



Integrating Gender in Medical Education

**SUBJECT : FORENSIC
MEDICINE &
TOXICOLOGY
COURSE : MBBS**

A Guide for Medical Teachers



**Centre for Enquiry into Health
and Allied Themes (CEHAT),
Mumbai**



**MUHS
Maharashtra
University of
Health Sciences**



**Directorate of Medical
Education and Research,
Government of Maharashtra**

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Preamble

The work done by CEHAT, the Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) to increase the knowledge and understanding of medical students about gender considerations (gender inequality, gender roles and behaviours, gender bias) as important social determinants of health and health care is to be commended.

This important effort directly responds to recommendations made at a 2006 meeting organized by WHO on *Integrating gender in the curricula for health professionals* that included to: Ensure that doctors and other health professionals are offered training with a gender-competent and human rights perspective; encourage and train health professionals to advocate for gender equality and health equity and to serve as agents for change; offer this training across all disciplines and along the learning continuum from undergraduate through continuing professional development; and work towards establishing accreditation standards on gender competencies within curricula.

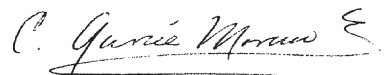
Medical education for long used the 70 kg male as the norm for determining, for example, dosages of drugs. It is only in the last few decades that awareness has grown about the fact that sex-based differences in women's bodies, related to size, distribution of fat, hormones and other characteristics, mean they may metabolize drugs differently and may at times require different dosages. It has taken time for medicine to pay attention to biological differences between women and men, beyond those related to the reproductive system, and to understand how these differences may manifest themselves in specific diseases or conditions, such as cardiovascular disease. Better understanding has developed also on how social constructions of femininity and masculinity (i.e., gender norms and behaviours) and the related unequal power relationships between women and men (i.e. gender inequality) are important risk factors and can impact negatively on health. Biological differences interact with gender inequality in ways that adversely affect the health of women and girls in many societies. Furthermore, gender interacts with other inequalities related to class, caste, ethnicity, migrant status that can exacerbate the negative health impacts. Gender biases may also affect the treatment and care they receive.

It is important that doctors have a clear understanding of how both biological differences and gender and other inequalities impact different aspects of health, how disease manifests itself, as well as the capacities of patients to protect themselves from disease. Doctors with this competency are more likely to provide appropriate and relevant care to their patients, be aware of the doctor-patient power differential and communicate

sensitively with patient of different ages, status and cultures. They are also more likely to identify and assist women and children affected by violence and abuse, an extreme manifestation of gender and other inequalities.

The content in these modules has been developed with attention to how to integrate gender-related content within existing topics and with minimal additional time requirements which make it more likely that this material will be used beyond this initial group of medical colleges.

A new generation of physicians with this knowledge and competency can lead to better medicine and better health care for all.



Claudia García-Moreno E *
World Health Organization

*This is not an endorsement of all the content in the modules. The views expressed are my own and do not necessarily represent the views or policy of the World Health Organization.



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Foreword

I am pleased to inform you that Maharashtra University of Health Sciences (MUHS) has taken an important step towards “Gender mainstreaming” and “Gender sensitization” by suggesting gender-integrated modules in the existing MBBS curriculum. It is a known fact that recognition of social determinants of health can inform and make health services gender sensitive. It is with this objective that an innovative project on Integration of “Gender in Medical Education” was implemented under the aegis of Maharashtra University of Health Sciences (MUHS) by Directorate of Medical Education and Research (DMER), Centre for Enquiry into Health and Allied Themes (CEHAT) and was supported by UNFPA.

The gender-integrated curriculum was rigorously reviewed at different stages, as is the case with any new additions to the academic curriculum. The Authorities of the University has resolved to implement the gender integration modules with an intension that it would complement the existing MBBS teaching and these modules are available on the University website www.muhs.ac.in.

I am happy to announce that these modules may be implemented soon in the Medical curriculum. Medical educators in Maharashtra are being trained to use these modules. I am pleased to state that MUHS is the first university to implement the directions of NHP (2017) which speaks of the urgent need towards gender mainstreaming. Integration of Gender in medical education is definitely a step forward in that direction

Prof. Dr. Deelip G. Mhaisekar

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Preface

Integration of “ Gender in Medical Education” (GME) has been a unique and challenging initiative of the Department of Medical Education (DMER), Maharashtra University of Health Science (MUHS) and Centre for Enquiry into Health and Allied Themes (CEHAT) supported by UNFPA. The Project was undertaken in seven medical colleges of Maharashtra with the aim to sensitise medical students and health professionals to gender inequity in health. As an outcome of the project a cadre of GME trained educators emerged, who enthusiastically participated in teaching gender integrated modules to the medical students.

An important contribution of this project has been the development of “Gender Integrated Modules” for the undergraduate medical curriculum for 5 disciplines namely-Obstetrics and Gynecology, Community Medicine, Internal Medicine, Forensic Medicine and Toxicology and Psychiatry. These modules have been specifically developed by trained medical educators in collaboration with CEHAT and experts in the field of gender equity and health. As this is the first such initiative in India, rigorous reviews of these modules were carried out by the board of studies and academic council of MUHS, Maharashtra.

The efficacy of these modules was tested by undertaking a research study in three of the seven medical colleges of Maharashtra. The study findings show a positive change in the overall gender attitude of medical students like a gender informed understanding of communicable and non communicable diseases, gender sensitive approach to the issues of violence against women (VAW), and sexual violence. Care had to be taken that the number of teaching hours are not increased. Hence, the focus was on using innovative teaching techniques such as case studies, role plays, games and quizzes to enhance learning and enable interactive sessions.

I would like to congratulate the medical educators and CEHAT for having undertaken such an important activity of developing gender integrated modules for five disciplines. I urge medical educators from different medical colleges of Maharashtra to use these modules with medical students so as to create gender sensitive doctors in the state of Maharashtra.

Dr. Pravin H. Shingare
Director Medical Education & Research,
Mumbai

From the Coordinator's desk

CEHAT has been working on the issue of women and health since its inception. It has been able to generate critical evidence on issues of access, discrimination and neglect of health equality in policy, programmes and practice. It has also been at the forefront in policy and legal advocacy on the issues of access to abortion services, gender insensitivity in healthcare response to VAW and sex selection/determination. The work also involved gender sensitisation of health providers and has been ongoing. A common issue that emerged was the need to impact the medical curriculum and make it gender sensitive so that doctors are sensitive to gender concerns when they enter the field.

The Integrating Gender in Medical Education (GME) initiative of CEHAT, DMER, MUHS and UNFPA was conceptualized after a lot of deliberation. Building on the earlier experiences in India and abroad, CEHAT decided to work closely with medical professors across 7 medical colleges in Maharashtra to train them as core faculty and bring about changes in medical curriculum in consultation with them. This was probably the best strategy as once the 19 professors completed the GME training; they were able to identify the gender gaps in their curriculum. The gender gaps were identified for every lecture of the UG MBBS curriculum as prescribed by the MUHS. Later, the CEHAT team along with the mentors and gender experts developed the gender content for each lecture. This was again reviewed by all the 19 trained faculty, mentors and gender experts.

The modules are supplementary efforts to existing MBBS curriculum and are structured with key messages for medical educators, and knowledge, skills and attitude changes expected in medical students. The section on content in the modules specifically provide examples of gender concerns related to health conditions and evidence snippet of steps by which gender can be integrated in a medical topic that is being taught by an educator. Each module has listed details of resources which can be read by the educator at their convenience. Case studies, debates, group discussions have been included as participatory exercises to assist medical educators in engaging students on gender and health.



Sangeeta Rege,
Coordinator, CEHAT

Acknowledgement

At the outset we acknowledge the contribution of several individuals and agencies in the preparation of these modules. We are grateful to Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) for guidance and encouragement received at all stages of the GME project, in particular Dr. Pravin Shingare who led the entire initiative. We also thank the Board of Studies and Academic council of MUHS (2016-2017) for supporting the Integration of Gender in Medical Education and approving the modules. We extend our heartfelt thanks to UNFPA for their funding support in carrying out this activity.

These modules have been developed jointly by the CEHAT team, the trained GME faculty, our mentors and gender experts. We thank each of them for their valuable feedback and suggestions on each draft. We would like to thank Dr. Shrinivas Gadappa and Dr. Priya Prabhu for guiding us at CEHAT through the project phase for administrative, strategic and intellectual inputs. They were always available and helped us navigate the system. We thank Dr. Hrishikesh Wadke for coming on board for developing the modules and helping in the pilot testing of the tools for the impact study. We are grateful to Anagha Pradhan for her extensive inputs in developing the modules for Community Medicine.

We also extend our sincere thanks to external reviewers for their critical feedback. We thank Dr. Manisha Gupte and Dr. Padmini Swaminathan for reviewing all the modules, Dr. Asha Oumachigi for Obstetrics and Gynaecology module, Dr. Rakhil Gaitonde for Community Medicine module, Dr. Rajendra Bangal for Medicine and Forensic Medicine and Toxicology module and Dr. Roopali Shivalkar for Psychiatry module. We thank Tejal Barai-Jaitly for critically reviewing the modules and helping in the finalisation of the content. We are grateful to Dr. Padma Prakash for language and content editing of the modules. We also thank Priyanka Shukla, Apurva Joshi and Vijay Sawant for helping us with referencing of the modules. We are grateful to Saramma Mathew for proof reading of all the modules.

We take this opportunity to thank our former colleagues from CEHAT who have contributed to the development of modules; we would like to thank Asilata Karandikar, Shreya Sen and Lakshmi Priya Menon who were involved in initial stage of module development. We would like to acknowledge Priya John and Ameerah Hasnain for their contribution in the content development for the Intervention modules related to the gender in medical education action research.

List of Contributors

The gender integrated modules have been a product of the joint efforts of 20 GME trained medical educators from seven medical colleges of Maharashtra in collaboration with CEHAT.

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Abbreviations

ANC - Ante Natal Care
ART - Anti Retroviral Therapy
ART - Assisted Reproductive Technologies
CLA - The Criminal Law Amendment Act (2013)
CrPC - The Code of Criminal Procedure (1973)
CWC - Child Welfare Committee
DV - Domestic Violence
EC - Emergency Contraception
FMT - Forensic Medicine and Toxicology
FP - Family Planning
GBV - Gender based Violence
HCP - Health Care Provider
HIV - Human Immuno Deficiency Virus
ICMR - Indian Council of Medical Research
ICU - Intensive Care Unit
IPC - The Indian Penal Code (1860)
IPV - Intimate Partner Violence
LGBT - Lesbian, Gay, Bisexual, Transgender
MCQ - Multiple choice questions
MLC - Medico-legal complaint
MTP -The Medical Termination of Pregnancy Act (1971)
NGO - Non-government organisation
PCPNDT -The Pre-Conception and Pre-Natal Diagnostic Techniques Act (1994)
PID - Pelvic Inflammatory Disease
POCSO - The Protection of Children from Sexual Offences Act (2012)
PWDV - The Protection of Women against Domestic Violence Act (2005)
SAFE Kit - Sexual Assault Forensic Evidence Kit
SAI - Sports Authority of India
SAQ - Short Answer Questions
STD - Sexually Transmitted Diseases
STI - Sexually Transmitted Infection
SV - Sexual violence
TB - Tuberculosis
VAW - Violence against Women
USG - Urine Specific Gravity
WHO - World Health Organisation

Semester 3

1. Personal Identity, its need and importance



Gender content added : Ethical, legal and social concerns related to sex verification

Lecture name	: Personal identity, its need and importance
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion, Brainstorming, Self-Awareness Exercise/ Test and Case study
Resources	: 1. Reddy, J.N. (2013) Sex verification tests: ethical, legal and social aspects. <i>Indian Journal of Medical Ethic</i> , 10(1), 49-51. doi: https://doi.org/10.20529/IJME.2013.011
Handouts	: 1. World Health Organization (2015). <i>Gender</i> . Retrieved from http://www.who.int/mediacentre/factsheets/fs403/en/

Key Points

1. Gender is an acquired identity that is shaped through social norms, changes over time and varies widely within and across cultures.
2. There is no single physiological or biological marker that allows for the classification of people into "male" or "female".

Learning Outcomes

Knowledge	Skill	Attitude
Student should be enabled to understand the difference between biological sex and gender	Student should demonstrate skill to examine and opine on queries by investigating officer, judicial officers, regarding sex and gender related issues	Student should be sensitive to social construction of gender

Knowledge	Skill	Attitude
Student should know the human rights and law pertaining to (LGBT) Lesbian, Gay, Bisexual, Transgendered (TG) individuals	Student should demonstrate skill to identify ethical and medico-legal considerations around sex verification tests	

Context: While teaching verification / identification of 'sex' of an individual and its medico legal importance.

