FROM REPORTED CRIME TO HIDDEN HARM: A VICTIM-CENTRED INSTITUTIONAL RESPONSE FRAMEWORK FOR GENDER-BASED VIOLENCE AGAINST WOMEN AND CHILDREN

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ABSTRACT

Gender-based violence against women and children is not institutionally resolved merely because a complaint has been lodged. In many cases, the First Information Report, medical intake, school disclosure, or helpline call is only the first point at which a longer pattern of hidden harm becomes visible to the state. This article develops a victim-centred institutional response framework for gender-based violence against women and children in India. Drawing on the Protection of Women from Domestic Violence Act, 2005, the Protection of Children from Sexual Offences Act, 2012, the Bharatiya Nagarik Suraksha Sanhita, 2023, One Stop Centre protocols, victim-compensation mechanisms, and international child-sensitive justice standards, it argues that institutional success must be measured beyond case registration. A survivor-centred response must include safe reception, immediate risk assessment, hiddenharm identification, medical and psychological care, evidence preservation, child-sensitive procedure, legal aid, shelter, compensation, institutional coordination, follow-up, and review of secondary victimisation. The article argues that dignity and evidentiary integrity are not opposing aims: when procedures are prompt, coordinated, trauma-informed, and legally careful, they strengthen both survivor protection and the reliability of evidence.

Keywords: gender-based violence; hidden harm; victim-centred justice; secondary victimisation; POCSO; domestic violence; One Stop Centres; victim compensation; childsensitive justice; institutional coordination

Introduction: Reported Crime and Hidden Harm

Filing a First Information Report (FIR), registering a medical intake form, disclosing abuse to a school authority, or contacting a helpline are the points at which gender-based violence becomes formally recognised by the state. These moments trigger the institutional response and determine how police, healthcare providers, courts, and welfare agencies become involved. However, they should not be mistaken for the beginning of the survivor's experience. Rather, they represent only the point at which the system first becomes aware of the harm. In many cases, the abuse has already occurred over months or years, and the survivor's recovery will continue long after the formal complaint has been made.

This distinction gives rise to the concept of **hidden harm**. Hidden harm refers to the indirect, cumulative, and often unrecorded consequences of crime that extend beyond the immediate criminal act. These consequences shape a survivor's vulnerability, capacity to seek help, and long-term recovery, yet they are frequently absent from official records such as the FIR, medical report, or charge sheet. As a result, an institutional response that focuses solely on the reported offence risks overlooking the conditions that continue to place survivors at risk.

Hidden harm can be understood through several interconnected dimensions. **Physical harm** includes untreated injuries, pregnancy, sexually transmitted infection (STI) risks, chronic pain, or disability arising from abuse. **Psychological harm** encompasses trauma, anxiety, depression, fear, dissociation, and fragmented memory, all of which may affect a survivor's ability to provide consistent testimony. **Economic harm** includes financial dependence on the perpetrator, unemployment, lack of independent income, or insecure housing, often preventing survivors from leaving abusive environments. **Familial harm** may involve threats regarding child custody, pressure from relatives to withdraw complaints, or dependence on an abusive caregiver. **Procedural harm** arises from repeated interviews, lengthy delays, hostile questioning, or insensitive treatment by institutions, contributing to secondary victimisation. **Social harm** includes stigma, public exposure of identity, school disruption, or social isolation. Finally, **continuing risk** refers to ongoing threats such as returning to an unsafe home, retaliation by the perpetrator, or coercive control that persists after disclosure.

An institutional response organised solely around the reported act tends to treat these surrounding conditions as peripheral, even though they often determine whether a survivor's safety and recovery actually improve. A framework attentive to hidden harm requires

institutions to identify these risks proactively during the first point of contact, recognising that survivors rarely disclose every aspect of their experience immediately and that trust develops gradually. Institutional success should therefore be measured not merely by whether a complaint has been registered or investigated, but by whether the underlying conditions that produced and sustained the violence have been identified, addressed, and monitored over time.

