Response of Health System to Sexual Violence

An exploratory study of six health facilities in two districts of Maharashtra

Amita Pitre, Meenu Pandey

Centre for Enquiry into Health and Allied Themes (CEHAT)

Published in December, 2009

By
Centre for Enquiry into Health and Allied Themes
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (East)
Mumbai - 400 055
Tel. : 91-22-26673571 / 26673154
Fax : 22-26673156
E-mail : cehat@vsnl.com
Website : www.cehat.org

Cover Designed by: Qudsiya Contractor

ISBN : 978-81-89042-49-3

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

Acknowledgments

We would like to thank Professor Lakshmi Lingam, Professor and Chairperson, Centre for Women's Studies. TISS for guiding us in the analysis of this study. She helped us to understand the data, which was unique in many ways and arriving at a methodology for analysing it. She also gave us feedback from time to time which helped us make the report meaningful. This report would not be complete without her moral support.

We would also like to thank two of our colleagues Joyce Patton and Aurina Chatterji who were with us throughout the study, but had to leave before the report was written. We owe them for the completion of this study.

We cannot forget to thank Dr. Amar Jesani, Trustee, Anusandhan Trust and Professor Vibhuti Patel, HOD, Department of Economics, SNDT Women's University, who introduced us to the problems in services for women facing violence and the women's anti-rape movement respectively. This motivated us to begin this research.

We wish to thank Padma Deosthali, Coordinator of CEHAT, for soliciting feedback on the report, organising a consultation for the same and for being patient while we completed the work. We wish to thank all the peer reviewers who gave valuable feedback on the first draft of this report. We need to mention the Program Development Committee of CEHAT and the Institutional Ethics Committee of Anusandhan Trust, which reviewed the proposal for research and gave directions for improvement. We thank all the members of the two bodies.
We would like to specially mention the efforts taken by Padma Prakash, (Editor), eSocialSciences, to edit the report and make it lucid and readable.

We thank the Directorate of Health Services, Maharashtra and the heads of various health facilities for giving us permission to conduct the study. The aim of this study is the improvement of services for women and children facing sexual violence and not to indict facilities which are doing their best in adverse circumstances. We have made every effort to maintain anonymity of the health facilities which helped us to conduct this research. We hope that the larger message of change will go through.

Funds for this research were provided by the Fund For Global Human Rights, Washington DC. We thank them for enabling us to conduct this research.

We would like to thank Centre For Enquiry Into Health and Allied Themes (CEHAT) for facilitating the completion of this research. Amita, one of the authors, was a full time researcher at CEHAT for seven years and then a few months as a consultant. Meenu, co-author, was also a researcher for one and half years with CEHAT.

Blank

Abbreviations

ACP	Assistant Commissioner of Police
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CH	Civil Hospital
CMO	Casualty Medical Officer
DNA	Deoxyribonucleic Acid
EDTA	Ethylene Diamine Tetra-acetic Acid
EPR	Emergency Police Register
FIR	First Information Report
HIV	Human Immunodeficiency Virus
IO	Investigating Officer
MAGMO	Maharashtra State Gazetted Medical Officer's Organisation
MBBS	Bachelor of Medicine and Bachelor of Surgery
BAMS	Bachelor of Ayurvedic Medicine and Surgery
MHSDP	Maharashtra Health Systems Development Project
MLC	Medico-Legal Case
MO	Medical Officer
MRT	Municipal Run Tertiary Hospital
NGO	Non Government Organisation
NRHM	National Rural Health Mission
OPD	Out Patient Department
PHC	Primary Health Centre
SDH	Sub-District Hospital
SEO	Special Executive Officer
SRT	State Run Tertiary Hospital
SRS	State Run Secondary Level Hospital
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UN	United Nations
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organisation
WPC	Woman Police Constable

Blank

Contents

Blank

Executive Summary

Sexual violence is a highly stigmatising form of violence. Precisely because of this it is invisible to the public, policy makers and agencies that need to respond to it. The public health system is an important source of care for women facing violence. Not only is the health facility the location for providing urgent medical attention but even more importantly this is where evidence is gathered that would help the criminal justice system to locate the victim and bring him to book. This evidence has to be gathered systematically, giving the survivor the least distress, and stored and saved in a prescribed manner if it is to be any use in the police system. This study focuses on the response of the public health system to sexual violence.