Note to Educator: The educator should explain the limitations of sex verification test and explain that sex and gender are not binary.

Content

I. "Sex" and "Gender"

Sex- refers to the biological and physiological characteristics that define men and women. Gender- refers to the socially constructed roles, behaviour, activities and attributes that society considers appropriate for men and women.

II. Social construction of gender It is the social meaning given to being a male or female in a particular place and time. Gender is, therefore, an acquired identity that is shaped through social norms, changes over time, and varies widely within and across cultures. Gender describes the array of different roles and relationships, personality traits, attitudes, behaviour, values, relative power and influence that a particular society assigns to men and women.

Examples of biological differences:

- Women can become pregnant and men cannot. Physiological changes to immune, respiratory, and cardiovascular systems during pregnancy can lead to especially severe outcomes of some infectious diseases including pandemics (e.g. H1N1).¹

¹ World Health Organization (2009). *Pandemic influenza in pregnant women: Pandemic (H1N1) 2009 briefing note 5*. WHO. Retrieved from http://www.who.int/csr/disease/swineflu/notes/h1n1_pregnancy_20090731/en/

- Biological differences between male and female immune systems affect vulnerability to infectious diseases.²

Examples of gender differences:

- Many more men smoke than women. It affects their vulnerability to infectious respiratory diseases such as influenza and tuberculosis (TB).^{3,4}
- Differences in activity patterns of males and females cause them to have different patterns of exposure to infectious pathogens.
- In many countries, gender influences access to economic resources. The lack of access to economic resources is sometimes a barrier to prompt and effective health care for women.⁵

III. Sex and identities

Gender identity: It is individual's preferred gender role and presentation, as masculine, feminine, both or neither. Gender identity therefore is not determined by chromosomal or anatomical sex of a person. Gender is not a binary and there are several other gender identities other than male and female.

Intersex: It is non-conformity of an individual's body to prevalent ideas of maleness and femaleness. It is used as a term for different biological possibilities and variations which may include, for instance, a large clitoris, absence of vagina, congenital absence of gonads, etc, among others.

Transgender: "transgender" has become an umbrella term that is used to describe a wide range of identities and experiences, including but not limited to: pre-operative, post-operative and non-operative transsexual people (who strongly identify with the gender opposite to their biological sex); male and female 'cross-dressers' (sometimes referred to as "transvestites", "drag queens", or "drag kings"); and men and women,

² Kark, J.D., Lebiush, M., Rannon, L. (1982). Cigarette Smoking as a risk factor for epidemic A (H1N1) influenza In young men. *New England Journal of Medicine*, 307(17), 1042-1046. Doi: 10.1056/NEJM198210213071702

³ Zellweger, J. P. (2008). Tuberculosis and tobacco: Meeting of two epidemics. *Revue Medicale Suisse*, 4(181), 2576-2578, 2580

⁴ Chan E., Keane, J., & Iseman, M. (2010). Should cigarette smoke exposure be a criterion to treat latent tuberculosis infection? *American Journal of Respiratory and Critical Care Medicine*, 182, 990-992

⁵ Interagency Gender Working Group and World Health Organization. (2005). *A summary of the so what report: A look at whether integrating a gender focus into programmes makes a differences to outcomes*. Geneva, Switzerland: IGWG, WHO. Retrieved from <http://www.who.int/gender-equity-rights/knowledge/so-what-report.pdf>

regardless of sexual orientation, whose appearance or characteristics are perceived to be gender atypical. A male-to-female transgender person is referred to as 'transgender woman' and a female-to-male transgender person, as 'transgender man'.

IV. Sexual orientation

Sexual orientation refers to a pattern of emotional, romantic and / or sexual attractions to men, women or both sexes. It includes individual's sexual preference such as being homosexual, heterosexual or bisexual.

Terminologies used:

Men having sex with men / Gay: A man who is attracted towards other men.

Lesbian women: A woman who is attracted to other women.

Bisexual: A person is attracted to both men and women.

Heterosexual: A person who is attracted to a person of opposite sex.

V. Sex verification and not sex determination

The two case studies provided at the end of the module should be read out and students should be asked to highlight ethical, legal and social issues. After they have presented their views, the teacher can conclude with a lecture covering the following.

Sex verification is required for the following reasons:

- For the purpose of identification in living: Sex, age and stature are said to be the primary characteristics of identification. Sex is important in any chain of identity data and determination of individuality of a person.
- For participation in sports: Sex segregation is based on the long term endogenous androgen exposure of men at puberty that lead to the physiological difference with women.
- For deciding whether an individual can exercise certain civil rights extended to only one sex.

- For deciding question relating to legitimacy, divorce, paternity, marriage, impotence, rape and affiliation.
- At present, there are three frequent circumstances where verification of sex is used - sports, pre-employment and sex specific crimes which require us to know whether the individual is a male or a female.

Key Points for Discussion

1. Sex verification tests are problematic:
Sex verification to identify an individual as 'male' or 'female' is often easy, barring the cases of variations. Although there are many biological markers of sex—chromosomes, gonads, external and internal genitalia and secondary sexual characteristics, but none is conclusive. Sex verification has been and continues to be problematic because there is no single physiological or biological marker that allows for the classification of people into either male or female. People cannot be classified into binaries-male-female, sexual orientation-heterosexual-homosexuals. Moreover, the limitations of the sex verification tests are never brought to the knowledge of the person undergoing the tests or those asking for it.
2. Treatment in such situations:
Doctors carrying out such tests on sportspersons also face the dilemma of whether to consider long-term health consequences or short-term gains in them (as sports person) whenever they supplement hormones in sex reassigned sports persons. The dilemma is further compounded when sport's governing bodies ask for mandatory 'treatment' of a sportsperson, before they wish to compete again, if their testosterone levels are abnormal. This violates the autonomy of the person tested.
3. Tests are discriminatory:
The tests are discriminatory as only females are tested. Also, as athletes they are unfairly disqualified for genetic abnormalities. These tests are unfair, unscientific and possibly discriminatory against women who may not meet the traditional notions of femininity. In the case of Santhi Soundarajan, her application for the post of coach was refused on the grounds of sex, even though sports team across countries have been having women coaches. Humiliation faced by Santhi Soundarajan drove her to attempt suicide. It is important to recognise the severe physical and psychological health consequences faced by people who are subjected to such tests.

4. Lack of guidelines:

At present, India does not have any guidelines from either Medical Council of India (MCI) or Indian Council of Medical Research (ICMR). Hence, good practice guidelines from the International Olympic Committee (IOC) sports field can be followed. It is recommended that a combination of tests be performed to verify the sex of an individual preferably by a team of doctors including gynaecologist, endocrinologist, internal medicine expert, geneticist, and an expert on gender / transgender issues. The forensic medicine specialist should also be part of the team to look into medicolegal issues.

Ethics of sex verification tests:

- Sex verification testing is often done compulsorily, although it ought to have been voluntary (autonomy of the person). The tests are regarded as invasive and abusive. They disregard the autonomy of female athletes. The testing is performed during sports competitions, once the athlete has arrived at an international competition site, away from home and without her personal support group. The opinions of athletes are not considered in the testing for sex verification.
- Sex verification tests are unscientific and also unethical. Besides a serious compromise on consent and autonomy of the athletes, there is no protection in terms of confidentiality. While the details of the tests in terms of exact readings may not be made public, a "failed" test is reported and often the female athletes are known to be stripped off their medals. This is public humiliation as a result of a forced and oftentimes even irrational test. Irrational as many of the so called "manly advantages" found post these tests, do not always contribute to increasing their ability to win.

Role of Doctor

- Be aware of various sex and gender identities.
- Understand social implication and provide accurate information to the family and other stakeholders.
- Understand limitations of sex verification tests and disseminate knowledge to police, judiciary and others.

Activity

Distribute / read out the following cases and facilitate discussions around it with the questions that follow the cases.

Case Study 1:

Pinki Pramanik Case

The arrest and subsequent humiliation of the Indian athlete and international medal winner, Pinki Pramanik that violated her right to privacy, bodily integrity and basic human dignity raised important and often sidelined questions about gender, sports and the way the world is organised. Twenty-six-year-old Pramanik was accused by her live-in partner of repeated rape and torture, and of being a man. She was arrested on 14th June 2012 and was not granted bail for 26 days. She had to spend the entire period in a male cell in a West Bengal jail, and had to undergo three sex verification tests at different state hospitals, because the necessary facilities were not available at a single hospital. An MMS clip, showing her in the nude while undergoing one of the tests was leaked online and went viral. The District and Sessions Judge, while granting Pramanik bail on 11th July held that she was physically incapable of rape and that the petitioner who alleged rape had been in a consensual live-in relationship with Pramanik for nearly three years. Pramanik was suspended from her job as a ticket collector with the Eastern railways; the suspension was revoked after her bail. She alleged that in police custody, sex verification tests were forcibly carried out on her after drugging and tying her hands and feet.

In November 2012, the West Bengal police submitted a charge-sheet before the district court in which, citing medical reports, they alleged that Pramanik was indeed male, and charged Pramanik with rape. Later, the doctor who headed the medical investigation in her sex verification clarified that Pramanik suffered from a disorder of sexual development, which may be described as male pseudohermaphrodite. Pramanik has responded by saying she feels 'like a joker in a circus', and is being driven by the police to the brink of suicide. According to some reports, she has planned to file a defamation case against the

police and the public prosecutor, and asked the West Bengal Chief Minister and the Union Sports Ministry to intervene in her case.

Case Study 2:

Santhi Soundarajan Case

Santhi Soundarajan was stripped of her 800 m silver medal after failing a sex verification test at the 2006 Doha Asian Games. She was later forced to work as a laborer in a brick kiln, before the government recently gave her an opportunity to become a qualified athletics coach. The government has removed its rider of ascertaining her sex before allowing her to pursue the diploma course in Patiala. There was a delay in getting the letter since Sports Authority of India (SAI) took a different view on the matter. Santhi's sex became the focal point, as the government agency summoned her for tests at the All India Institute of Medical Sciences on a couple of occasions. Santhi refused, wondering why she had to submit to tests if her aim was to become a coach.

The situation was unprecedented as the course rules do not specify sex tests for admission. SAI explained that they were insisting on the tests as it would have helped in clearing the air, since they anticipated some discomfort in the hostels. But later on, SAI took a refreshingly different view on the matter and said that there was no need for a sex test. They found no logic behind such a test when women are essaying major roles in men's teams and men were coaching women's teams. SAI's Director General too said he was against the sex determination test. Santhi got the letter stating that 'sex verification may be relaxed' for admission to the course. She would also be given a separate room to stay at the campus.

Question for Discussion

- What are the ethical, social and legal issues of sex verification tests?
 1. Sex verification is based on a suspicion or when the sex of a person is challenged. These tests are performed only on women. Women athletes are unfairly disqualified due to genetic variations termed as abnormalities.
 2. Sex verification tests are carried out when athletes reach international competitions and are away from their close ones and lack personal support. They may also not have adequate time to decide on whether they want to undergo a test or not and may fear being disqualified.
 3. These tests subscribe to the traditional notions of femininity.
 4. It is important to recognise that there is no single decisive sex verification test. Hence over reliance on such tests needs to be questioned.

Semester 3

2. Mechanical injuries and burns



Gender content added : DV as a cause of reported assaults, burns and poisoning

- Lecture name : Mechanical injuries and burns
- Subject : FMT
- Semester no : 3
- Duration : 1 hour
- Methodology : Lecture, Discussion and Case study
- Resources : 1. Bhate-Deosthali, P., Roy, N. (2015) The invisible face of burns in India. *Current Medicine Research and Practice*, 5(2), 53-54. Retrieved from [http://www.cmrp-journal.com/article/S2352-0817\(15\)00040-9/fulltext](http://www.cmrp-journal.com/article/S2352-0817(15)00040-9/fulltext)
- Handouts : 1. GOI. Ministry of Women and Child Development (1961) *Relevant laws: The Dowry Prohibition Act, 1961*. Retrieved from <http://wcd.nic.in/act/dowry-prohibition-act-1961>
2. GOI (n.d) IPC section 304 B. Retrieved from <https://indiankanoon.org/doc/653797/>
3. *The Workmen's Compensation Act, 1923*. Retrieved from [http://www.labour.gov.in/sites/default/files/TheWorkmenAct1923\(1\).pdf](http://www.labour.gov.in/sites/default/files/TheWorkmenAct1923(1).pdf)

Key Points

1. Violence against Women (VAW) refers to any act that is inflicted on women with the intention of causing harm, to humiliate or put them down.
2. Women and girls suffer injuries as a result of physical and sexual violence from their partner / husband and / or their family members. The Protection of Women against Domestic Violence (PWDV) Act, 2005 recognises various kinds of domestic Violence (DV) in the form of physical, sexual, verbal and economic abuse.
3. The injuries suffered by a woman may be as a result of DV, and may not be as a result of the reason stated on presentation.