Research Question, Aim, and Methodological Note

Research Question: How can institutions respond to reported gender-based violence against women and children in a victim-centred manner that recognises hidden harm, preserves evidence, prevents secondary victimisation, and supports protection and rehabilitation?

Aim: To develop a victim-centred institutional response framework that moves beyond FIR registration to integrate safety assessment, medical care, evidence preservation, childsensitive procedures, institutional coordination, compensation, and rehabilitation for women and child survivors of gender-based violence.

This paper is a conceptual and doctrinal-policy synthesis. It neither presents new empirical fieldwork nor survivor interviews. Rather, it uses Indian statutory provisions, government service-delivery mechanisms, victim-compensation schemes, medical and child-sensitive justice guidelines, as well as international standards to build a practical institutional response structure. It is most useful in reshuffling the existing legal and service structures into a streamlined series of institutional functions starting from the initial disclosure, through protection, evidence preservation, rehabilitation, and review.

Conceptual Framework

If we talk about victim-centred institutional response, it means prioritising the victim's needs and rights, such as ensuring their safety, maintaining dignity, keeping up with consent, protecting privacy and acknowledging the psychological condition instead of just making the administrative processes easier or a basic assumption of distrust. And, it involves keeping victims well-informed about their situation, lessening the instances of having to recount the traumatic experiences, as well as making sure that blaming is never part of the communications.

Hidden harm, as explained earlier, is the conceptual opposite of recorded crime. Institutions that focus only on the recorded event can easily mistake a single conspicuous episode for the

entire problem. In contrast, it can well be a point of the whole pattern, mostly in the cases of domestic violence or long-term child abuse.

Institutional coordination also acknowledges that a single agency or actor cannot address all of a survivor's needs and characteristics. If a woman reports domestic violence, she may need police protection and arrest, medical evidence, a protection order, a shelter and counselling. In contrast, a child who discloses abuse may need CWC intervention, a support person, safeguarding at school level and a Special Court process. Coordination breakdowns are an autonomous harm; she will have to bear the same system over and over again.

Evidence-and-protection balance considers the rigorous nature of evidence and respect for survivor dignity to be equally persuasive priorities. Single events, explained processes that are carried out swiftly and calmly, should preserve stronger evidence than methods with multiple repetitions, unexplained procedures, and intimidating environments that retraumatise witnesses or result in weak, withdrawn testimony.

Women Survivors: Safety, Shelter, Economic Dependence, and Continuing Risk

Domestic violence is rarely a single incident; it is typically a continuing pattern of physical, emotional, sexual, and economic abuse. The Protection of Women from Domestic Violence Act, 2005, reflects this reality by providing protection orders, residence orders, and monetary relief alongside criminal law remedies.

A woman who discloses abuse may return to the same unsafe home within hours. Immediate protection should therefore not depend on whether she is ready to pursue formal legal proceedings. One Stop Centres, shelters, and Protection Officers must actively facilitate access to accommodation, legal remedies, and safety planning rather than requiring survivors to navigate these systems independently.

Economic dependence remains one of the greatest barriers to leaving abusive relationships. Without independent income, housing, or financial resources, many women have no practical means of escape. Monetary relief, legal aid, and livelihood support should therefore be treated as essential components of protection rather than welfare measures.

Healthcare should operate as the entry point into continuing medical, reproductive, and psychological care instead of being limited to the preparation of medico-legal reports.

Institutions must also recognise coercive control, including restrictions on movement, communication, and finances, as a continuing pattern requiring sustained intervention. Children living in violent households require separate safeguarding assessments coordinated with, but distinct from, their mother's case. Follow-up after registration is equally important because risks often change during the weeks and months following disclosure.

Child Victims: POCSO, CWC, Support Persons, and Child-Sensitive Justice

Child victims require procedures specifically designed around their developmental needs. Although the Protection of Children from Sexual Offences Act, 2012, provides child-friendly procedures, support persons, Special Courts, and identity protection, implementation remains inconsistent.