Conducted in the over-arching context of a collapsing public health system in Maharashtra, this small exploratory study of six health facilities at various levels of the public health system in two districts of Maharashtra, India describes the procedures followed in the public health system for women and children who have been subject to sexual assault, and analyses them from a gender perspective. It also attempts a comparative analysis of the procedures, the quality of medico-legal examination and health care, organisation of services, examination facilities, equipment, medical supplies and medicines in these facilities with the prescribed international and national norms.

The study uses semi-structured interviews with doctors and nurses, and a smaller number of counsellors, forensic laboratory technicians and police personnel and observation of examination rooms in the health facilities . Facilities were assessed on three kinds of indicators, medico-legal service provision, health care provision and gender sensitivity in the provision of services. The health facilities included a State Run Tertiary Hospital (SRT), a Municipal Run Tertiary Hospital (MRT), a State Run Secondary Level Hospital (SRS), a Civil Hospital (CH), a Sub-district Hospital (SDH) and a Primary Health Centre (PHC).

The assessment was on the basis of a 'Model of Optimum Quality of Care' that was developed through a review of literature. Facilities were graded comparing them to the model by reviewing each category of care that impacted on the quality of response of the facility to the survivors or violence and to the quality of evidence being accumulated.

On the issue of provision of critical services the study finds that the facilities were ill equipped to care for the survivors in a sympathetic and women-friendly manner. They were neither trained to do so and nor did they have in place adequate protocols for such care. Health care providers have no guidelines to follow regarding emergency contraception, pregnancy tests, diagnosis and treatment of sexually transmitted infections, counselling for HIV and other infections. There is no prophylaxis provided for HIV and Hepatitis B infection in any of the health facilities. The State Run Secondary Facility which examines up to 200 cases in a year, the maximum among the selected facilities, provides no health care.

Facilities did not fare well in gender sensitivity either. Other than the PHC where only one doctor is on duty, in all other facilities, the survivor was examined by more than one doctor. This is not only distressing to the woman but it also affects the quality of the evidence. None of the facilities had in place a policy that directed woman doctors to preferably examine survivors of violence. Counselling was not routinely provided. Psycho-social support was sought only for children who found it difficult to communicate and only in tertiary care hospitals.

Health professionals seem to think that evidence collection is their principal duty. However there were many lacunae in the procedure of collection and preservation of evidence. For example, neither air drying nor refrigeration are always available and there do not seem to be adequate procedures for safeguarding samples. There was often a delay in despatch of samples. Only three facilities had any standard protocol to follow for examination and documentation. Consent is taken in all facilities before examination, but consent procedures are not standardised and do not include permission to release examination findings to investigation agencies.

Facilities are not well equipped for child survivors. The two tertiary facilities had a child psychology unit each, one of which has closed down. None of the facilities have systematic linkages to organisations working with children. Very often families decide not to report sexual abuse and in such circumstances no other services are available to the child.

All facilities provided for a separate and adequate private room for examination. They were also equipped for basic evidence collection and collection of blood samples. Facilities were not woman friendly. Not a single facility provided a separate waiting room attached to the examination room, bathroom, shower facility, change of clothes and sanitary napkins. Overall, the tertiary facilities generally fared better than the rest. The sub-district hospital had difficulties procuring specialist help and PHCs fared poorly in all services.

The National Rural Health Mission and the Urban Renewal Mission are attempting to rejuvenate the rural and the urban health systems, respectively. Hopefully these improvements will also include services essential for women and children facing violence. On the basis of our findings in this study we are making specific recommendations on issues of quality of care, evidence gathering and police requirement and mandatory procedures.

- On issues of care: A standard protocol to be adopted for examination, treatment and documentation of sexual assault cases. A separate fully equipped examination room (other than Casualty) should be provided in all facilities. A 'Model of Optimum Quality of Care' to be adopted and implemented. Linkages to be developed with counselling centres, crisis centres, women's organisations, children's organisations, free legal aid providers and shelters. Training and gender sensitisation to be provided to enable examination, treatment and basic emotional support by all medical officers and nurses.

- On the issue of the criminal justice system's requirements: Forensic laboratories should provide periodic orientation to medical officers. All medical officers should be trained to conduct examination and provide treatment and only a single designated medical officer (other than Casualty Medical Officer) to be responsible for the entire examination. Mandatory police reporting should be reconsidered and its recall should be considered. A separate consent should be asked for reporting the case to the police. Health care should be provided to all irrespective of whether the case was reported to the police or not.