4. Domestic violence (DV) can be an underlying factor for burn injuries, assaults, falls and accidental poisoning; that are routinely presented in hospitals.

Learning Outcomes

Knowledge	Skill	Attitude
Student should be made aware that lack of visible injury marks does not rule out DV	Student should recognise health consequences and injuries as a result of various forms of DV such as pulling hair, banging head, twisting arm, hitting on knuckles etc	Student should acknowledge that asking about DV is part of doctor's responsibility
Student should be able to differentiate between self-inflicted, homicidal and accidental nature of injuries.	Student should develop skill to describe and document injuries, with diagrams and sketches and ask about abuse as part of clinical enquiry	Students should recognize DV as a health issue, be sensitive and non-judgmental to women and girls who disclose violence.
Student should be able to recognise DV as a possible cause for burn injuries and be aware of legal obligations	Student should record history of DV in cases of burns injuries, be familiar with procedure to be followed for recording of dying declaration.	Student should create an enabling environment in which patient can speak out about DV.

Note to Educator: 'Gender-based violence' and 'violence against women' are terms that are often used interchangeably as most gender-based violence is inflicted by men on women and girls. However, it is important to retain the 'gender-based' aspect of the concept as this highlights the fact that violence against women is an expression of power inequalities between women and men.

Medical books only depict male models of injuries, hence students do not visualise that women also suffer injuries. Educators could consciously incorporate use of gender neutral language (such as "individual" / "human" / "person" instead of "man" or "they" instead of "he") to sensitise students and to have a more gender inclusive perspective on injuries.

Content

I. Violence against women is any act that is inflicted on women because she is a woman. Domestic Violence is one of the most pervasive forms of violence against women. As per PWDVA 2005, any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it

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

- Physical violence may include pulling of hair, pushing, shoving, kicking, and banging against wall amongst others. These acts are humiliating and inflict pain and the nature of injury may be in the form of blunt trauma, swelling and tenderness.
- Women experiencing domestic violence, suffer in silence as they are emotionally and financially dependent on their partners. There is high acceptance of domestic violence within families that contributes to this culture of silence.
- Women may report to health facilities with complaints such as "accidental" poisoning or "accidental" burns. It is important to speak to the woman and ask about experience of domestic violence and provide her with the relevant services as well as referrals. Documentation in such cases is useful for her in seeking justice.

II. DV as a possible cause for burn injuries

- Burns is a major public health issue. More women in the age group of 21-40 years report burns, than men, and the percentage of burns and mortality is higher among

women than among men Burn injuries among women can be a result of DV. Much of the medical literature published in India use retrospective research designs using either post-mortem reports or burns registers / hospital records as source of information and report on the profile of burns patients based on sex, vehicle of burns, percentage of burns, causes- suicide / homicide / accident and burns outcomes. This literature points to a preponderance of young women in the age group of 18 to 35 years dying with burns due to accidents in kitchens. This is further explained by the nature of clothing worn by women in India such as saree and dupatta which make them susceptible to fire related accidents / deaths.

- Why so many young women die of accidental burns in kitchens after marriage when they are initiated into cooking at early age? So, when they cook safely in their natal homes, what could be the possible reasons for this "carelessness" in marital homes? Some state suicide as the cause and explain this as due to quarrels in family due to dowry harassment, alcoholism, family stress. Domestic violence is not listed as a cause. Further, that domestic violence is considered to be nothing but "quarrels at home" is of concern, as medical professionals do not seem to engage in the socio-political context of burn injury.
- Discrepancies in reporting are quoted in some studies. In one study it was found that in 29% of cases, the cause of death was reported as bursting of kerosene stove although there was no stove in the kitchen.⁶ One study found that in many cases even the dead body of the victim was unavailable because the offenders had disposed of the body by cremation without informing the police or relatives of the deceased individual. This was done deliberately to destroy evidence

Role of Doctor

The role of a doctor becomes very important and crucial in cases of assessing all injuries. Doctors should be sensitive and alert to the fact that DV may be a cause.

- A doctor has a therapeutic and medico legal role in case of burn injuries. History taking and documentation of the case becomes very important part of doctor's duty.
- Following details should be captured in the documentation for burn injuries:
 - a. Smell of kerosene, Singeing of hair

⁶ Rao, NKG. (1997). Study of fatal female burns in Manipal. *Journal of Forensic Medicine and Toxicology*, 5(2), 57-9.

- b. Blackening, charring, extent and degree of burns
- c. Collecting burnt material from body
- d. In case of impending death, arrange for recording of dying declaration
- e. Is it possible to say whether these are accidental, suicidal or homicidal

The doctor also needs to be vigilant towards minute details while taking the history and documenting, such as, if the household really has a stove in the case of stove burst, when most of the households use LPG nowadays; if the timing of cooking is reported as an odd hour (e.g., 2 am); why was the woman cooking at that time, nature of burns indicating that kerosene had been poured on the woman, etc., as all these issues indicate foul play.

Assessment of burn Injury

- Doctor should first assess the extent of burn injuries on the body (surface area of skin burnt) using the Wallace rule of Nine.
- Then assess the depth of burn injuries whether they are either (1) superficial or deep or (2) Epidermal or epidermal dermal or deep burn injuries.
- Assess whether the burn injuries are on vital structures or not; is there an immediate threat to life of the individual?
- Assess cause for burn injuries-dry flame or scalds or chemical or any other? Possible use of any inflammable fluid or not?
- Make assessment whether those burn injuries could have been sustained accidentally or self-inflicted or by use of force?
- Initiate treatment-fluid and electrolyte management, infection control, temporary or permanent methods for replacement of burnt skin, and also to prevent scars, contractures, etc;
- If the death is imminent, ensure that a dying declaration is recorded and if there is no time to get a magistrate then the doctor should record it himself / herself. This is mandatory by law.

Activity

Case Study 1:

Mrs. K reports to the magistrate in her dying declaration that the burns sustained were due to stove burst accidentally. But later that night she discusses with you (doctor) that it was indeed her husband who poured kerosene and lit her for failing to bring dowry. Next morning she succumbed to her injuries.

Question for Discussion

- What should have been done in this case by you ethically / legally?

The doctor should inform her that she can record a second Dying Declaration before a magistrate and also initiate the process for the same if she wishes to.

The doctor should record in the medical records the history of homicidal burns given by the patient. This must include date, time, compos mentis, and detailed history given by her. The doctor should be aware that such documentation is permissible in court.

Key Points for Discussion

1. Doctor should have complete knowledge about their role in recording of dying declaration wherein they have to certify that the patient is in a sound mental state to give a statement, and should be aware of the procedure for ensuring that the dying declaration is taken. This may require interface with the police and / or magistrate.
2. Importance of dying declaration: Documentation is of critical importance. Whatever information a patient has shared with the doctor during her stay should be recorded. The doctor should not feel compelled to toe the line with police, but should concentrate on documenting history provided by patient, interpretation of clinical observations and present the same.

Case Study 2:

Mrs. G reports to you (doctor) during her antenatal checkups that she sustained cigarette stub burns and scalds as a result of constant abuse by her husband pestering her for a male child. But you ignored it as you are an obstetrician concerned only with the ANC. After few months you find that she has committed suicide by consuming insecticide, unable to bear the abuse.

Question for Discussion

- Did you do anything wrong ethically and / or legally?

Key Points for Discussion

1. The obstetrician neglected marks of burns and scalds sustained, thinking that it was not his / her duty to pay attention to them and so did not consider that DV could be a possible cause for it.
2. A doctor did not try to intervene in the case, by making necessary referrals, and talking with woman.
3. Legally doctor could have been booked for abetment to suicide if the woman had left written evidence that the doctor had not helped her.

III. DV as a possible cause for poisoning

Doctors need to probe in to the medical complaint of accidental consumption of poison to assess whether this was an attempt to suicide because of domestic violence

Poisoning among female patients:

Patient may be brought to the doctor with presenting complaints related to poisoning as:

- With a history of poisoning;
- Unable to give a history of poisoning as the patient may be unconscious;
- With history of snake bite/ hanging / injuries;

- Suspected poisoning

Actions needed to be taken by the doctor in case of poisoning:

- In emergency conditions like acute or chronic poisoning saving life of the person should be considered most important.
- The name/s of the person and relatives who brought the patient to hospital should always be recorded. However, if they are reluctant to tell their names/disclose their identity, one should not force them; however, such fact should be documented.
- Name of the 'informant' of patient's history should be noted.
- All findings of general and local examination should be recorded including the level of consciousness of the person, his / her orientation to time, place, person, etc.
- Doctor should document the clinical features and provisional and final diagnosis.
- In case of suspected homicidal poisoning, a second opinion should be obtained / sought.
- Stomach wash / vomitus / urine / faeces / secretions / blood / poison / and / or container / suspected drink or food should be collected.
- All samples should be carefully collected, proper preservatives added, containers properly sealed and labelled and preserved as per prescribed guidelines till they are handed over to the police. Acknowledgment should always be obtained from police. The chain of custody of samples preserved should always be maintained.
- If, at a later time / date, the police bring back the sample to the doctor (after they have duly received it from the doctor under acknowledgment) with a broken seal or damaged label, with a request to 're-seal' the sample, it should never be accepted. Such fact should be noted in the records.
- In case of impending death (homicidal, suicidal or accidental) of the patient a doctor should arrange for dying declaration. In case of death (homicidal, suicidal or accidental) of the patient a doctor should arrange for medico legal autopsy.

Role of Doctor

- The role of doctor is both therapeutic and medico legal in case of poisoning.

Activity

Case Study 3:

Ms. B, a recently married lady is brought unconscious to your private nursing home with history of consumption of excessive sleeping pills requiring ventilator care. In spite of your treatment for a week, she dies in the ICU. What do you do?

After one-week police have served you a notice that you have concealed the murder of Ms. B by her husband and did not allow them to record dying declaration. What next?

Key Point for Discussion

1. The doctor should be aware about medico legal procedures and recognise that consumption of excessive sleeping pills is a sign of attempted suicide.

IV. Alcohol - drunkenness examination

It is the prevalent notion that consent is not required for examination of an accused. It should be noted that a person accused of any crime has right to refuse an examination or any part of it. The concept of informed refusal can be implemented for accused too. This means that the accused has been explained the consequences of refusing a medical examination.

Section 53 CrPC does not say that examination of a drunken accused can be performed without consent. In case of an accused person who is drunk and not in a position to give consent, a doctor should record accused person's state of consciousness. It should be remembered that if examination of a drunken accused is performed without the person's consent, the doctor could be sued for the breach of consent. Also, if the accused is not in a position to give consent, a doctor can go ahead with the examination but the findings should not be revealed till the entire consent is obtained when the person is in consciousness. This will be based on requisition only. It clears the position

of the doctor that he / she had to go ahead with examination as there was a requisition, but the doctor has not divulged any details without permission, so the doctor is safeguarded legally and ethically.

Actions that need to be taken

- Screening test-breath analyser-positive then sent for medical exam
- Requisition
- Informed Consent and Informed Refusal
 - Conscious person
 - Unconscious person
- Medical exam-Clinical exam and Lab investigations

Drunkenness Opinion

- Not consumed alcohol
- Consumed alcohol but not under the influence
- Consumed alcohol and under the influence

Role of Doctor

- The doctor should be able to carry out the necessary identification and documentation of injuries in women experiencing domestic violence interpretation of injuries on women experiencing DV.
- Doctor should be able to interpret both presence and absence of injuries and reasons for both.
- Doctor should understand that there could be delayed reporting due to social reasons; and recognise that non-disclosure of abuse is due to social pressure in case of SV, DV
- He / she should be able to identify women's burn injuries as homicidal / suicidal when the relatives often allege it as accidental and explore reasons behind the same.

Semester 3

3. Medico legal aspects of sex, marriage and infant death



Gender content added : Concept of sexuality

Lecture name	: Medico legal aspects of sex, marriage and infant death
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion, Brainstorming, Self-Awareness Exercise/ Test and Case study
Resources	: 1. World Health Organization (2015). <i>Sexual Health, Human Rights and the Law</i> . Geneva, Switzerland: WHO. Retrieved from http://www.who.int/reproductivehealth/publications/sexual_health/sexual-health-human-rights-law/en/
Handouts	: ---

Key Points

1. A person's life is constituted by a large ambit of sexual behaviour.
2. Intolerance towards non-heterosexual individuals hampers their access to legal help and medical care.
3. Lesbian women are vulnerable to violence due to their sexual identity.

