@gmail.com	
57		Mr.D.Ashokkumar	Counsellor		8110029813	sinamtn@gmail.com	
58	32	Ms.A.M.Rajagowri	Counsellor	Mass Welfare Association	044 28178473	mawaindia@gmail.com	
59	35	Ms.M.Bharathi	Counsellor	Mahila Vikas, Thiruvallur	8778053821	rassorg@yahoo.com	
60		Mr.K.Srikanth	Counsellor	Mahila Vikas, Thiruvallur	8106866376	rassorg@yahoo.com	
61	34	Mr.Prahbakar	Counsellor	Bharathi Women Development Centre, Thiruvarur	9942985619	info@bharathiwomen.org	
62		Ms.R.Madhubala	Counsellor		8778234891	info@bharathiwomen.org	

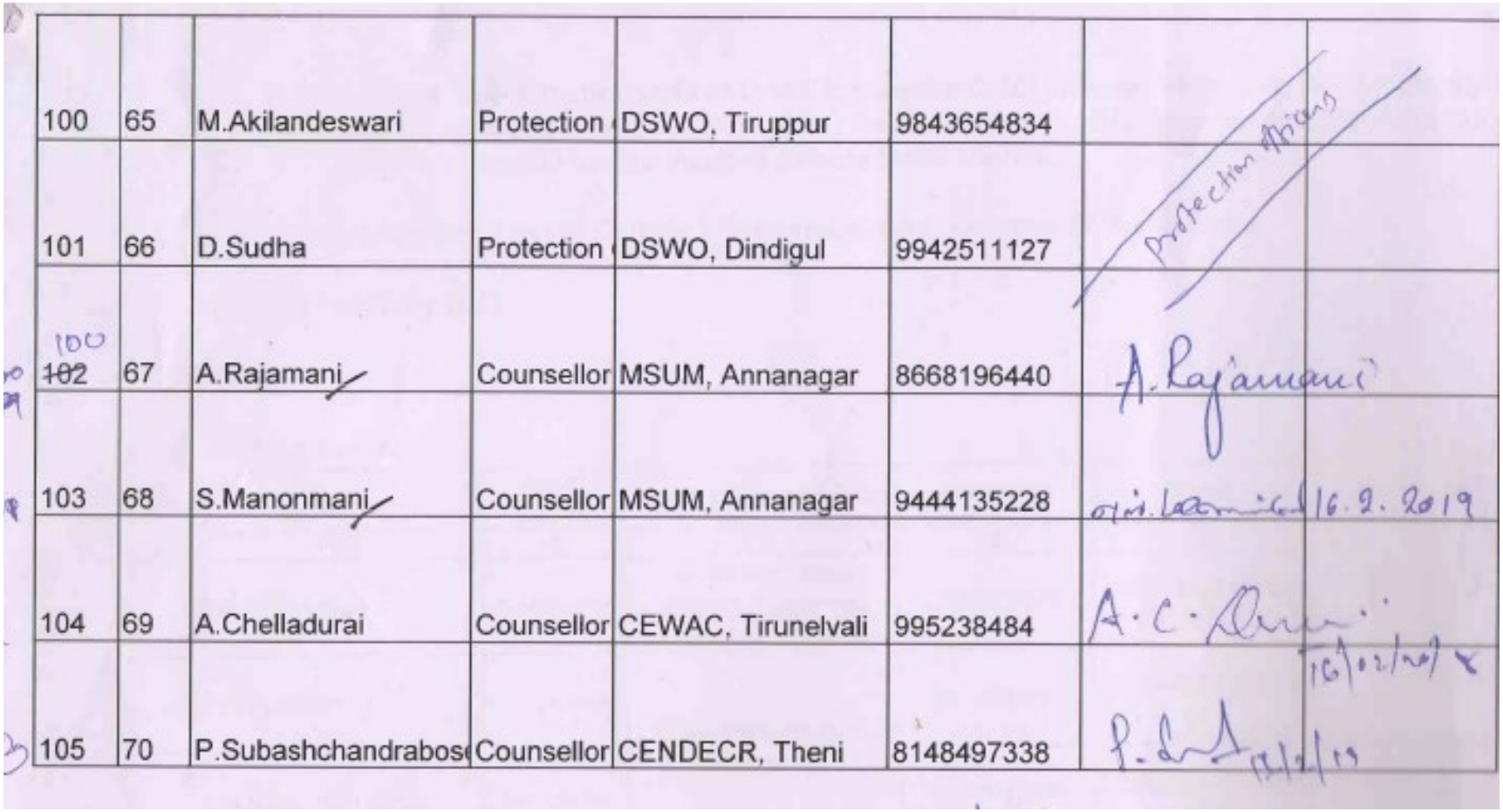
63	35	Mr.P.Raguvaran	Counsellor	Women's Organisation for Rural Development, Namakkal	8754244656	raguvaranp15@gmail.com	
64		Ms.K.Gowsalya Devi	Counsellor		04268-220960	siva_word@hotmail.com	
65	36	Ms.D.Grace Thistlethwate	Counsellor	Sri Ayyanar Women Education and Development Organisation, Ramnad	9790268525	thistlethwate@yahoo.co.in	
66		Ms.M.Mainar Selvi	Counsellor		7639366219	selvi.m142@gmail.com	
67	37	Ms.A.Mariagracy	Counsellor	Sivaganga Multi-Purpose Social Service Society, Ramnad	8489592009	gracy4mg@gmail.com	
68	38	Mr.P.Ravi	Counsellor	Integrated Rural Community Development Society, Sivagangai	9842142388	raviircds@gmail.com	
69		Ms.M.Suganya	Counsellor		7639644830	sonydvs419@gmail.com	
70	39	Ms.K.Bhuvaneswari	Counsellor	CARE, Erode	98651 29422	pragashbhuvana@gmail.com	
71	40	Ms.S.Antony Shermila	Counsellor	Good Hope Foundation,	8124710000	antonyshermila@gmail.com	