Chapter 1

Introduction

Sexual Violence is a highly stigmatising form of violence and precisely because of this it is invisible to the public, policy makers as well as various agencies which need to respond to it. The public health system is one of the important sources of care for women facing violence. This study focuses on the response of the public health system to sexual violence. This is a small exploratory study of six health facilities, selected from various levels of the public health system in two districts of Maharashtra, India. It describes the procedures followed in the public health system when accessed by women and children facing sexual assault, and analyses them from a gender perspective. It also attempts a comparative analysis of the procedures, quality of medico-legal examination and health care, organisation of services, examination facilities, equipments, medical supplies and medicines in these facilities with prescribed international and national norms. The conclusions of the study are summarised and recommendations suggested for the improvement of services.

Gender-based violence, a health and human rights issue

Violence against women has been on a steady rise for several years. From 1980s onwards it also became visible globally as a major issue hindering women's participation in development. Violence faced by women takes many forms and is pervasive throughout their lives. Sex selection[1], female genital mutilation, acid attacks, physical, sexual, psychological and verbal abuse by intimate partners ranging up to murder, 'honour killing'[2], rape and sexual violence during conflicts and at other times, branding of women as witches and burning them are just some of the prevalent modes of violence. Measure and forms of violence faced by women vary across the world, but there are no societies or cultures where none exists. Women face violence largely in their home, which are considered 'safe' places, mainly from known or trusted persons. In this context violence is used as a tool of subjugation. In contrast men face violence generally outside the home and from strangers. Almost all the violence perpetrated on women is by men. Violence against women may aptly be defined as 'gender based violence' or "*violence that is directed against a woman because she is a woman or that affects women disproportionately*". (CEDAW, General Recommendation 19).

Gender based violence constitutes a systematic form of 'discrimination' against women, which "impairs or nullifies the enjoyment by women of human rights and fundamental freedoms". (CEDAW, General Recommendation 19). These rights and freedoms include:

- the right to life;
- the right not to be subject to torture or cruel, inhuman or degrading treatment or punishment;
- the right to equal protection according to humanitarian norms in time of international or internal armed conflict;
- the right to liberty and security of person;

[1] Selective abortion of female foetuses or other means to eliminate unwanted female children

[2] Honour crimes are acts of violence, usually murder, committed by male family members against female family members, who are held to have brought dishonour upon the family. A woman can be targeted by (individuals within) her family for a variety of reasons, including: refusing to enter into an arranged marriage, being the victim of a sexual assault, seeking a divorce - even from an abusive husband - or (allegedly) committing adultery. The mere perception that a woman has behaved in a way that "dishonours" her family is sufficient to trigger an attack on her life. (Human Rights Watch. www.hrw.org)

- the right to equal protection under the law;
- the right to equality in the family;
- the right to the highest standard attainable of physical and mental health; and
- the right to just and favourable conditions of work.

The violation of these rights and consequent decreased women's participation in economic, social and political arena effectively make violence a human rights issue for women.

Studies all over the world now recognise that women face a large variety of fatal and non-fatal health consequences of violence. Apart from loss of life, other consequences include physical, mental, reproductive and sexual health problems and personality disorders both in the short and long term. Violence causes not only severe health consequences and disabilities but many healthy years of women's lives are lost, and considerable public and private funds are spent on restoring healthy and secure lives. This effectively makes gender based violence a public health issue.

Sexual violence as a form of gender-based violence

Sexual violence is defined as, *"Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women'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.".* (Jewkes, 2002). Sexual violence, thus defined covers a spectrum of sexual abuses ranging from sexual harassment and molestation to forced oral, vaginal or anal sex. It also underlines the fact that although forms of sexual violence differ only in their degree of violation, all violate a woman's sexual integrity. The terms sexual assault, sexual violence, sexual abuse and sexual offence are often used synonymously. Rape is also used synonymously with sexual assault in some parts of the world.