Learning Outcomes

Knowledge	Skill	Attitude
Student should be introduced to the concept of 'sexuality'	Student should be non-judgmental and respect different sexual orientations	Student needs to be made aware to ethical dilemmas or constraints in legal provisions related to homosexual relationships

Knowledge	Skill	Attitude
Student needs to be made aware that women and sexual minorities are vulnerable to GBV which has severe health consequences	Student should learn to identify health consequences of gender - based violence amongst patient coming to them	Student should be non -judgmental and professional in delivering health care irrespective of sexual orientation and identity of the person

Context: Sexual offences and perversions; natural (rape, sexual assault, adultery, incest), unnatural (rape, sexual assault, sodomy, bestiality, buccal coitus), lesbianism, perversions and relevant sections of IPC and CrPC.

Note to Educator: Doctors should not treat alternative sexual orientation as a disorder and should respect the rights of all sexual minorities.

Content

- Sexuality of a person is not just defined by the act of sex but also comprises their sexual thoughts, expressions, desires, orientation and their preferences. Therefore, men who are attracted to women (heterosexual) and men who are attracted to men (homosexual) would both be considered to be expressing their sexuality.
- However, most societies accept heterosexuality as the only form of sexuality. Non - heterosexual people are often seen as 'immoral' or 'abnormal' and are subjected to mistreatment and discrimination.
- In India, IPC Section 377 makes consent and age of a person irrelevant while imposing a prohibition on 'unnatural offences'. Therefore even consenting adults in same sex relationships are criminalised for being involved in anal sex. Section 377 penalises sexual acts which are 'against the order of nature' but such acts could constitute a large ambit of non peno vaginal sexual practices that are followed by people of all sexualities and not just people in same sex relationships.
- IPC 377 has implications for heterosexuals and homosexuals alike, but the act has been used to harass and target primarily the homosexual community. Societal stigma and discriminatory treatment such as extortion by the police, unsympathetic behaviour by health care providers hampers access to legal and medical help. When a person is

identified as a homosexual, he can be imprisoned up to ten years as per Section 377 IPC and can also affect his / her employment status.

Violence against lesbian women^{7,8}

Since IPC Section 377 focuses primarily on penetrative intercourse, lesbian women are often excluded from discussions around violence against homosexual people. However, lesbian women too are subjected to various forms of violence, particularly in the private domains of home and family.

Disclosure of sexual identity can lead to physical and verbal abuse from parents and other family members. Violence can be in the form of battering, restricting mobility and expulsion from home. Lesbian women are also vulnerable to sexual violence in the form of coerced marriage or 'corrective rape' (where they are subjected to forced sexual intercourse as a 'cure').

Elopement and suicide have been documented in some narratives as means used by victims to put a stop to the oppression.

Role of Doctor

- A doctor should be sensitive towards gender-based violence perpetrated against sexual minorities, especially lesbian women.
- A doctor needs to be sensitive towards unique physical and mental health needs of lesbian women owing to their sexuality and the violence they face because of it.

⁷ Creating Resources for Empowerment in Action (CREA). (2012, December 31). *Count me IN!: Research report on violence against disabled, lesbian, and sex-working women in Bangladesh, India, and Nepal*. Action Canada for Sexual Health and Rights. Retrieved from [https://doi.org/10.1016/S0968-8080\(12\)40651-6](https://doi.org/10.1016/S0968-8080(12)40651-6)

⁸ Fernandez, B., Gomathy, N. B. (2003). *The nature of violence faced by lesbian women in India*. Mumbai: Research Centre on Violence against Women, Tata Institute of Social Sciences. Retrieved from https://www.tiss.edu/uploads/files/8The_Nature_of_violence_faced_by_Lesbian_women_in_India.pdf

Semester 3

4. Medico legal aspects of sex, marriage and infant death



Gender content added : Unscientificity of virginity testing; Sterilisation and family planning; Infertility; ART; Surrogacy; Legitimacy; Recognition of marital rape

Lecture name	: Medico legal aspects of sex, marriage and infant death
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion and Case study,
Resources	: 1. Moaddab, A., McCullough, L.B., Chervenak, F.A., Dildy, G.A., & Shamshirsaz, A. A. (2016). Virginity testing in Professional Obstetric and Gynaecological Ethics. <i>The Lancet</i> , 388(10039), 98-100. doi: http://dx.doi.org/10.1016/S0140-6736(15)01275-1 ⁹ 2. Sama Resource Group. (2016). <i>Commercial surrogacy: a contested terrain in the realm of rights and justice</i> . Kuala Lumpur, Malaysia: Asian-Pacific Resource & Research Centre for Women. Retrieved from http://arrow.org.my/wp-content/uploads/2016/12/Commercial-Surrogacy_Thematic-Paper.pdf ¹⁰
Handouts	: ---

Key Points

1. It is medically impossible to prove whether or not a woman is a virgin.
2. Past sexual history of a woman is irrelevant in cases of sexual assault / rape.

⁹ Moaddab, A., McCullough, L.B., Chervenak, F.A., Dildy, G.A., & Shamshirsaz, A.A. (2016). Virginity testing in Professional Obstetric and Gynaecological Ethics. *The Lancet*, 388(10039), 98-100.

¹⁰ Nadimpally, S., Banerjee, S., & Venkatachalam, D. (2016). *Commercial surrogacy: A contested terrain in the realm of rights and justice*. Kuala Lumpur: Asian-Pacific Resource and Research Centre for Women (ARROW). Retrieved from http://arrow.org.my/wp-content/uploads/2016/12/Commercial-Surrogacy_Thematic-Paper.pdf

3. Forced sexual relation within marriage (marital rape) is a civil offence under PWDVA 2005 and a woman cannot be forced to have sex in the name of consummation of marriage or in the course of her married life.
4. Contraceptive counselling enables women to make choices that are best suited for them.
5. The onus of child bearing is often put on women.
6. Women have no biological role to play in determining the sex of the foetus after becoming pregnant or at the stage of pre - conception sex.
7. There is need for better and clearer guidelines to support surrogate mothers in order to protect their rights.
8. The PCPNDT Act, 1994 and MTP Act, 1971 do not contradict each other. Denying women access to safe abortion might force them to seek assistance from unsafe / illegal providers.
9. Women's right to confidentiality and privacy in seeking MTP are being violated due to laws around mandatory reporting of sexual assault.

Learning Outcomes

Knowledge	Skill	Attitude
Student should recognize that medical examination cannot with scientific certainty diagnose virginity and that the value attached around virginity of women is socially assigned one.	Student should be non-judgmental and professional in delivering health care and medico legal examination irrespective of her past sexual conduct.	Student needs to be sensitive to the fact that conducting virginity tests leads to stigma, bias and violence against women.
Student should know that forcing sex on wife is marital rape.	Student should be able to recognize signs such as PID, vaginal boils, vaginitis etc. as signs of	Student should acknowledge that even a wife's consent for sexual intercourse is

Knowledge	Skill	Attitude
	sexual violence in marriage.	respected in law (PWDV ACT, 2005).
Student should be aware of different methods of contraception.	Student should counsel women / couple about different methods of contraception and help them make an informed choice.	Student should be aware that no coercion should be used for any contraceptive method.
Student should understand that investigation of infertility in men is non - invasive where as in women it is invasive.	Student should be able to promote involvement of male partner / husband in the investigations of infertility.	Student should be sensitized to the gender bias in investigation of infertility.
Student should be aware of ethical implications of "consent" in case of surrogate mothers.	Student should be unbiased, non - judgmental and should provide complete information to woman undergoing surrogacy to make an informed choice.	
Student should know provisions under PCPNDT and MTP acts and that they do not contradict each other.	Student should ensure that access to safe abortion is not restricted due to concerns around PCPNDT act.	Student should respect the right to safe abortion for all women who report with an unwanted pregnancy.

Context: Fertility, Impotence, sterility, virginity and nullity of marriage and divorce on medical ground.

Note to Educator: Gender implications of: Fertility, impotence, sterility, virginity and nullity of marriage and divorce on medical grounds should be explained to the students.

Content

Patriarchy is commonly understood as a social system that discriminates on the basis of gender. In a patriarchal system, men are more likely to be placed in a position of power and authority than women. Patriarchy restricts women's autonomy in the following ways:

- Control over women's productive or labour power (e.g. excluding women from better paid jobs, not allowing women to work outside the home).
- Control over women's reproduction and sexuality (e.g. prohibiting sex outside marriage, SV, and forced abortion and forced pregnancies).
- Control over women's mobility (e.g. enforcing practices like purdah, restricting women's movement outside their homes).
- Control on property / economic resources in the household, excluding daughters from inheriting property.
- Control over women's sexuality is one of the major ways in which women's autonomy is restricted in a patriarchal society.

I. Unscientificity of virginity testing

- In India as in many other countries, women's virginity is conventionally associated with notions of purity and virtue. Commonly, women who lose their virginity outside of marriage are considered to be morally corrupt and face societal stigma and judgment on this basis. For this reason, survivors of sexual violence who are not virgins often tend to get an unsympathetic and discriminatory treatment. An example of this is seen in the way the sexual history of a woman was (and often is) considered in cases of sexual violence against her. The presence of the hymen is primarily considered to be the proof of virginity. However, it is medically impossible to prove a woman's virginity, as the hymen could be torn due to a number of reasons that are not sexual.
- A systematic review of studies on virginity testing¹¹ found that hymen examination does not accurately or reliably predict virginity status. Other studies have reported that virginity testing could cause physical, psychological, and social harms to the

¹¹ Olson, R.M., García-Moreno, M. (2017). Virginity testing: A Systematic review. *Reproductive Health*, 14(61). Retrieved from <https://doi.org/10.1186/s12978-017-0319-0>

examinee. Health professionals must be better informed and medical and other textbooks updated to reflect current medical knowledge. Moaddab A et al, state that Virginity testing is completely incompatible with ethical responsibilities and human rights obligation of doctors and professional associations committed to the care of female patients have the professional responsibility to lead efforts to enact legislation that prohibits virginity testing.¹²

- Countries should review their policies and move towards a banning of virginity testing.
- Sexual violence against a woman cannot be justified just because she happens to be sexually active. Sexual activity is a matter of consent and cannot be forced upon another person.
- The Government of India Ministry of Health and Family Welfare's (MoHFW) guidelines and protocols for medico legal care of survivors or victims of Sexual Violence (SV) state that "the status of the hymen is irrelevant because hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse. Hymen examination should therefore be treated like any other part of the genitals while documenting findings in cases of sexual violence. Only findings that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema, etc on hymen) are to be documented. It further states that "'two finger test' must not be conducted for establishing rape / sexual violence". It should be remembered that presence of injuries does not necessarily indicate SV, just as absence of injury does not indicate consensual sex. There can be many reasons for the absence of vaginal injuries such as, use of lubricants, threatening to harm or kill the survivor or loved ones which may result in the absence of resistance and hence absence of injuries. There are some gendered assumptions about sexual assault which are entirely wrong and unscientific, such as "A woman who is well built cannot be raped".
- Virginity and marriage: Sex outside of marriage, especially for a woman, is often considered shameful and immoral. Therefore, a lot of value is attached to the virginity of a woman at the time of her marriage. On the other hand, sexual intercourse becomes an immediate expectation from the woman after her marriage. Non-consummation of marriage is even provided as grounds of divorce. However, it

¹² Moaddab, A., McCullough, L.B., Chervenak, F.A., Dildy, G.A., & Shamshirsaz, A.A. (2016). Virginity testing in Professional Obstetric and Gynaecological Ethics. *The Lancet*, 388(10039), 98-100. Retrieved from [https://doi.org/10.1016/S0140-6736\(15\)01275-1](https://doi.org/10.1016/S0140-6736(15)01275-1)

should be remembered that forced sexual relations within marriage (marital rape) is a civil offence under PWDVA ACT 2005 and the woman cannot be forced to have sex as a necessary act in the consummation of marriage or in the course of marriage.