Many One Stop Centres face staff shortages, trained support persons are insufficient, specialised services remain inaccessible in remote areas, and trauma-informed policing varies considerably across jurisdictions. Institutional reluctance to register complaints, weak coordination between police, healthcare, and welfare agencies, delays in compensation, poor follow-up, and inadequate privacy safeguards further reduce the effectiveness of statutory protections.

These shortcomings reinforce rather than weaken the need for a coordinated institutional framework. Effective implementation requires sustained investment in personnel, specialised training, standardised referral protocols, regular monitoring of secondary victimisation, and long-term assessment of survivor outcomes beyond case closure.

Evidence Preservation Without Retraumatisation

Evidence preservation and survivor dignity are complementary rather than competing objectives. Trauma-informed procedures frequently improve both the quality of evidence and survivor well-being.

Physical injuries should be documented promptly with informed explanation before examination or photography. Sexual assault examinations should be conducted once, where possible, with informed consent, privacy, and proper forensic procedures. Clothing and other exhibits should be carefully preserved while ensuring replacement clothing is available. Medical documentation should be clearly explained to survivors, and pregnancy or sexually

transmitted infection findings should be accompanied by counselling. Digital evidence should preserve original metadata while protecting privacy, and survivor statements should be obtained through comprehensive interviews that minimise repeated questioning.

Compensation applications should be supported through organised documentation and legal assistance.

A prompt, consent-based, and trauma-informed process both strengthens evidence and reduces retraumatisation.

First Contact as the Point of Institutional Trust

The survivor's first interaction with an institution frequently determines future engagement with the justice system. Respectful communication, privacy, clear explanations, and immediate safety assessment establish trust, whereas disbelief, insensitive questioning, or delay often discourage continued participation.

Although statutory frameworks establish legal duties, practical barriers continue to undermine implementation. Staff shortages, inadequate trauma-informed training, weak interagency coordination, limited specialised services, delays in compensation, and inconsistent follow-up remain widespread. Addressing these barriers requires sustained investment, standardised referral systems, regular institutional audits, and accountability mechanisms that evaluate survivor outcomes rather than administrative compliance alone.

Institutional Coordination Across Agencies

No single institution can address every consequence of gender-based violence. Effective protection depends upon coordinated action across police, healthcare, welfare, legal aid, and judicial institutions.

The Protection of Women from Domestic Violence Act provides civil protective remedies, while the Protection of Children from Sexual Offences Act establishes child-sensitive procedures. The Bharatiya Nagarik Suraksha Sanhita, 2023, governs criminal procedure, investigation, and victim compensation. One Stop Centres provide integrated access to police assistance, medical care, counselling, shelter, and legal aid. District and State Legal Services Authorities facilitate legal representation and compensation claims. Child Welfare

Committees determine care and protection measures for children, while Women Helpline

(181) and Child Helpline (1098) provide entry points into the institutional network. WHO, UNODC, and UNICEF standards further inform trauma-informed healthcare and childsensitive justice.

Institutional coordination may be summarised as follows:

Institution	**Primary role**	**Coordination required**
Police	Complaint registration, safety assessment, investigation	OSC, hospital, CWC, Protection Officer
One Stop Centre	Integrated support	Police, hospital, shelter, DLSA/SLSA
Hospital	Treatment, forensic examination, MLC	Police, OSC, counsellor
Protection Officer	Domestic Violence Act remedies	Magistrate, police, shelter
Child Welfare Committee	Child protection decisions	Police, school, support person
DLSA/SLSA	Legal aid and compensation	Court, OSC
Special Court	Child-sensitive trial	Prosecutor, support person
School	Safeguarding and confidentiality	CWC, counsellor
Helplines	Initial response and referral	Police, OSC, CWC

Failures in coordination create additional harm by forcing survivors to repeat their experiences and delaying access to services. A designated case coordinator, ideally based within the One Stop Centre or Legal Services Authority, should ensure that records and referrals move with the survivor rather than requiring survivors to manage institutional processes themselves.