Health and social consequences of sexual violence

Sexual violence can have immediate as well as long term and severe repercussions for women's health and social well-being. These include physical injuries and mental trauma, risk of pregnancy and consequences of unsafe abortions, risk of sexually transmitted infections including HIV and long term psychological effects as well as personality disorders. There is a risk of losing life during the assault (as in rape-murders) or an increased likelihood of suicides as also 'honour killings'. Sexual violence may lead to Post Traumatic Stress Disorder (PTSD)[3] and a range of other psychological disorders including depression, anxiety, suicidal tendencies and phobias. Some psycho-somatic disorders such as gastro-intestinal problems (example, irritable bowel syndrome) are also known to occur. (World Report on Violence and Health, 2002).

A study of intimate partner sexual assault showed that most physically abused women also faced sexual assault, and they attributed one or more incident of sexually transmitted diseases and incidents of pregnancy to sexual abuse. Sexually assaulted women reported significantly higher incidence of Post Traumatic Stress Disorder (PTSD) than those only physically assaulted (McFarlane et al, 2005). Apart from these direct health consequences women may face severe social consequences such as being rejected by families, forced to leave their homes and change their identities and may be forced to go into hiding. Social and psychological stresses following abuse may force women into alcohol, drug and substance abuse and these in turn may add to the risk of further sexual abuse. Forced marriage with the perpetrator may be an added social consequence in some parts of the world (World Report on Violence and Health, 2002).

Studies in India have also documented health consequences of sexual violence. The physical and mental health of school going teenagers was significantly worse as measured by self-reported

[3] Post-Traumatic Stress Disorder, PTSD, is an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. (National Institute of Mental Health (NIMH), www.nimh.nih.gov).

complaints and General Health Questionnaire (GHQ) scores. Those who experienced forced sexual intercourse also had significantly poorer scores in their board examinations. (Patel, Andrew et al, 2001)

Coercive sexual experiences within marriages are observed to be associated with serious and far-reaching outcomes in the lives of young women. Unintended pregnancy and abortion as well as the experience of sexually transmitted infections, including HIV, appear to be more likely among young women who have experienced coercive sex than among others. Finally, adverse mental health and psychosocial outcomes are reported, including low self-esteem and depression. (Jejeebhoy, Bott, 2003).

Sexual Violence in India

Laws in India do not recognise a broad definition of sexual violence and rape as sexual assault or sexual violence. Rape is defined rather narrowly and is classified under various 'Sexual Offences' that loosely covers other crimes such as Attempt to Rape, Molestation, Eve teasing and Unnatural Sexual Offences.

The Rape Law in India was enacted in 1860 and amended in 1983 under the pressure of the women's movement. Rape is defined under section 375 of the Indian Penal Code as intercourse with the woman against her will or without her consent. Intercourse is further defined as penetration of the vagina with penis. Crimes involving oral sex or forced insertion of objects, bottles, sharp instruments into the vagina do not come under the ambit of rape. Thus many sexual crimes against very young girls as also brutal crimes with objects or involving oral sex are classified under a lesser offence, section 354 that defines molestation, an act done with the intent to outrage the modesty of a woman (Singh, 2004).

Forced anal sex or forced insertion of objects into the anus is also not rape. As peno-vaginal intercourse is the basis of rape law, many crimes against male children, crimes against men and forced anal sex are not considered Rape and are classified as 'Unnatural Sexual Offences' under section 377, which is also a lesser offence. Unnatural Sexual Offence is defined as 'carnal knowledge against the order of nature'. The crime of Rape if proved in court invites a minimum penalty of seven years. No such minimum penalty is defined for any of the lesser offences of Attempt to Rape, Molestation or Unnatural sexual offence. (Singh, 2004)

Thus, courts spend a lot of time in proving whether the crime was rape or a lesser offence, instead of grading the crime according to its severity. This also defeats the purpose of the understanding of sexual violence as a spectrum and not a series of discrete crimes.

In addition, the Indian Rape Law does not recognise sexual assault committed by a husband on his wife, except if the wife is less than 15 years of age. This, coupled with the fact that age of consent for sexual intercourse is 16 years, adds to the discrepancies in understanding sexual violence as a crime in India. To give an example, a woman between the age of 15 and 16 years, forced to have sexual intercourse by her husband cannot be said to be raped. It also runs contrary to the minimal legal age of marriage in India for girls which is 18 years. Much of the sexual violence in society is almost made invisible to the law as in the case of abuse faced by under aged but married women and the degree of sexual violence may be inadequately recognised in others, for example, violence faced by children.