Case Study:

Sadhavis, sexuality and societal morality

In a midsized city in India with two medical colleges, a religious sect was having a group of sadhavis undertaking religious as well as social work. This sect had a very sizeable following in the city. Some of these sadhavis were working in collaboration with an NGO working among children for last two decades. One of the projects of the NGO was to educate and rehabilitate street children in few Children's Homes established by it. Sadhavis of this sect were managing one of these homes for some years. They had left their homes at an early age and fully dedicated themselves to religious and social work. One of them was 45 years and another 38 years old. They were very popular in the community for their dedication, caring nature and simple life-style. The children's home run by them had two rooms - a big room that served as dormitory where the children slept at night. By day it doubled as a place for educational classes for the 21 children (all boys) housed in the Home. The second small room had two cots and tables and chairs where these two sadhavis used to live. A door connected both the rooms, and both rooms had a door each opening to the outside courtyard independently. At night the children slept in the dormitory, the room connecting two rooms used to remain locked from the side of the sadhavis room and if a child needing assistance had to knock to be heard. The young inmates were provided basic education and taught skills - most of them started doing some work in the city or elsewhere using such skills by the age of 14 or 15 years and used to leave this Home. The sadhavis and the NGO used to maintain contact with them as these rehabilitated children looked at the Home as their own home and sadhavis like their mother.

One day, at around 5 a.m. a small child needed the assistance of the sadhavi. He knocked at the door of sadhavi's room several times, but did not get any response. Hearing the noise other children got up and

they all knocked. The children went to the courtyard and knocked on the other door of the sadhavi's room, found it unlocked, went inside; and found both sadhavis dead in a pool of blood. The children panicked and shouted for help, when the neighbours came rushing in. The news spread like wildfire in the town, the priest and other sadhavis of the sect gathered there in no time. They and all the children were crying around the dead bodies when police reached the scene. The police had hard time to get all of them out, cordon off the area and look for clues. Both sadhavis had been stabbed but no weapon was found. A team of forensic experts also visited the scene of crime.

The following morning, there was a bandh in the city to pay respect to the deceased, and the newspaper ran the front-page story of the murder, and wrote superlative articles on the dedication and popularity of the sadhavis, and above all, blasted the police for the deterioration of the law and order. Speculations were rife about the involvement of a powerful underworld gang having political connections that had attempted to grab the Children's Home which occupied a large amount of land. The police said that they were on the trail of murderers but they would be able to say more after the post-mortem of the bodies. The Chief Minister of the State issued a statement expressing sympathy with the head of the sect to which the sadhavis belonged, and severely pulled up the police chief for inefficiency and negligence. The post-mortem of both bodies was conducted by early afternoon.

On the second day after the murder, three of the four newspapers in the city published front-page news with a different story on the murders and the sadhavis. Citing a reliable source, they said that the autopsy had revealed they were not raped but at the same time it showed that they were used to having sexual intercourse and one of them was also suffering from a sexually transmitted disease. They also stated that perhaps police was investigating sadhavis' relationship with ex-inmates of the Home - the boys who grew up there and subsequently moved to some other towns; and also with some sadhus or priests of the sect who were frequent visitors to the Home and with the head of the NGO. In these stories there were indirect references to the licentious behaviour of the men and women who were supposed to remain pure. With the publication of these stories, the public outcry on the murder suddenly

died down; even the priests of the sect stopped giving statements. In the following few days the furore subsided; the media moved the story to the inside pages, and mainly reported statements of police about the progress of investigation.

Three months after the murder a meeting of the sadhavis took place where all of them revealed that since the murder, their image in the community had gone down, people were regarding them as of loose moral character and they were finding it difficult to continue with their work. At that time, a lawyer, journalist and a doctor along with a few other public-spirited individuals constituted an investigation team. These sadhavis provided them with a copy of the autopsy report and they went around for two weeks interviewing doctors, who were involved in conducting the autopsy, police officers, newspaper reporters and many others. It was discovered that apart from findings of injuries that killed them there were only two other positive findings. In both women the hymen was found to have been absent or torn, and vaginas were patulous; and there was a small inaugural wart near the vagina of the younger woman. The autopsy report was dated seven days after the murder and the doctor who did the autopsy refused to take responsibility for the kind of interpretation given by the media. He also said that at the time of autopsy his senior professor was present and he actually had used these bodies to teach five students from a medical college. The said professor had actually said some uncharitable things about the women in general and the morality of sadhavis and sadhus in religious sects. The professor refused to talk to the team saying that he had not done the autopsies.

The team also discovered that a few years back both sadhavis had undergone D&C at the public hospital due to some severe menstrual problems. The reporters of the newspapers claimed that they had written truthfully whatever was reported to them but they refused to divulge their source.

When the investigation team released its report there was furore in public. While acrimonious debates continued in the media, the followers of the sect that had kept quiet for so long suddenly felt that the sadhavis of their religion were deliberately maligned, and they protested.

However, the murderers of sadhavis were never found and the police closed the files.

Questions for Discussion

- Did doctors and reporters do anything wrong? If so, what? Why did they do it? Were they correct in refusing to apologise?
- Was it correct for a citizens' team to do its own investigation in this episode? Why? What should be the rights and ethical responsibilities of the team?
- What are the ethical obligations of forensic doctors?

Key Points for Discussion

1. The post-mortem was delayed and the doctor made unwelcoming remarks about the sadhavis while teaching his students. Doctors should have known that the hymen can tear naturally.
2. The media was wrong in reporting information without thoroughly investigating the matter. They also focused only on the sexual history of the sadhavis rather than the murder itself.
3. There was a need for independent investigations, which required permission from the authorities and that data are made available. The investigation should have been conducted with caution in a systematic and unbiased manner. Even if the truth is unpalatable, there should have been a readiness to publish.
4. The sadhavis, the children and society were found to be victims while the health providers, journalists, politicians and police formed a chain of beneficiaries. When morality comes into the picture, the larger issue of ethics and rights were forgotten.

II. Sterilisation and family planning

Context: Pregnancy, delivery, Paternity, Legitimacy, Artificial Insemination, Fertilisation in Vitro, Sterilisation (Family Planning Measures).

Content

- Family planning is often regarded as the woman's responsibility, but there is growing recognition of the need to involve men in family planning programmes.
- Sterilisation and family planning measures: Women should have access to temporary methods of contraception so that they are able to exercise their sexual and reproductive rights. However, some women may not be in a position to negotiate contraception use with their partners. Even after undergoing sterilisation, unprotected sex within three months of a vasectomy or failure of tubectomy may result in pregnancy. These can often result in allegations of extra marital affairs and subsequent violence against women.
- Women often seek medical termination of pregnancy due to failure of contraception as is evident from the number of married woman seeking medical termination of pregnancy under the MTP Act. The Act is biased, with the precondition that the women seeking abortion have to be married and contraceptive failure as a precondition for abortion is applied for them. Significantly, among sexual partners prevention of pregnancy is always again the duty or responsibility of the woman who however has no rights to negotiating for contraceptive usage.
- Informing women about the advantages and risks of all methods of contraception would enable her to strategise her contraception requirements based on accessibility, availability and need. Counselling the couple after sterilisation is also important to sensitise male partners on the chances of pregnancy.
- Men's fertility intentions, reproductive preferences and their attitude towards family planning seem to influence the fertility behaviour of their wives and their attitude towards the use of contraceptives. Although male sterilisation operations are easier to perform, the focus for family planning is invariably on women. Myths about male sterilisation such as it impacts a man's virility, leads to inability to carry out heavy work etc have not been debunked. Despite its benefits no efforts have been made to promote male sterilisation. Therefore new attempts to promote reproductive health should focus on contraceptives use by men specifically at all levels of the programme.
- International human rights bodies have explicitly condemned coercive population policies and programmes, noting that government or health-care workers should not subject women and men to forced sterilisation or impose decisions related to sterilisation.

III. Infertility, ART, Surrogacy and Legitimacy

A) Infertility:

Stigma: Inability to have a child or to become pregnant can result in being greatly ostracised, feared or shunned, and may be used as grounds for divorce. Such a stigma justifies keeping such women away from family rituals and family traditions. Infertility has a disproportionate effect on women and the burden of infertility is often ascribed to women, one of the reasons being that pregnancy and child birth are manifested in the woman.

Violence: Domestic Violence (DV) has been shown to have significant associations with individuals and couples suffering from unwanted childlessness or involuntary infertility.

Investigation of infertility in men is largely non-invasive while for women, it is invasive. Despite this, women are often examined first through invasive procedures and only when the wife is proved fertile, is the husband examined. Though both male and female are equal contributors in deciding the outcome of insemination, it generally starts with the gender bias that the female is "abnormal" (infertile) and the male is "normal" (fertile).

B) Assisted Reproductive Technologies (ART):

Due to prevailing preference for sons in the society, women who give birth to daughters are considered inferior to women who bear sons and often subjected to violence. It is important to re-iterate that women have no role in determining the sex of the foetus as men contribute the 'Y' chromosome. Additionally, preference for sons and discrimination against daughters is an unacceptable social norm. The PCPNDT Act bans not just sex selective abortions but also preconception sex selection through ART.

C) Surrogacy:

Even though opting to be a surrogate mother is a woman's choice, many women who do so may be in difficult financial circumstances. In such situations, the 'choice' of a woman may become very limited. Her economic situation poverty, financial emergencies due to illness, etc. may compel her to have the procedure. Providers need to understand that "consent" plays out differently in the case of such women. In

the absence of enforceable protocols to protect the rights of surrogates, women from already marginalised communities become further disempowered. Providers can offer legal counselling and let the surrogate know of all her rights and options. This will enable the woman to make a more informed decision around surrogacy.

Case Study:

Baby Manji

(Source: Points Kari (n.d) commercial surrogacy and fertility tourism in india: The Case of Baby Manji. Durham, USA: The Kenan Institute for Ethics. Retrieved from <http://web.duke.edu/kenanethics/casestudies/babymanji.pdf>

Japanese couple Ikufumi and Yuki Yamada travelled to India in late 2007 to consult the fertility specialist Dr. Nayna Patel about hiring a surrogate mother to bear a child for them. The doctor arranged a surrogacy contract with Pritiben Mehta, a married Indian woman with children. Dr. Patel supervised the creation of an embryo from Ikufumi Yamada's sperm and an egg harvested from an anonymous Indian woman. The embryo was then implanted into Mehta's womb. In June 2008, the Yamadas divorced, and a month later Baby Manji was born to the surrogate mother. Although Ikufumi wanted to raise the child, his ex-wife did not. Suddenly, Baby Manji had three mothers-the intended mother who had contracted for the surrogacy, the egg donor, and the gestational surrogate-yet legally she had none. The surrogacy contract did not cover such a situation. Nor did any existing law help to clarify the matter. Both the parentage and the nationality of Baby Manji were impossible to determine under existing definitions of family and citizenship under Indian and Japanese law. The situation soon grew into a legal and diplomatic crisis. The case of Baby Manji illustrates the complexity and challenges faced by institutions in the face of emerging technologies.

Questions for Discussion

- Can an unmarried woman become surrogate mother?
- Who gets the primary right over the child?

Key Points for Discussion

1. Role of lawyers in surrogacy clinics to protect the interests of clinics.
2. Rights of abandoned or disabled babies born out of surrogacy
3. Contradictions: A surrogate mother cannot claim custody of the child, but if the contract parents refuse the baby, then she is compelled to accept the baby.
4. Legitimacy: Concerns related to legitimacy of a child born out of wedlock and / or after 280 days of husband's death are considered illegitimate. Thus the sexual rights of woman outside the marriage are not recognised whereas such societal restrictions are not imposed on men. Thus there is bias against sexual needs of the woman. The children who are born as illegitimate have to be adopted to get the status of legitimacy.
5. According to Indian Council for Medical Research (ICMR) guidelines only married women with two children can become surrogate mothers, the guideline contradicts government's two child norm.

IV. Marital rape

- Marital rape refers to intercourse by a man with his wife through the use of force, threat of force, or physical violence, or when she is unable to give consent. Marital rape could be by the use of force only, a battering rape or a sadistic / obsessive rape. It is a non-consensual act of violent perversion by a husband against the wife where she is physically and sexually abused.
- Marital rape is not a criminal offence in India. Despite amendments, Law Commission recommendations and new legislations, one of the most humiliating and debilitating acts that a woman may be subject to is not an offence in India.
- Section 375, the provision of rape in the Indian Penal Code (IPC), echoing very archaic sentiments, mentions as its exception clause-"Sexual intercourse by man with his own wife, the wife not being under 15 years of age, is not rape." Section 376 of IPC provides punishment for rape. This contradicts the law related to Protection of women from domestic violence act (PWDVA) 2005, which recognises forced sex as a form of violence.