72		Mr.K.Nagarajan	Counsellor	Madurai	8124810000	nagarajan1004@gmail.com	
73	41	Ms.S.Sumaa	Counsellor	FED CROT, Formation Education Development Centre for Rural Organization and Training, Madurai	9952731926	sumaasj@gmail.com	
74	42	Mr.K.Magesh	Counsellor	Young Women's Christian Association of Coimbatore,	9787002687	fccmanoshanthi@gmail.com	
75	43	Ms.A.Arullakshmi	Counsellor	Annai Karunalaya Social Welfare Association, Villupuram	9600563482	aksavpm@yahoo.com	
76		Ms.M.Joycelin Faith Prisi	Counsellor	Annai Karunalaya Social Welfare Association, Villupuram	9843806126	aksavpm@yahoo.com	
77	44	G.Mary Jenitha	Counsellor	AWARD Thoothukudi	9442303194	jenithabens@gmail.com	
78	45	L.Abirami	Counsellor	Social Service Trust, Chennai	7299018021	sstmdb@gmail.com	
79		D.Uma maheswari	Counsellor	Social Service Trust, Chennai	9841679679	sstmdb@gmail.com	

80	46	B.Parameswari	Counsellor	MAWA, T.V.Malai	9047832091	mawaindia@gmail.com	B.Parameswari
81	47	A.Kanmani	Counsellor	CRED, Madurai	9894558205	creed.ngo@gmail.com	
82	49	K.Anugraha	Counsellor	IRCDS, Tiruvallur	8668156828	ircds1986@gmail.com	K.Anugraha
83		C.Mahesh	Counsellor	IRCDS, Tiruvallur	9677866219	ircds1986@gmail.com	C.Mahesh
84	50	P.Sankari	Counsellor	ORD, Vellore	7871210826	[illegible]	P.Sankari
85		C.~~Prince~~ PRIYA	Counsellor	ORD, Vellore	9003591196	[illegible]	Priya.c
86	51	C. GOVINDAN ~~C.Govindhan~~	Counsellor	SPET, Dharmapuri	9943320316	cgovindan001@gmail.com	C.Govindan

87	52	M.Aruldoss	Counsellor	BOSCO, Vellore	9894488517	marul1955@gmail.com	M. Aruldoss
88	53	T.S.Yazhinidevi	Counsellor	Salem	7200688953	Yazhinitanya@gmail.	T.S.yazhinidevi
89	54	P.Bhuvaneswari	Counsellor	OBWWUO	8876694073	bhuviibuvana15@gmail.com	P. Bhuvaneswari
90	55	G.Kalaivani	Counsellor	SPET, Dharmapuri	8300446215	kalaivanisanjana@gmail.com	G. Kalaivani 16/7/15
91	56	M.Meena	Counsellor	DOW Trust, Trichy	8124958723		M. Meena
92	57	SURIYA.M ~~P.Manimegalai~~	Counsellor	St. Thomas Charitable & Educational Trust, Erode	8072322213		P. Manimegalai
93 ~~92~~	58	A.C.Jegadish	Counsellor	SSMS. Salem	9840307239	jagancc696@gmail.com	A.C.Jegadish