These are also the definitions that are used in Forensic Science textbooks that train medical students in medico-legal procedures in sexual offences. Research and surveys conducted, however come across a wide variety of sexual abuses which are difficult to categorise according to these legal definitions and more generic terms such as sexual abuse, sexual crimes and sexual violence are used in describing them.

Prevalence and Context in India and Maharashtra

Sexual violence occurs in all age groups and both sexes in India, but is predominant among younger persons and women. Studies showed 63 to 76 per cent girls were abused as children, 30 to 40 per cent by a male family member and up to 30 per

cent by another known person. 25 per cent were raped and 50 per cent faced abused before the age of 12 years (Sakshi, 1997; Rahi 1999). A recent 13-state National Study by the Ministry of Women and Child Development, UNICEF and Save the Children, showed 69 per cent children were abused and 89 per cent perpetrators were family members. (Kacker, Varadan, Kumar, 2007) More boys reported facing physical abuse (72.61 per cent) than girls (65 per cent) in this study. Abusive behaviour ranged from rape, sodomy, exposure to pornographic material, fondling, forcible kissing and sexual advances, among others. Paedophilia and abuse is common in the orphanages and institutions for children, but conducting research in these settings is difficult, indicating a lack of transparency and accountability.

Teenaged school-going children too face a considerable risk of sexual abuse. A study in eight schools of Goa among higher secondary students reported that one third students were abused sexually in the previous year and about 47 per cent had faced abuse more than once in their lifetime. Those facing abuse were also at risk of other physical and verbal abuse. 53 per cent perpetrators were older students, 8 per cent were parents or relatives, 4 per cent were teachers and 27 per cent were miscellaneous. (Patel, Andrew et al, 2001) In another study of sexual offences brought to the AIIMS hospital between 1993 and 94, about 62 per cent victims were between 11-20 yrs of age and 20 per cent victims were 0-10 years of age. (Sarkar, Lalwani, Rautji et al, 2002). Sexual harassment of adolescents and women is a common feature in colleges, work places, streets and public places.

According to NFHS III, 45 per cent girls in India and 39 per cent of girls in Maharashtra get married before the legal age. Women who marry in adolescence or have an early and arranged marriage find their first sexual experience early and coerced. They are also more likely to continue facing sexual coercion within marriage. (Jejeebhoy, Bott, 2003).

In conflict times- war, ethnic strife, riots, political agitations- sexual violence against women serves as a strategic function, to terrorize civilian communities, wage war against certain communities, enforce hostile occupations, or seek revenge against the enemy. In India, for instance sexual assaults on women were reported during partition in 1947, in Kashmir and North East regions by armed forces, in the 1984 anti-Sikh riots, 2002 communal riots in Gujarat and recent political strife in Nandigram in West Bengal. Sexual violence on women in conflict situations serves as harming, intimidating, punishing women and through them subjugating the nation, region, religion, caste or ideology that they belong to. Daily occurring rapes and tolerance of violence against women during 'normal' times is heightened during social strife. (Kriti, 2005; MFC, 2002; Noorani, 2002). In conflict situations, where access to health facilities or medical care is non-existent, sexual violence has been reported to have dire consequences on women's physical and mental health (MFC, 2002).

The National Crime Statistics shows a 100 per cent increase in reported rape cases between 1990 (9518) and 2005 (18359) (Crime in India, 2005). The real picture could be much worse, as the official records of sexual violence in the National and State reports are an under-reporting and a telling commentary both on the status of women and law enforcement. Example, in a community based study conducted in Chandigarh it was found that with every case of sexual assault reported to authorities, 68 cases went unreported (Kumar, Dagar , 1995).

Maharashtra ranks fourth in crimes against women (NCRB, 2005). 55 per cent of crimes registered against women in 'Crime in Maharashtra, 2006' (Table 1) are related to domestic violence. Women facing domestic violence may also be experiencing marital sexual violence.