Semester 3

5. Medico legal aspects of sex, marriage and infant death



**Gender content added : Second trimester abortions and PCPNDT Act,
Gender discrimination and power dynamics in abuse of children,
women, disabled and elderly.**

Lecture name	: Medico legal aspects of sex, marriage and infant death
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion, Problem based learning, Case study, moot court
Resources	: 1. CEHAT and UNFPA. (2015). <i>Abortion, sex determination and gender biased sex selection: Answers to critical questions</i> . Mumbai, India: CEHAT and UNFPA. Retrieved from http://www.cehat.org/go/uploads/Publications/FAQs%20on%20Abortion.pdf
Handouts	: ---

Key Points

1. The Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT) Act and Medical Termination of Pregnancy (MTP) Act do not contradict each other.
2. Denying women access to safe abortion might force them to seek assistance from unsafe/ illegal providers.
3. Confidentiality of abortion seekers needs to be maintained even in cases of mandatory reporting laws. Laws related to sexual violence such as POCSO Act of 2012 and CLA Act of 2013 seek mandatory reporting of sexual offences, but doctors need to also recognise that survivors of sexual violence have a right to confidentiality; this needs to be upheld.
4. Confidentiality of the information about abortion seekers and investigation of offences under PCPNDT Act should be maintained.

Learning Outcomes

Knowledge	Skill	Attitude
Student should be aware of the various provisions of the PCPNDT and MTP Act.	Student should develop skill towards proper and effective documentation in routine practice complying with provisions of these acts.	Student needs to be sensitised to the implications of denying 2nd trimester abortion.
Student should know provisions under PCPNDT and MTP Acts and that they do not contradict each other.	Student should ensure that access to safe abortion is not restricted due to concerns around PCPNDT Act.	Student should recognise that MTP and PCPNDT Act are not conflated and do not contradict each other.
Student should be aware that mandatory reporting of sexual assault / rape is violating the right to confidentiality for women seeking MTP.	Student should seek informed consent of the woman respecting her autonomy and following law of the land.	Student should respect the right to safe abortion for all women who report with an unwanted pregnancy.

Context: Abortion, medical termination of pregnancy, battered baby syndrome, cot deaths and relevant sections of IPC and CrPC Act of 1973, MTP Act of 1971 and PCPNDT Act of 1994.

Note to Educator: *Be aware of legal provisions across various laws as well as doctor's ethical obligations to the patients.*

Content

The medical fraternity under pressure to curb sex selection often restricts women's access to abortion.

- Providers are reluctant to perform second trimester abortions because of potential legal issues, particularly when the woman already has daughters. There is a fear that

the abortion being requested may have followed a sex determination test and the doctor would be held liable.

- However, sex discrimination and selection is a manifestation of a larger system of deep rooted bias and discrimination against women in the society. Merely outlawing second trimester abortions or implementing other restrictive measures will have limited or no impact on dwindling sex ratios. Such measures will only serve to put women at risk and lead to the flourishing of illegal / unsafe providers. If women are forced to seek unsafe abortions, they will bear risk for increased morbidity and/or mortality.
- It is important to note that the PCPNDT Act of 1994 does not criminalise abortion. It addresses the issue of misuse of medical technology to identify or select sex of the foetus and criminalises such misuse for such sex selection undertaken for non-medical reasons. The MTP Act of 1971 specifies the conditions in which abortion is legal, where, by whom and with whose consent abortion can be performed. The PCPNDT Act of 1994, on the other hand regulates the use of pre-natal and preconception diagnostic techniques. The law criminalises use of preconception methods to select foetal sex and the conducting of tests to determine the sex of the foetus. This understanding is essential to ensure that rights of abortion seekers are not violated in the interest of safeguarding abortion providers from prosecution under PCPNDT Act of 1994.
- Right to confidentiality for women seeking medical termination of pregnancy: The MTP Act of 1971, recognises the right of the woman to MTP when her pregnancy is as a result of sexual violence. It also guarantees privacy and confidentiality of her information. But with the mandatory reporting laws of sexual violence (see 357C CrPC Act and Section 19 POCSO Act) now all these rights of the woman are being denied / affected because now such pregnancies as a result of sexual violence have to be mandatorily reported to the police (even if the woman does not want to report).

Activity

Four case studies have been provided (The educator can discuss any one of the four case studies below or all of them depending on the time available).

Case Study 1:

Ahalyabai is pregnant for the fourth time. Because of her extreme poverty, she has been unable to save the money needed for terminating her pregnancy and has delayed going to the government health centre for several months. She is just past the 16th week of pregnancy, when she finally manages to reach a health centre known to provide abortion services. At the centre, however, health workers and doctor abuse her accusing her of having come for a sex-selective abortion. Ahalyabai is unable to understand what is going on and pleads with them to help her but she does not know whether or not they will terminate her pregnancy.

Questions for Discussion

Q1: What will be the consequences if the doctor refuses to perform the medical termination of pregnancy?

A - Ahalyabai may visit a quack and have an unsafe abortion, may face health complications. She may have to continue with the unwanted pregnancy which may cause maternal morbidity and mortality.

Q2: List different actions that can be taken and the persons who can take them, so that women like Ahalyabai are not denied access to safe abortion services.

A - Educate doctors about the provisions of the MTP Act and dispel any misconceptions that they may have. Ensure that the abortion facilities are not turning away women on such grounds.

Case Study 2:

Lata lives in a village of a district that has become notorious in recent years for its very low female child sex-ratio. People of this district believe that increasing dowry demands for daughters' weddings are an important reason why couples would like to avoid having female children. This is Lata's second pregnancy. Her first child is a girl. Having found out through ultra-sound scanning that the sex of the foetus in the current pregnancy is female, Lata approaches a health centre for abortion. The doctor, after finding out that Lata's first child is a girl, refuses to conduct an abortion. Lata continues with her pregnancy

and delivers a female child. She faces serious violence and abuse in the household because of having produced a second daughter. In vulnerable health and mental state, Lata is traumatised and unable to cope with this situation.

Questions for Discussion

Q1: What are the different things a doctor can do in situations such as Lata's? Which of these will be supportive of her, and which, not?

A - Ensure private space to discuss laws that prohibit sex selection. Encourage Lata to discuss her domestic situation, relationship with her husband and if she is suffering from domestic violence, communicate to her that you believe her and she can trust you, provide her information about DV law and refer her to protection officer/social worker / NGO providing support services. Explain to her that living in abuse will impact her health.

Q2: List different actions that can be taken and the persons who can take them, so that sex-selective abortions do not take place in this area.

A - Create community level awareness on how gender and patriarchy play an important role leading to son preference. Discuss that the sex of the foetus is not dependent on women, but is an act of nature. Encourage communities to discuss that boys and girls are equal. Inform the community that sex selection is a crime under PCPNDT Act of 1994 and why it has been made a crime. Inform appropriate authority under PCPNDT Act of 1994 about the agency that carried out sex determination while also protecting Lata's privacy.

Case Study 3:

Mrs. A lives in a village in north Maharashtra, she has a daughter who is 5 years old and is pregnant now for the second time. Her husband decides to stand for local elections again and is worried about the outcome of the pregnancy. He wants a son but cannot have more than two children to stay eligible to stand for elections. He wants his wife to have an ultrasound and terminate the pregnancy if the foetus is female. She refuses and he threatens to send her back to her parents' home and marry again if she does not obey him. She goes to a private nursing

home and asks about USG but is told that the machine has been sealed and they have stopped performing second trimester abortions since PCPNDT officials have been conducting raids in the area. Her husband then makes arrangements for her to go to the neighbouring state for the ultrasound.

Questions for Discussion

Q1: What do you think is likely to happen next?

A - The husband may arrange for getting an ultrasound examination in another place and seek a sex selective abortion. If she has to continue the pregnancy she may face violence and neglect during pregnancy, which may have adverse effect on her physical and mental health, which may continue even after child birth. The new born girl may also face neglect and discrimination.

Q2: List different actions that can be taken and the persons who can take them, so that women like Mrs. A are not turned away by abortion providers

A - The doctor can report to the appropriate authority under PCPNDT Act against the USG centre for disclosing the sex of the foetus. Pressurizing a woman to have a sex selective abortion due to son preference and subjecting a woman to DV because she has had a girl child are against the law and forms of violence listed under the PWDVA Act. As Mrs A is facing domestic violence the doctor can make a Domestic Incident Report (DIR) and provide the necessary support to her.

Case Study 4:

S is a 23 year old woman and is in relationship with her boyfriend. Her boyfriend wishes to have sex with her without using contraception. Though S tries to convince him to use one, he argues saying he does not enjoy sex with a condom. He also said that since they are anyway going to get married soon she should not worry about the consequences. After a while S finds out that she is pregnant and informed her boyfriend, after which he stops taking her calls. She finally musters courage to go to the health care facility for an abortion. The doctors file a medico legal case, as she is unmarried and an investigation by the police will be carried out. The hospital has a procedure of recording a medico

legal case for single women seeking MTP services. But S just wants an abortion and does not want to file a MLC. The doctors say they cannot offer an abortion without filing a MLC.

Questions for Discussion

Q1: Identify the issues / problems faced by S?

A - Refusal by partner to use condom, desertion by boyfriend upon disclosure of pregnancy, record as a MLC case and pressure from doctor to file a police case. Some of the problems can be woman's reluctance to file a police complaint which can lead to doctors refusal to provide abortion services.

Q2: What according to you should a doctor do to ensure that she gets a safe abortion?

A- S is an adult woman who wants an abortion and does not want to file any complaint against her partner and that an MLC is not a requisite for an abortion by an unmarried woman. If an abortion is not provided, S will be pushed into getting an unsafe abortion or will have to pay a lot of money to get it from a private doctor. As MTP guarantees confidentiality for abortion seekers, the doctor can record an informed refusal to call police so that she is not denied abortion. This needs to be clearly stated in the records and informed to the police so that S is not harassed.

Role of Doctor

- A doctor should be aware that MTP Act of 1971 and PCPNDT Act of 1994 do not contradict with each other.
- A doctor should be aware that not all second trimester abortions are sex selective and denying them to women may land women in risky situations.
- A doctor should recognise that recording an MLC case in single adult pregnant women seeking abortions is a contravention of MTP Act of 1971.

Semester 3

6. Medico legal aspects of sex, marriage and infant death



Gender content added : Examination of sexual assault survivor, Irrelevance of past sexual history

Lecture name	: Medico legal aspects of sex, marriage and infant death
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion, Computer simulation and Case study
Resources	: 1. Reddy, J.N. (2014). Recent changes in medical examination of sexual violence cases. <i>JKAMLS</i> . 23(1), 36-40. ^{13,14}
Handouts	: ---

Key Points

1. Be aware of the medical as well as the forensic role in caring for survivors of sexual violence.

Learning Outcomes

Knowledge	Skill	Attitude
Student should understand different forms of sexual violence (SV) and its health consequences.	Student should be able to elicit history of SV in its various forms such as-vaginal, anal, oral from the survivor in a sensitive way.	Student should believe, validate and document history given by women, and not question the veracity of what she is saying.

¹³ Reddy, J. N. (2014). Recent changes in medical examination of sexual violence cases. *Journal of Karnataka Medico Legal Society*, 23(1), 36-40. Retrieved from <http://kamls.in/wp-content/uploads/2016/11/Vol-23-1-2014.pdf#page=36>

¹⁴ Reddy, J. N., Bhate-Deosthali, P., Contractor, S., & Rege, S. (2014). Responding to sexual assault. *Economic and Political Weekly* 49(48), 96-101.

Knowledge	Skill	Attitude
Student should know the standard prescribed format for documentation of findings of examination of a survivor of sexual violence.	Student should develop skill for collection preservation and dispatch of the evidentiary material collected examination while maintaining the chain of custody.	Student should be sensitised towards the necessity of this knowledge of this knowledge and skill, which ultimately affects the conviction rate.

Content

I. Definitions and forms of sexual violence:

- Sexual violence is a significant cause of physical and psychological harm and suffering for women and children. Although sexual violence mostly affects women and girls, boys are also subjected to child sexual abuse. Adult men, especially in police custody or prisons may also be subjected to sexual violence, as also sexual minorities, especially transgender community.
- Sexual violence takes various forms and perpetrators range from strangers to State agencies to intimate partners; evidence shows that perpetrators are usually persons known to the survivor.

The World Health Organization (WHO) defines Sexual Violence 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".¹⁵

- 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 person's consent to forced sexual intercourse-oral and sexual acts, child molestation, fondling and attempted rape.