94 ~~93~~	59	S.Nirmalarani	Counsellor	TMSSS, Trichy	9894891308	nirmalafcc@gmail.com	
95 ~~94~~		D.Arulselvi	Counsellor	TMSSS, Trichy	9788191448	arulselvimsw@gmail.com	
96 ~~95~~	60	U.Mahalingam	Counsellor	Gramadhana Nirmana	9688344263	ngogrs@gmail.com	
97 ~~96~~	61	D.Navis Rani	Counsellor	BWDA, Villupuram	9789175796	Familycounselor@bwda.org.in	D Navis
98 ~~97~~	62	M.Priyamary	Counsellor	YWCA, Thiruppur	7598485660	priyamary.m@gmail.com	
99 ~~98~~	63	C.Mariya	Counsellor	New Life Social Welfa	7502663794	mariya christopher@gmail.com	C.mariya
100 ~~99~~	64	S.Nagamani	Protection Officer	DSWO, Namakkal	9952507068		



100	65	M.Akilandeswari	Protection	DSWO, Tiruppur	9843654834	
101	66	D.Sudha	Protection	DSWO, Dindigul	9942511127	Protection officers
100 ~~102~~	67	A.Rajamani	Counsellor	MSUM, Annanagar	8668196440	A. Rajamani
103	68	S.Manonmani	Counsellor	MSUM, Annanagar	9444135228	16.2.2019
104	69	A.Chelladurai	Counsellor	CEWAC, Tirunelvali	995238484	A.C.
105	70	P.Subashchandrabos	Counsellor	CENDECR, Theni	8148497338	16/02/19

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

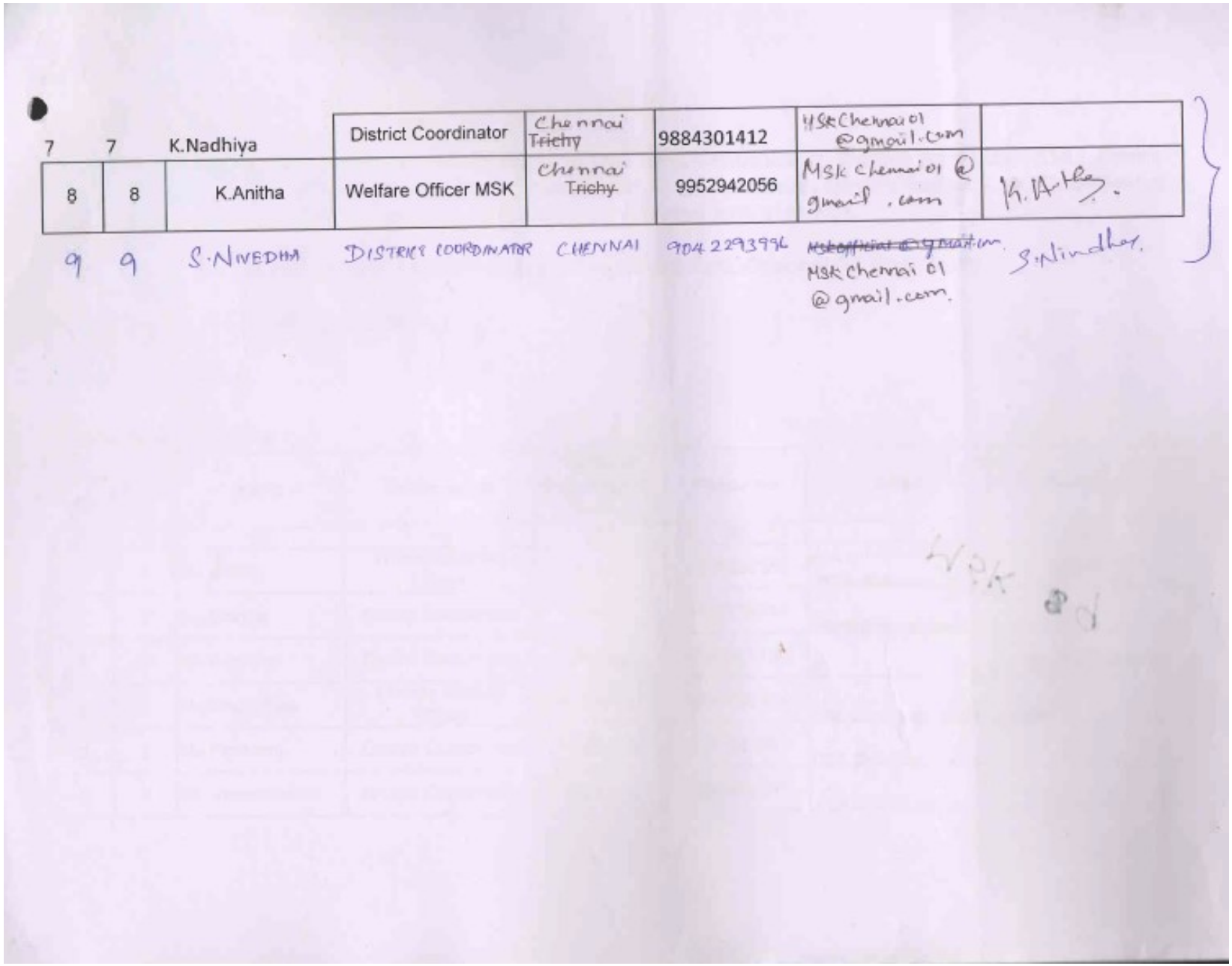
Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