Of the reported crimes against women, about 45 per cent either constitute sexual violence or lead to sexual violence. These crime heads are Rape, Molestation, Sexual Harassment, Indecent Representation of Women, Kidnapping and Abduction (of Women and Girls), Importation of Girls and Immoral Traffic of girls. Each of the crime heads shows an increased rate, if compared to the previous years. Though the rate of reported

Table 1: Crime against Women, 2004 to 2006

Crime Head	2004	2005	2006	Percentage variation in 2006 as compared to 2005
Murder for Dowry	150	120	168	40
Attempt to Commit Murder for Dowry	94	76	98	28.95
Dowry Death	314	341	387	13.49
Abetment to commit suicide	1244	1436	1329	-7.45
Cruelty by Husband and Relatives	5646	6233	6738	8.1
Sati Prevention Act	0	0	0	0
Dowry Proh. Act	21	23	55	139.13
Rape	1388	1545	1500	-2.91
Kidnapping and Abduction (W & G)	787	851	921	8.23
Molestation	2831	3228	3479	7.78
Sexual Harassment	862	919	984	7.07
Importation of Girls	0	0	1	100
Immoral Traffic (P) Act	309	222	378	70.27
Indecent Rep. of Women (P) Act	11	8	9	12.5
TOTAL	13657	15002	16047	6.96

Source: Crime in Maharashtra, 2006

rape seems to have reduced as compared to the previous year, it is still on the rise if compared to year 2004.

Women facing violence may need to report to the police and access various services of the state such as shelters, lawyers, health facilities, public prosecutors, family and criminal courts among others. But research across the world shows that a large majority of women do not seek help or even report the crime when assaulted (Fisher et al, 2003; Rennison, 2002). Women are more likely to report violence in case of severe injury or threat of harm (Bachman, 1993; Schei, et al, 2003). Women are reluctant to report the crime because of the social stigma attached, the fear of being disbelieved, unfriendly and insensitive procedures followed by state machinery which makes women feel further victimised. Health Care Facilities often play an important part in detecting violence, reducing impact of violence, healing the mind and body and restoring the woman's confidence. Persons facing violence are more likely to visit a health care facility, though they may not report the crime (Shepherd et al, 1989; Kruger et al, 1998; Houry et al, 1999). Women facing violence utilize health facilities more often than others (Sansone et al, 1997; Koss et al, 1991; Koss 1994). How the health sector responds to women facing violence can send a strong message, either positive or negative. On the positive side an empathetic response, with provision of information and care can build her confidence and morale. Incidence of re-assault on women, physically and sexually assaulted by intimate partners, reduced by 32 per cent in those who received medical care (McFarlane et al, 2005). On the other hand, an apathetic response may increase the sense of worthlessness that survivors feel.

Obligations of Health Care Provider and Health Facility

Obligations on the health care providers and health facilities are imposed from the three perspectives of medical ethics, human rights and international law and legal requirements. Tenets of medical ethics require that caring for survivors of violence be a fundamental duty of the health professional and the health system. Ethics emphasize that health professionals give immediate care to every victim-survivor of violence, provide necessary

information to enable her to make an informed decision and provide a whole range of essential services including care and evidence collection and documentation for aiding any investigations that she may authorise. In doing so maintaining the dignity of the woman is given paramount importance.

With specific reference to sexual abuse and assault, ethicists have argued for the right of assaulted women to receive sexually transmitted infection counselling, diagnosis and treatment, emergency contraception, information and counselling on abortion irrespective of the religious beliefs of the service provider. If the service provider has conscientious objection, then it is still her fundamental responsibility to provide immediate referral to another service provider (Dickens, Cook, Kismodi, 2006). This would logically extend to other barriers of service provision beyond conscientious objection, where every effort must be made to make these services available.

To enable doctors to provide comprehensive services it is important to build linkages with women's organisations, crisis centres, shelters, human rights groups and lawyers. Training and education of doctors and pursuing a campaign for medical neutrality is important so that doctors perform their duty without taking sides (Jesani, 1998).

Human Rights and International Law

The Convention for Elimination of All Forms of Discrimination Against Women recognises the need for a national strategy and appropriate policies, protocols and capacity building for the health sector to comprehensively respond to gender based violence.

> State parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include….responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health (CEDAW, GR 24, Recommendation for Government Action, 29).
>
> Since gender based violence is a critical health issue for women, State Parties should ensure:
>
> Formulation of policies, including health care protocols and hospital procedures to address violence against women and sexual abuse of girl children and the provision of appropriate health service (CEDAW, GR 24, Key Elements, Article 12 (1), 15 (a).)
>
> Gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence (CEDAW, GR 24, Key Elements, Article 12 (1), 15 (b)).
>
> It emphasizes women's right to information, confidentiality, dignity and care for reproductive and sexual health concerns, the absence of which could be deterrence to access services for sexual violence. Women's concerns of emergency contraception, early pregnancy detection and safe abortion also need to be addressed on time.
>
> While lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment……. for diseases of the genital tract, for contraception….and where they have suffered sexual or physical violence (CEDAW, GR 24, Key Elements, Article 12 (1), 12 (d)).
>
> It requires states to eliminate discrimination against women in their access to the health and well-being of women….particularly in the areas of family planning, pregnancy….. (CEDAW, GR 24, Background, 2)