¹⁵ Krug, EG., et. al., eds. *World report on violence and health*. Geneva, World Health Organization, (2002). Retrieved from http://www.who.int/violence_injury_prevention/violence/world_report/en/introduction.pdf

- Forms of sexual violence include:
 - a. coerced / forced sex in marriage or in live in relationships or dating relationships;
 - b. rape by strangers;
 - c. systematic rape during armed conflict, sexual slavery;
 - d. unwanted sexual advances or sexual harassment;
 - e. sexual abuse of children;
 - f. sexual abuse of people with mental and physical disabilities;
 - g. forced prostitution and trafficking for the purpose of sexual exploitation;
 - h. child and forced marriage;
 - i. denial of right to use contraception or to adopt other measures to protect against STIs;
 - j. forced abortion and forced sterilisation;
 - k. female genital cutting;
 - l. inspections of virginity;
 - m. forced exposure to pornography, and
 - n. forcibly disrobing and parading any person naked.

- The Criminal Law Amendment Act (CLA) of 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 recognised right to treatment for all survivors / victims of sexual violence by public and private health care facilities.

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

- Health professionals are legally mandated to play a dual role in responding to the survivors of sexual violence. First is to provide the required medical treatment and psychological support. Second is to assist survivors in their medico-legal proceedings by collecting evidence and ensuring good quality documentation.
- The first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs.
- Health professionals need to respond comprehensively to the needs of survivors. The components of a comprehensive response include:
 - a. providing necessary medical support to the survivor of sexual violence;
 - b. examination and evidence collection by following the protocols;
 - c. informed consent for examination, evidence collection and informing the police;
 - d. first contact psychological support and validation;
 - e. maintaining a clear and fool proof chain of custody of medical evidence collected;
 - f. referring to appropriate agencies for further assistance (e.g. Legal support services, shelter services, etc.).

The following 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.
- Emphasise that this is not loss of honour, modesty or chastity but a violation of his / her rights and it is the perpetrator who should be ashamed.

II. Facilitating medical procedures

- The health care provider (HCP) 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 marginalised groups such as children, persons with disability, LGBTI persons, sex workers or persons from minority may be required.
- Confidentiality should be ensured and the survivor should be assured that she/he may reveal the entire history to health professionals without fear of disclosure. The survivor may be persuaded to be frank and make a full disclosure.
- 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 other departments.

III. Seeking history, examination and collection of samples and consent taking

History taking and 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 equipments required for a thorough examination, and a kit containing all the items required for collecting and preserving physical evidence following sexual violence.

A survivor may approach a health facility under three circumstances:

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

- with a police requisition after police complaint; or
- with a court directive.

In all three circumstances, it is mandatory to seek informed consent/refusal for examination and evidence collection. Consent should be taken for examination, sample collection for clinical and forensic examination, treatment and police intimation as well.

- While taking the SV history the health care provider needs to be sensitive to the survivor as she has experienced a traumatic episode and s/he may not be able to provide all the details.
- An environment of trust needs to be created so that the survivor is able to speak out and no judgmental remarks should be passed.
- Health care provider needs to keep in mind that 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. Absence of injury may be due to: use of lubrication, inability of survivor to offer resistance to the assailant because of being drugged/ under the influence of a stupefying substance or threats or delay in reporting for examination.
- '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. Per -vaginum examination can be done only in adult women when medically indicated. Conducting a two finger test and commenting on the past sexual history of the woman and her character is an unscientific and insensitive practice.
- The status of hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence, and a torn hymen does not prove previous sexual intercourse. 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, oedema etc.) are to be documented.

While collecting medical evidence if the survivor is found to be positive for any sexually transmitted disease (STD), it needs to be corroborated with the accused. This would enable the doctor to secure proof on whether she contracted it from the accused of sexual violence proof of victimisation .

In case the survivor is found positive for an STD, the accused should also be tested for the same. This is a valuable contribution of evidence against the accused and should be made available to the police and prosecutor. The detailed documentation should also be mentioned to police and prosecutor.

- The health care provider should understand that height, weight and built of a survivor does not have any bearing on the episode of sexual assault. It is a myth that a well-built female cannot be raped.

IV. Carrying out medical examination

The purpose of forensic medical examinations is to form an opinion on the following:

- Whether a sexual act has been attempted or completed. 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. 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 glands between the labia with or without emission of semen or rupture of hymen.
- 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, absence of signs of struggle or of consequent injuries does not imply consent. Whether alcohol or drugs have been administered to the survivor needs to be ascertained.
- The age of the survivor needs to be verified in the case of adolescent girls / boys.

V. Components of psychological first aid

- Explain to the survivors that 'rape' is a violation of bodily integrity and not a loss of honour and that assault is an abuse of power and not an act of lust.

- Provide positive messaging such as "you are not responsible for rape"; "it is not about the clothes you wear". This will 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.

VI. Responding to persons from marginalised groups

Health professionals need to recognize specific health care needs of marginalized groups and respond to them in an appropriate, comprehensive and sensitive manner in a difficult situation. The MoHFW guidelines stem from recognition of the historical stigmatization faced by marginalized groups in accessing health services. For the purpose of these guidelines, marginalized groups are defined as

- 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.
- Individuals who face discrimination based on the sexual orientation they practice.
- Individuals who face discrimination because they are involved in sex work.
- Individuals with physical, psycho social and / or intellectual disability.
- Individuals from religious minorities, castes or tribes.

Role of Doctor

- Doctors need to be sensitive while conducting the examination for survivors of sexual violence.
- Confidentiality, privacy and dignity of patient should be maintained while conducting the examination.
- All the evidentiary material should be collected during a single examination. It should be well preserved and dispatched while maintaining the chain of custody. The doctor must fix an appointment for a follow up examination and care as symptoms of sexually transmitted infections or other health consequences may appear at a later stage.
- The survivor of sexual assault should not be made to go from one department to another in the hospital without reason and the entire process should be completed in a single sitting.

Semester 3

7. Legal and ethical aspects of the practice of Medicine



Gender content added : Ethical issues, beneficence, non - maleficence, justice, autonomy

Lecture name	: Legal and ethical aspects of the practice of Medicine
Subject	: FMT
Semester no	: 3
Duration	: 1 hour
Methodology	: Lecture, Discussion, Brain storming and Case study
Resources	: The Patient's Rights Charter-South Africa
Handouts	: ---

Key Points

1. To understand and practice principles of ethics such as beneficence, non - maleficence, justice, autonomy

Learning Outcomes

Knowledge	Skill	Attitude
Student should understand the four basic principles of ethics and its implications on practice	Student should be able to demonstrate ethical practice such as informed consent, respecting privacy, confidentiality and patient's rights	Student should integrate ethics into teaching and practice

Context: While teaching legal and ethical aspects of practice in medicine

Note to Educator: Be aware of legal and ethical obligations while treating patients.

Content

Respect for Persons / Autonomy Acknowledge a person's right to make choices, to hold views, and to take actions based on personal values and beliefs.

Justice Treat others equitably, distribute benefits / burdens fairly.

Non-maleficence (do no harm) Obligation not to inflict harm intentionally; In medical ethics, the physician's guiding Maxim is "First, do no harm."

Beneficence (do good) Provide benefits to persons and contribute to their welfare. Refers to an action done for the benefit of others.

Charter for patient's rights¹⁶ : (Developed by CEHAT in Indian context)

1. Right to access health care: Patients have a right to equal access to health services without any discrimination as regards class, caste, gender, HIV status or any other such factor.
2. Right to emergency treatment: As per Supreme Court Directive, patient should get emergency treatment irrespective of any legal or financial considerations.
3. Right to Information:
 - 3.1 The patient or designated representative should be provided with the necessary information about the likely cause of illness, investigations and treatment being planned, its cost, expected outcomes including likely complications, alternatives available and consequences of not taking treatment.
 - 3.2 The patient should have access to his / her clinical records at all times.

¹⁶ Centre for Enquiry into Health and Allied Themes. (2006). *Draft rule for Bombay Nursing Home Registration Act (Amendment)*. Mumbai, India: CEHAT. Retrieved from <http://www.cehat.org/go/uploads/Bnhra/bnhraDraft%20rules%20DGHS.pdf>

- 3.3 On admission, the patient shall be informed about the treating doctor, rules and regulations of the nursing home, approximate expenses that will be incurred.
- 3.4 At the time of discharge the patient should get a discharge card containing the summary of clinical findings, investigations, diagnosis, treatment, state of his/her health at the time of discharge and follow up advice.

4. Right to privacy:

All examinations should be carried out in a private environment with any person present on request of the patient. In case of a woman a female attendant must be present at the time of examination.

5. Right to Confidentiality:

All records of patients must be kept restricted to the team treating the patient. This information can be disclosed to any person only with patient's consent.

6. Right to autonomy and decision making:

6.1 An informed consent should be taken before giving anesthesia, blood or blood product transfusions and any invasive/high risk procedures/treatment.

6.2 In case of minor or unconscious patient, consent should be obtained from close relative.

6.3 The patient has a right to refuse treatment.,

6.4 The patients have a right to second opinion. The current physician should cooperate by providing necessary information to the second physician and the second opinion should be in writing.

7. Right to quality care:

Every patient should receive good quality care, which reflects satisfactory levels of technical performance and care that reflects consideration for personal values, beliefs and optimise comfort and dignity.

8. Right to seek redressal:

Every patient has the right to complain about any aspect of service provided and get it investigated by a competent authority if any. Every nursing home should display the information on such competent authority prominently.

9. In case of nursing home undertaking clinical research:

Documented policies and procedures should guide all research activities in compliance with the National and International Guidelines.

10. In case of HIV positive patients:

No person suffering from HIV should be denied care on the basis of the HIV status. Not having voluntary testing and counselling centre cannot become grounds to refuse care. For management of a patient who is HIV positive, the nursing home should follow guidelines circulated from time to time by NACO (National Aids Control Organization)

There are particular health conditions or issues of women where ethics play an important role:

1. Ethics in assisted reproductive technologies

- ART is a process that may benefit couples who are childless to produce a child that can be biologically and legally owned. The doctor should explain the ART in detail and inform the woman about the procedure in detail and the chances of its success. False promises should not be made. The health consequences of ART should also be explained.
- It is important to assess who would be the appropriate person to speak to the surrogate mother. It is also important to see the role of the physician when the commissioning mother and the surrogate woman have the same treating physician.
- There are issues related to conflict of interest if the treating doctor for surrogate mother and commissioning mother is the same.
- Doctors also need to recognise social consequences for women owing to infertility and understand factors that make women seek surrogate mothers for bearing a child.

- It is important for doctors to explain health consequences for women who decide to become surrogate mothers. There are physical health consequences for women who may be undergo repeat pregnancies for surrogacy and psychological health consequences of delivering baby and giving it up in surrogacy related contract, feelings of anxiety, depression.
- It is important for doctors to inform the couple about adoption as an option and make appropriate referrals.

2. The epidemic of hysterectomies

- Students are presented with a common occurrence: "Women beyond the age of 35 with a gynaecological complaint being routinely offered hysterectomy as the solution is unethical." The students are asked to respond to it.
- The medical system states the following reasons why the uterus becomes useless:
 - a. A medical system that values maternity without valuing women (non-maleficence)
 - b. A society that sees women as reproducers instead of productive citizens, valued as human beings (autonomy)
- Comprehensive health care requires that women experiencing excessive bleeding be followed up to assess whether the suggested treatment is working. This requires doctors to develop specific treatment plans for women and assessment on follow up. When hysterectomies are carried out, it is seen as a one stop intervention and therefore doctors feel that they do not have to carry out active interventions post hysterectomy. There is also a financial incentive for doctors to offer hysterectomies.
 - a. What are the types of morbidities?
 - Un-necessary health burden due to hormonal imbalance and musculo-skeletal disorders,

3. What are the ethical problems in mis-diagnosing / not treating women adequately?

- Beneficence: None, unless doctors teach themselves about the biologically and socially determined causes that make women sick.
- Non-maleficence: If doctors do not diagnose or sustain the efforts at treating both the physical conditions doctors can do more harm for women.

- Autonomy : Many women may not have the autonomy to take decisions about their health and doctors may be the only port of call.
- Justice: Doctors therefore have an ethical obligation to address gendered access to health services and provide gender sensitive services to women.

Role of Doctor

- Gender is a key component in the practice of medicine and an absolute necessity for the actual success of the treatment. Ethical practice requires that doctors learn of the differences both biological and gendered influences on health, health needs and health seeking behaviour.
- It makes doctors better professionals and enables them to treat patients better.

Reading

The Patient's Right Charter - South Africa

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this PATIENTS' RIGHTS CHARTER as a common standard for achieving the realisation of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

A healthy and safe environment

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

Participation in decision-making

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health

Access to healthcare

Everyone has the right of access to health care services that include:

- i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
- ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;

- iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
- v. palliative care that is affordable and effective in cases of incurable or terminal illness;
- vi. positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
- vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

Knowledge of one's health insurance / medical aid scheme

Every user must have information about his/her health insurance or medical aid scheme and can challenge, where necessary, the decisions of such health insurance or medical aid scheme.