Mahila Shakti Kendra

Total S.No	S.No	Name	Designation	Name of Organization/ District	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	1	Ms.Kokila	Women Welfare Officer	Salem	9025258126	msk.salem1cb@gmail.com	
2	2	Ms.Sathya	District Coordinator	Salem	8072789517		
3	3	Ms.Sumithra	District Coordinator	Salem	8220035450		
4	4	Ms.Madhubala	Women Welfare Officer	Virudhunagar	9487736504	msk.dswvnr@gmail.com	
5	5	Ms.Ponmani	District Coordinator	Virudhunagar	9677335861	msk.dswvnr@gmail.com	
6	6	Ms.Veeralakshmi	District Coordinator	Virudhunagar	9655892297	msk.dswvnr@gmail.com	



7	7	K.Nadhiya	District Coordinator	Chennai ~~Trichy~~	9884301412	MSKChennai01 @gmail.com	
8	8	K.Anitha	Welfare Officer MSK	Chennai ~~Trichy~~	9952942056	Msk chennai01 @ gmail .com	K. Anitha.
9	9	S.NIVEDHA	DISTRICT COORDINATOR	CHENNAI	9042293996	~~mskofficial@gmail.com~~ MSKChennai01 @gmail.com.	S.Nivedha.

16.2.201

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

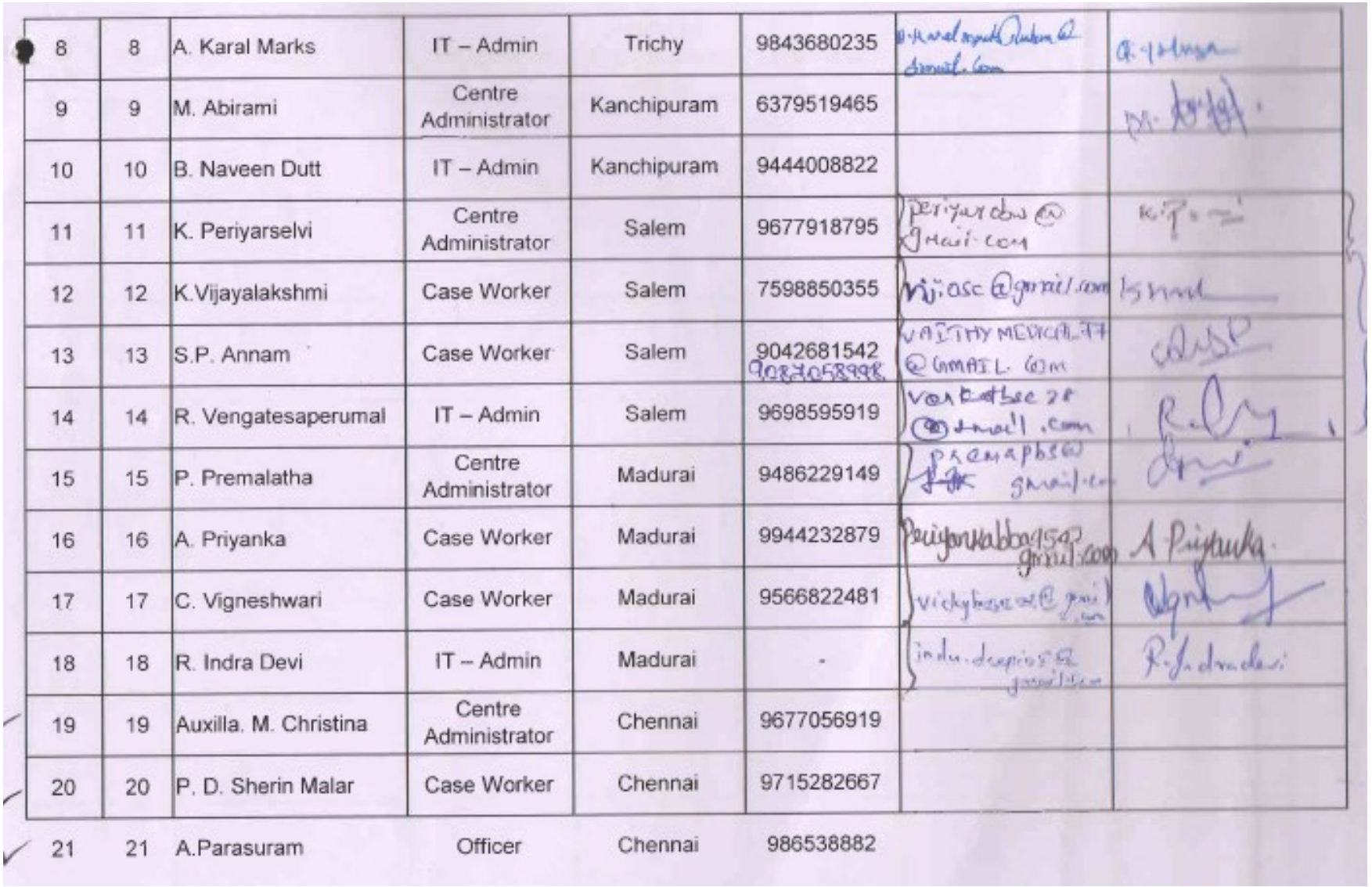
Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

One Stop Centres

Total S.No	S.No	Name	Designation	Name of Organization/ District	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)`	(6)	(7)	(8)
1	1	A. Priyanka	Centre Administrator	Coimbatore	9791357905	priyankaarjunan5.L@gmail.com	