Legal Perspective: Doctors have the added responsibility to understand the woman's story, document injuries and collect and preserve any evidence to aid in the investigation of the case, all with the woman's consent. They are also required to testify as an expert witness in court. In this regard the 172nd report of the Law

Commission (of India) has recommended the following-

(1) Where, during the stage when any offence under section 376, section 376A, section 376B, section 376C, section 376D or section 376E is under investigation and it is proposed to get the victim examined by a medical expert, such examination shall be conducted by a registered medical practitioner, with the consent of the victim or of some person competent to give such consent on his/her behalf. In all cases, the victim should be sent for such examination without any delay. Provided that if the victim happens to be a female, the medical examination shall be conducted by a female medical officer, as far as possible.

(2) The registered medical practitioner to whom the victim is forwarded shall without delay examine the person and prepare a report specifically recording the result of his examination and giving the following details
   (i) the name and address of the victim and the person by whom he/she was brought, (ii) the age of the victim,
   (iii) marks of injuries, if any, on the person of the victim,
   (iv) general mental condition of the victim and
   (v) other material particulars, in reasonable detail.

(3) The report shall state precisely the reasons for each conclusion arrived at.

(4) The report shall specifically record that the consent of the victim or of some person competent to give such consent on his/her behalf to such examination had been obtained.

(5) The exact time of commencement and completion of the examination shall also be noted in the report, and the registered medical practitioner shall without delay, forward the report to the investigating officer, who shall forward it to the Magistrate referred to in section 173 as part of the documents referred to in clause (a) of sub-section (5) of that section.

(6) Nothing in this section shall be construed as rendering lawful an examination without the consent of the victim or any person competent to give such consent on his/her behalf. (paragraphs 4.5.1 and 4.5.2, supra)

(Source: 172nd report of Law Commission of India)

Role of Health Care Providers: The health care provider thus has dual responsibilities in providing services to women and children facing sexual violence. One is to provide physical and mental health care for effects of violence and the second is to document injuries and collect medical evidence to assist the investigation and prosecution of crime. Research conducted in Canada has shown that documentation of injuries in cases of sexual assault were significantly associated with legal outcome, that is, charge sheeting and conviction (McGregor et al, 1999; McGregor et al, 2002). The description of injuries and trauma given by the health professional after examination of sexually assaulted women and children was found helpful in civil law suits in awarding compensation to the victim (Soutoul et al, 1988**).**

Need for women friendly services: A thorough medical examination is required for good quality evidence documentation. This has the potential to further traumatize the woman. Therefore it is important to organize health services in a manner to maximize accessibility, help the survivor gain a sense of control over the situation and minimize unnecessary trauma.

Response of health facilities would thus depend upon:

- Organisation of services and women friendly procedures
- Adequate equipments, medical supplies required to address concerns of violence

- Training and sensitisation provided to health care providers
- Attitudes of health care providers

Literature from across the world and in India is reviewed here to know about the experiences of women and children facing sexual violence, reported to health services.

Barriers to accessing health care: Studies show that health facilities are often not women-centred in their approach and may not give equal importance to all the three above mentioned aspects, that is, health care, medico-legal services and gender sensitivity. Schei et al note,

> Adult sexual abuse has been, and still is, primarily framed within the legal system. The role of health professionals has been mainly in forensic documentation and collection of evidence. The victim's need of medical treatment and psychological counselling and follow up has been considered as secondary (Schei et al, 2003).

Schei et al also note that services may be variable depending on the reporting of the woman, example, women reporting directly to the health facility may get better health services but may not receive complete medico-legal services and the other way round if they present to the police instead. Barriers to services may also differ by region- urban or rural areas, stereotypical or otherwise presentation, grave injuries or no injuries, immediate or delayed reporting and an overall difference in developed and less developed countries, with services better in all former categories as compared to latter (Logan et al, 2005).