Choice of health services

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

Be treated by a named health care provider

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

Confidentiality and privacy

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

Informed consent

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

Refusal of treatment

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

Be referred for a second opinion

Everyone has the right to be referred for a second opinion on request to a health provider of one's choice.

Continuity of care

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

Complain about health services

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

Responsibilities of Patients:

Every patient or client has the following responsibilities:

- To inform the health care providers on his or her wishes with regard to his or her death.
- To comply with the prescribed treatment or rehabilitation procedures.
- To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- To take care of health records in his or her possession.

- To take care of his or her health.
- To care for and protect the environment.
- To respect the rights of other patients and health providers.
- To utilise the health care system properly and not abuse it.
- To know his or her local health services and what they offer.
- To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

Semester 3

8. Practicals



Context : Medico-legal certificates.

Objective : To know protocols around Medical Examination of Sexual Violence.

Resource : Ministry of Health and Family Welfare (2014). *Guidelines and Protocols for Medico-legal care for survivors/victims of sexual violence*. Government of India. Retrieved from <https://mohfw.gov.in/sites/default/files/953522324.pdf>

Content

Medical Examination of victim of sexual violence

The Ministry of Health and Family Welfare (MoHFW), Government of India, recognises the critical role to be played by health professionals and health systems in caring for survivors/victims of sexual violence and collecting relevant evidence so that the culprit could be brought to the book. The protocol and guidelines recognise role of health sector in strengthening legal frameworks, developing comprehensive and multi-sectoral national strategies for preventing and eliminating all forms of sexual violence. Through these, the MoHFW 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 marginalisation based on disability, sexual orientation, caste, religion, class, have immediate access to health care services that includes 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. It recognises the need to create an enabling environment for survivors/victims where they can speak out about abuse without fear of being blamed, where they can receive empathetic support in their struggle for justice and rebuild their lives after the assault. The MoHFW feels that sensitive handling can reduce self blame and enhance healing for survivors.

The students should be provided with different case scenarios and asked to fill in the proforma so that they familiarize themselves with the format and also read the guidelines to be able to ask history of the incident, nature of sexual violence, documenting the history

in the required format, determine the nature of relevant evidence to be collected, procedure for drying and sealing of the evidence, treatment guidelines and psychological first aid. They should also practice drafting of provisional opinion and final opinion as mentioned in the Guidelines.

Accordingly the person can be referred to appropriate agencies like Police, NGOs, self-help groups, counsellors, etc., for appropriate redressal or to dedicated centres providing all the required services under one roof.

These guidelines for health workers are aimed at providing an appropriate understanding of sexual violence and the needs and rights of survivors / victims of sexual violence, and to highlight the medical and forensic responsibilities of health professionals.

The protocol and guidelines aim to achieve the following:

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

Gender Sensitive Clinical Practice

CHECKLIST TO ENSURE GENDER-SENSITIVE APPROACH IN CLINICAL FORENSIC MEDICINE EXAMINATIONS¹⁷

Items	Yes	No	NA
<p>General</p> <ul style="list-style-type: none"> ● Don't keep pregnant or distressed women waiting unnecessarily ● Provide adequate comfortable seating arrangement in relatively secure and private area ● Greet with warm, friendly smile, be attentive, maintain appropriate eye-contact ● Ensure dignity and respect 			
<p>Procedures in place to ensure privacy</p> <ul style="list-style-type: none"> ● Have an enclosed space to talk to the patient that ensures auditory and visual privacy, e.g. curtains, some amount of soundproofing <ul style="list-style-type: none"> a. During history taking b. During abdominal and pelvic examination ● Ensure that you speak with the patient alone, apart from speaking in the presence of relatives or accompanying persons 			

¹⁷ The following checklist was developed by the mentors and GME faculty under the Integrating Gender in Medical Education project in Maharashtra. It was felt that this must be taught to students before they are placed for their clinical postings. The checklist was reviewed by 37 medical educators across Maharashtra in a Workshop on Evolving Evidence based Clinical Practice held on 24th - 25th November, 2017 in Mumbai. This was organized by CEHAT in collaboration with the DMER, UNFPA, Seth GS Medical College and K.E.M.Hospital.

Items	Yes	No	NA
<p>Information obtained from patients treated in a confidential manner</p> <ul style="list-style-type: none"> ● Ensure that information given by the patient remains confidential in any form, verbal, written, recorded or computer-stored, and is not revealed to any person without the patients' consent ● Do not discuss patient with other staff or in front of other patients, with family or friends ● Make patients aware of and get consent for reasons for which the information given by them needs to be communicated to any other person: <ul style="list-style-type: none"> a. Other doctors b. Partner and family members c. Police / lawyers <p>This information may pertain to HIV status, incidence of domestic violence or sexual abuse</p>			
<p>Details of sexual and reproductive health i.e. menstrual history, childbirth / pregnancy, obtained in sensitive manner</p> <ul style="list-style-type: none"> ● Maintain a non-judgmental attitude, being sensitive and maintaining confidentiality towards disclosures about abortion, sex selection, sexual orientation, sexual practices and gender identity ● Maintain a non-judgmental attitude towards patient when provided with history regarding genital lesions ● Maintain a non-judgmental attitude towards sex workers 			

Items	Yes	No	NA
<p>Physical examination done in a manner that respects patient's privacy and dignity</p> <ul style="list-style-type: none"> ● Auditory and visual privacy ensured ● Appropriate covering of patient ● Ensure gender-appropriate chaperone wherever necessary ● Informed consent explaining indication, details of procedure ● Adequate lubrication, instruments at comfortable temperature (avoid hot / cold instruments) ● Be non-judgemental about patients/clients during examination irrespective of clinical conditions they present with - eg. STI, pregnancy out of marriage ● Explain findings, discuss diagnosis and further management plans after examination sensitively and countercheck to confirm that patient/legally authorized representative understands ● Be respectful in language and behaviour ● Autonomy - right to partial or total refusal for examination, treatment options ● Radiological examination (exposure to X-rays, sonography is contraindicated among pregnant women) 			
<p>Domestic violence assessment</p> <ul style="list-style-type: none"> ● Ensure that women or girls showing signs and symptoms of any form of violence will be assessed for domestic violence incidence 			

Items	Yes	No	NA
<p>Procedure or admission services</p> <ul style="list-style-type: none"> • All available options and alternate scenarios discussed with woman and if she desires so, with her partner • Informed consent - with adequate information on advantages, side effects and complications provided • No coercion or conditional provision 			
<p>Adolescent services</p> <ul style="list-style-type: none"> • Non-judgemental attitude regarding marital status, sexual practices, sexual orientation, request for contraception • Provision of services - information, contraception, abortion, referral • Consent of adolescent regarding disclosure of information to parent / guardian 			

CHECKLIST TO ENSURE GENDER-SENSITIVE APPROACH IN MEDICO LEGAL AUTOPSIES

Items	Yes	No	NA
<ul style="list-style-type: none"> • Be courteous, patient and sympathize with grieving relatives / friends • Provide adequate comfortable seating arrangement in relatively secure and private area to grieving relatives / friends • Ensure dignity and respect of the deceased as well as grieving relatives / friends • Explain procedures of conducting medico legal autopsies and purpose of collecting evidence and criminal investigation 			

MCQs on Gender Module of Forensic Medicine and Toxicology

1. **Gender of a person relates to**
 - a. Social constructed role
 - b. Biological characteristics
 - c. Differentiating as Male and Female
 - d. Genetic markers of individual identity

2. **Sex verification tests are by**
 - a. By verifying external genitals and internal gonads
 - b. By verifying internal gonads and chromosomal pattern assay
 - c. By verifying chromosomal pattern assay and hormonal assay
 - d. By verifying all the above

3. **Ethical aspects of Sex verification tests include all EXCEPT**
 - a. Tests are done compulsorily violating the autonomy of the individual
 - b. Test results are available for media scrutiny violating confidentiality
 - c. Tests are done on voluntary request by seeking informed consent of the individual
 - d. Tests are invasive and abusive violating the autonomy of the individual

4. **Role of doctor in handling domestic violence cases is all EXCEPT**
 - a. Draft Domestic incident report if the victim reaches hospital directly
 - b. Persuade victim to lodge a criminal complaint against the abuser
 - c. Treat the victim immediately for physical and psychological consequences
 - d. Provide documents of care and treatment free of cost

5. **Domestic violence as defined under PWDVA law includes**
 - a. Physical and sexual violence
 - b. Physical, sexual and economic violence
 - c. Economic and Mental violence
 - d. All of the above

6. **Role of doctor during recording of dying declaration**
 - a. Certifying compos mentis
 - b. Physically present right throughout the recording
 - c. Cross examine the person giving declaration
 - d. Administer oath before recording

7. **Domestic violence includes all EXCEPT**
 - a. Leads to health consequences
 - b. Addresses forced sexual relations within contract of marriage
 - c. Violence against children
 - d. It is a criminal offence

8. **Gender based violence is high in the society due to**
 - a. Power imbalance between perpetrator and victim
 - b. Lack of medical evidence on the victim
 - c. Poor investigation of such cases by police
 - d. Low conviction rate in Courts

9. **Due to gender discrimination Lesbian women suffer**
 - a. Corrective rape and / or coerced marriage
 - b. Physical and verbal abuse
 - c. Restricting mobility and/or expulsion from home
 - d. All of the above

10. **Forced sexual relations within the contract of marriage is all EXCEPT**
 - a. Civil offence punishable under Domestic Violence Act
 - b. Punishable under POCSO Act if wife is less than 18 years
 - c. Punishable under section 375 IPC if wife is more than 18 years
 - d. Punishable under section 375IPC if wife is less than 18 years

11. **Patriarchy means all EXCEPT**
 - a. social system that discriminates on the basis of gender.
 - b. Allowing women to inherit property
 - c. men are more likely to be placed in a position of power
 - d. Control over women's reproduction and sexuality

12. Which of the following statement is true?

- a. A woman who is well built cannot be raped
- b. In Gang rape case there should always be resistance injuries on the victim
- c. Hymen examination does not accurately or reliably predict virginity status
- d. Non-consummation of marriage is not a ground for divorce

13. Which of the following statement is true?

- a. Family planning is woman's responsibility
- b. Women always are in a position to negotiate contraception use with their partners
- c. Unmarried women have right to terminate pregnancy for contraceptive failure
- d. International human rights bodies have explicitly condemned coercive population policies

14. Which of the following statement is false?

- a. women have no role in determining the sex of the foetus
- b. Investigation of infertility in men is largely non-invasive
- c. Child born during a lawful wedlock is illegitimate
- d. Married women with two children can only become surrogate mothers

15. Which of the following statement is false?

- a. PCPNDT Act does not criminalise abortion
- b. MTP Act and PCPNDT Act contradict with each other.
- c. MTP Act specifies the conditions in which abortion is legal
- d. PCPNDT Act regulates the use of pre-natal and preconception diagnostic techniques.

16. Role of doctor handling a case of sexual violence is all EXCEPT

- a. Doctors need to be sensitive while conducting the examination
- b. Confidentiality, privacy and dignity of victim should be maintained
- c. Entire victim examination and care should be done in one sitting
- d. Evidentiary material should be collected, preserved and dispatched

17. Which of the following statement is false with regard to Patients' Rights charter?

- a. Patient has a right to refuse treatment
- b. Patients have a right to second opinion
- c. Patients cannot force that all examinations be carried out in a private environment
- d. Patient has the right to complain about any aspect of service provided

18. Which of the following statement is true with regard to medical certificates?

- a. Copy of entire medical certificate of victim of sexual violence is given free of cost immediately after the victim examination to victim
- b. Copy of entire medical certificate of accused of sexual violence is given immediately after the accused examination to accused
- c. Copy of entire medical certificate of victim of sexual violence is given free of cost immediately after the victim examination to accused
- d. Copy of entire medical certificate of accused of sexual violence is given immediately after the accused examination to victim

Answers on Gender Module of Forensic Medicine and Toxicology

1. a
2. d
3. c
4. b
5. d
6. a
7. d
8. a
9. d
10. c
11. b
12. c
13. d
14. c
15. b
16. c
17. c
18. a



Centre for Enquiry Into Health And Allied Themes

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

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

Gender integrated modules for the following subjects are available:

- | | |
|-------------------------------|-------------------------|
| 1. Community Medicine | ISBN: 978-81-89042-78-3 |
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