2	2	S. Thenmozhi	Case Worker	Coimbatore	7708707756	honey.honeyreddy@gmail.com	
3	3	J. Sherin Reshma	Case Worker	Coimbatore	9629360744	sherinreshma.j@gmail.com	
4	4	K. Vanitha	IT – Admin	Coimbatore	9629327679	Vanitha12693@gmail.com	
5	5	A. Meenakshi	Centre Administrator	Trichy	8098007634	[illegible]	
6	6	N. Revathy	Case Worker	Trichy	9994394383	[illegible]	
7	7	S. Meharunnisha	Case Worker	Trichy	9384971305	Nishasathar9[illegible]@gmail.com	



8	8	A. Karal Marks	IT – Admin	Trichy	9843680235		
9	9	M. Abirami	Centre Administrator	Kanchipuram	6379519465		
10	10	B. Naveen Dutt	IT – Admin	Kanchipuram	9444008822		
11	11	K. Periyarselvi	Centre Administrator	Salem	9677918795		
12	12	K.Vijayalakshmi	Case Worker	Salem	7598850355		
13	13	S.P. Annam	Case Worker	Salem	9042681542		
14	14	R. Vengatesaperumal	IT – Admin	Salem	9698595919		
15	15	P. Premalatha	Centre Administrator	Madurai	9486229149		
16	16	A. Priyanka	Case Worker	Madurai	9944232879		
17	17	C. Vigneshwari	Case Worker	Madurai	9566822481		
18	18	R. Indra Devi	IT – Admin	Madurai	-		
19	19	Auxilla. M. Christina	Centre Administrator	Chennai	9677056919		
20	20	P. D. Sherin Malar	Case Worker	Chennai	9715282667		
21	21	A.Parasuram	Officer	Chennai	986538882		