Secondary Victimisation as Institutional Harm

Secondary victimisation refers to harm caused not by the original offence but by institutional responses. Common examples include disbelief, repeated narration, delays, identity disclosure, pressure to compromise, insensitive medical examinations, hostile courtroom procedures, lack of interpretation support, unsafe return to abusive environments, and absence of follow-up.

These harms are avoidable because they arise from institutional practice rather than criminal conduct. Reducing them requires trauma-informed procedures, coordinated case management, privacy safeguards, timely investigations, and regular institutional review.

A Twelve-Stage Victim-Centred Institutional Response Framework

This article proposes a twelve-stage institutional response framework in which stages are sequential in principle but may overlap in practice.

Stage	**Purpose**	**Main actors**	**Victim-centred safeguard**
1. Safe reception	Respectful first response	Police, hospital, school, helpline, OSC	Privacy, calm communication
2. Immediate risk assessment	Identify continuing danger	Police, OSC, Protection Officer, CWC	Assess whether home is safe
3. Hidden harm identification	Identify ongoing vulnerabilities	Police, counsellor, CWC	Assess coercive control, dependence, threats
4. Medical and psychological care	Immediate treatment	Hospital, OSC	Consent and traumainformed care
5. Evidence preservation	Secure evidence	Police, hospital, forensic team	Single, explained procedures
6. Complaint and legal pathway	Register complaint	Police, legal aid	No pressure to compromise
7. Child-sensitive process	Activate child protections	Police, CWC, Support Person, Special Court	Child-friendly interviews
8. Referral to support services	Connect survivor with assistance	OSC, shelters, DLSA/SLSA	Survivor need not selfnavigate
9. Compensation and rehabilitation	Financial recovery	DLSA/SLSA, Protection Officer	Active application support
10. Protection and follow-up	Ongoing safety	Police, counsellor, Protection Officer	Scheduled risk review
11. Institutional coordination	Prevent fragmentation	OSC/DLSA coordinator	Shared referrals and records
12. Secondary victimisation audit	Monitor institutional performance	Police, hospitals, courts, OSC	Review delays, privacy breaches, repeated narration

The framework argues that institutional success should be measured not merely by complaint registration or prosecution, but by sustained survivor safety, dignity, coordinated service delivery, and long-term access to rehabilitation. Registration is only the beginning of the

survivor's journey; the effectiveness of the institutional response depends upon whether the survivor can safely progress from disclosure to recovery without encountering further avoidable harm.

Implementation Barriers and Safeguards

A publication-worthy account cannot treat statutory schemes as automatic fixes. Practical barriers routinely arise: understaffed One Stop Centres, shortages of trained support persons, weak rural access, shelter shortfalls, inconsistent police training, institutional reluctance to register complaints, weak inter-agency communication, slow compensation processing, poor follow-up, privacy breaches, and inadequate trauma-informed training generally.

These barriers don't invalidate the twelve-stage framework; they clarify what implementation requires: sustained funding, standardised referral protocols, regular secondary-victimisation audits, and monitoring of survivor outcomes beyond registration or closure. Without addressing them, even a well-designed framework risks functioning only on paper.

Conclusion

This article has argued that the institutional response to gender-based violence against women and children must begin where the formal record usually stops. An FIR, medical form, school

disclosure, or helpline call captures only the visible entry-point of harm; it does not automatically reveal economic dependence, coercive control, delayed disclosure, psychological injury, family pressure, unsafe housing, or continuing risk. A victim-centred institutional response must therefore move from case registration to coordinated protection. The proposed framework links safe reception, risk assessment, hidden-harm identification, medical and psychological care, evidence preservation, child-sensitive procedure, legal aid, shelter, compensation, follow-up, and secondary-victimisation review. Its central claim is that survivor dignity and evidentiary integrity need not be treated as competing goals. When institutions communicate clearly, reduce repeated narration, protect privacy, preserve evidence properly, and coordinate referrals, they strengthen both the survivor's recovery and the justice process. Institutional success should therefore be measured not only by whether a case is registered or concluded, but by whether the survivor remains safe, heard, protected, and supported after the first report.

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