16.2.20

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Protection Offiers

Total S.No	S.No	Name	Designation	District	Phone No	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1	1	J.Vellammal	Protection Officer	Ariyalur	9842074680	
2	2	M.Santhi Saraswathi	Protection Officer	Chennai	9940801968	
3	3	S.Pandiyammal	Protection Officer	Chennai	9884527527	
4	4	K.Aruna	Protection Officer	Coimbatore	9780763260	
5	5	S.Andal	JA	Cuddalore	9486793372	
6	6	S.Sarasu	Protection Officer	Dharmapuri	7010025455	
7	7	D.Sudha D Sutha	Protection Officer	Dindigul	9942511127	
8	8	N.Ramayee	Protection Officer	Erode	9865826081	16/2/19

9	9	Shakeen Bhanu	Protection Officer	Kancheepuram	9500190590	
10	10	T.Visudha	Protection Officer	Kanniyakumari	9488407667	
11	11	V.Parvathi	Protection Officer	Karur	9150368751	
12	12	D.Thangamani	Protection Officer	krishnagiri	7904312356	
13	13	S.Vasugi	Protection Officer	Madurai	9942656138	
14	14	B.Rama Maheswari	Protection Officer	Nagapattinam	8903392839	
15	15	S.Nagamani	Protection Officer	Namakkal	9952507068	
16	16	A.Dhanalakshmi	JA	Nilgiris	6379536498	
17	17	T.Muthuselvi	Protection Officer	Perambalur	9488018205	
18	18	R.Sumathi	Protection Officer	Pudukkottai	9600941391	
19	19	K.Saraswathi	Protection Officer	Ramnad	9751453179	
20	20	V.Gowsalya	Protection Officer	Salem	9894957867	
21	21	K.Sudha	Protection Officer	Sivagangai	9629667716	
22	22	P.Idarajam	Protection Officer	Thanjavur	6380802548	

23	23	A.Rajeswari	Protection Officer	Theni	9894854837	
24	24	V.Vanitha	Protection Officer	Thirunelveli	8220387754	
25	25	M.Akilandeswari	Protection Officer	Thiruppur	9843654834	
26	26	M.Goamthi	Protection Officer	Tiruvannamalai	9840369614	
27	27	M.Amutha	Protection Officer	Thiruvarur	8825669037	
28	28	J.Latha	Protection Officer	Tiruvallur	8610999482	
29	29	Selvamercy	Protection Officer	Thoothukudi	9585831850	
30	30	Flora Margrett	Protection Officer	Trichy	9843072080	
31	31	K.Nithya	Protection Officer	Vellore	9600394037	
32	32	M.Muthamizh Sheela	Protection Officer	Villupuram	9444930680	
33	33	S.Indira Jeyasheeli	JA	Virudhuangar	9842835483	

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Famil Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

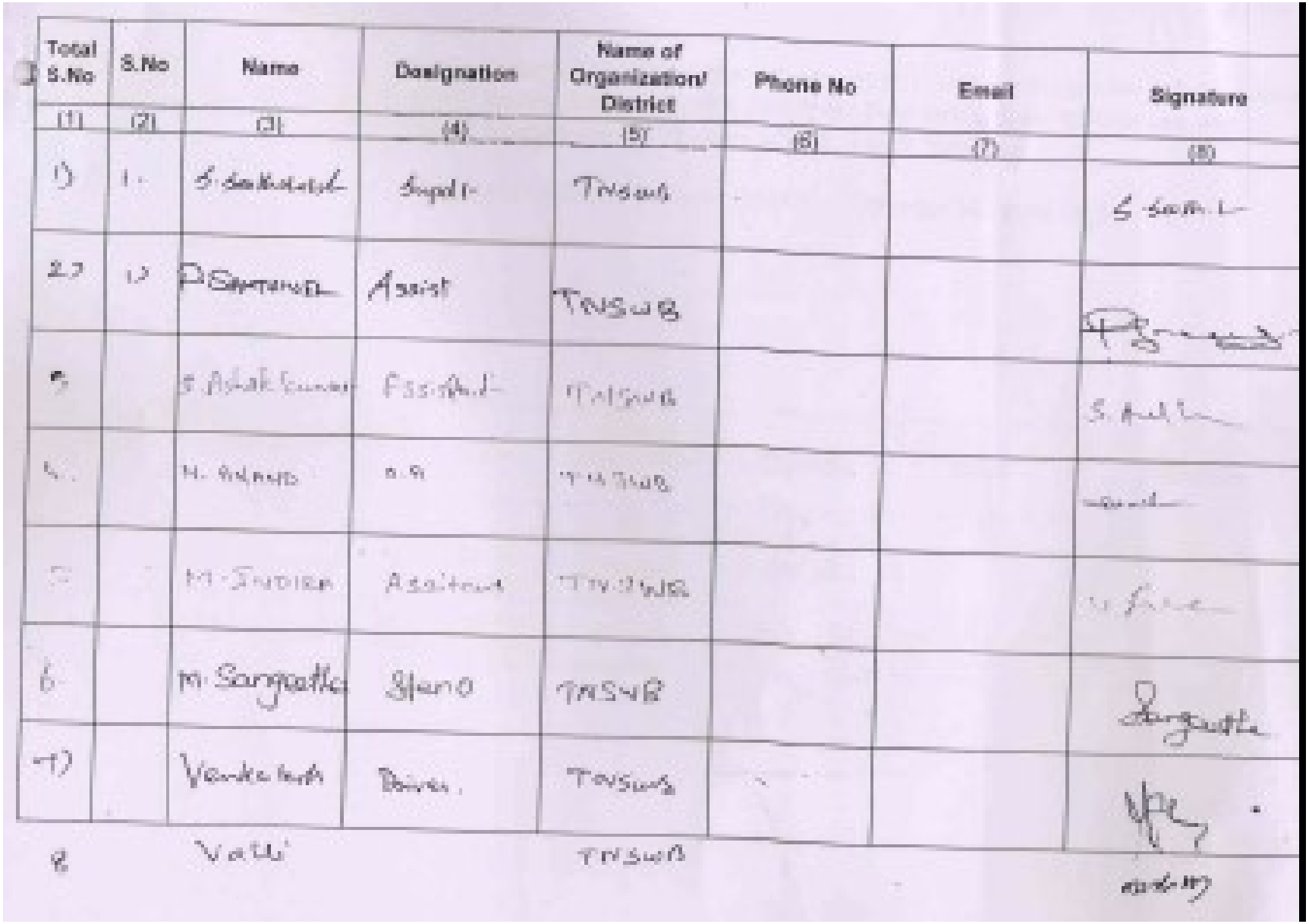
Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

State Officers (JD & DD)

Total S.No	S.No	Name	Designation	Name of Organization/ District	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	1	Tmt. S Revathy	Joint Director, Women Welfare	Chennai	8056026815		
2	2	Tmt. S. Malathi	Deputy Director, Women Welfare	Chennai	8754571103	malathi_helen @yahoo.co.in	



Total S.No	S.No	Name	Designation	Name of Organization/ District	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1)	1.	S. [illegible]	Supdt	TNSWB			
2)	2	D. [illegible]	Assist	TNSWB			
3		S. Ashok Kumar	Fss Asst	TNSWB			
4.		M. Anand	A.S	TNSWB			
5		M. Sridhar	Assistant	TNSWB			
6		M. Sangeetha	Steno	TNSWB			
7)		Venkatesh	Driver	TNSWB			

8 Vallu TNSWB

16.2.2019

Advanced Training for Front Line Functionaries of One Stop Centre)OSC), Women Help Line (WHL), Family Counselling Centre (FCC) and Mahila Shakti Kendra (MSK) for Rendering Quality Serivces and Coordinated Assistance for Women Affected with Violence.

Venue: Lowrence Sundaram Hall Loyola College, Nungambakkam, Chennai-34 Tamil Nadu

Date: 15th and 16th February 2019

List of Participants

Book is

Women Help Line

Total S.No	S.No	Name	Designation	Name of Organization/ District	Phone No	Email	Signature
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1	1	J.Arul Thangam	Helpline Manager	Chennai	9789040682		
2	2	N.Ramu	IT Staff	Kanchipuram	8940617406		
3.	3.	G. Karthiga	Cell Respondent	Chennai			

Towards a new dawn

CENTRAL SOCIAL WELFARE BOARD
MINISTRY OF WOMEN AND CHILD DEVELOPMENT
GOVERNMENT OF INDIA
DR. DURGABAI DESHMUKH SAMAJ KALYAN BHAVAN
B12, QUTUB INSTITUTIONAL AREA, NEW DELHI 110 603
WWW.CSWB.GOV.IN