Organization of services: Women facing family violence and visiting Emergency Departments (ED)[4] have talked about the problems of lack of privacy, space and time to talk with the doctor, lack of continuity in care and lack of training and sensitization to enquire about episodes of violence (Bacchus et al, 2003). From 1980s onwards, nursing professionals in the United States have documented problems of long waits in the emergency department and less priority given to sexually assaulted women over life-threatening emergencies. This helped in the formulation of dedicated Sexual Assault Nurse Examiner (SANE) Programmes to care for survivors. Kelly and Regan have noted that health facilities in the United Kingdom often lack forensic specialists and gynecologists, women doctors, arrangements for privacy and woman's comfort, basic hygiene, ventilation, equipments and standardized kits for medico-legal examination (Kelly, Regan, 2003). A study of post rape services conducted in the city of Karachi in Pakistan highlighted lack of funding, inadequate equipment, training and even lack of separate examination room for the purposes of examination (Ahmad, Ghani, 2007).

Inadequate health care delivery: Studies to assess whether women received all components of health care that they ought to, have shown unsatisfactory services in one or the other component. Most studies point to inadequate emotional support, lack of standard policy on emergency contraception and HIV prophylaxis, lack of emergency contraception, prophylaxis for sexually transmitted infections and HIV, adequate information and follow-up (Amey & Bishai, 2002; Azikiwe et al, 2005; Suffla et al, 2001; Christofides et al, 2006). Health Care Providers also find it difficult to discuss risk of HIV infections with a traumatized woman (Christofides, Webster, Jewkes et al, 2003). Another study has documented women's feelings of humiliation, inadequate care and referral services and less importance given to their problems by Emergency Health Personnel (Campbell, J. et al, 1994; Ahmad and Ghani, 2007). It has also been noted by the same authors that in Pakistan, even though women received medico-legal services they were not provided with emergency contraception, prophylaxis for sexually transmitted infections and emotional support.

Inadequate medico-legal services and absence of standard protocols: Studies conducted in the United States to compare quality of services provided by SANEs in comparison to others have

[4] Emergency Department is the same as Casualty Department and is the place in the hospital where all emergencies, cases of trauma, violence and patients with no prior scheduled appointments are seen.

shown less than optimum medico-legal services by non-SANE set-ups (Sievers, Murphy, Miller, 2003). Situational Analysis of sexual assault services done in South Africa noted that health care providers' awareness of the presence of a standard protocol in the facility was significantly associated with a higher quality of care but such protocols were not available in all facilities. Standard kits for medical evidence collection in cases of rape were also not available uniformly to health care providers and there was often delay in examination while waiting for the police to provide the kits. Kits were also found to be incomplete at times and sometimes health care providers were not trained in their usage (Christofides, Webster, Jewkes et al, 2003). *The World Report on Violence and Health* specifically notes that standard and uniform protocols to guide medico-legal examination in cases of Sexual Assault, adds to the quality of care.

Inter-disciplinary approach neglected: Responding to sexual violence is often complex as it involves multiple disciplines and departments, such as police, health facilities, forensic laboratories and legal services. In addition, liaison between other civil society agencies to provide emotional and other social support and inter-disciplinary team work is important, but often lacking. In South Africa, situational analysis of health service providers across the country was unlikely to have any relationship with NGOs and therefore seldom referred patients to them for counselling. While most health providers had an average relationship with the police, up to a third of the providers described their relationship as poor depending on province. Nearly one in ten providers had no relationship with social workers (Christofides, Webster, Jewkes et al, 2003).

Models of service delivery, training and sensitization: Among models of service deliveries, those that had adequate personnel on site or on call to immediately respond, provided services 24 hours a day, had appropriate policies, protocols to guide service delivery, were trained and sensitized to women's needs and provided emotional support were better able to provide services and meet women's expectations. Among the SANE programs studied in the United States, those who offered at least two SANEs on site or 24 hour on-call facilities were rated the best model of service delivery (Plichta, Clements, Houseman, 2007). SANE programmes have consistently conducted a more complete medical evidence collection and provision of health care than other services. They also demonstrated better knowledge regarding the crime of sexual assault and skills in service provision. Testing for pregnancy and providing emergency contraception, screening and prophylaxis for sexually transmitted infections and HIV, were found to be high (more than 90 per cent) in most health settings where special 'Sexual Assault Nurse Examiner Programs' were in place pointing to role played by training and sensitization (Plichta et al, 2007; Ciancone et al, 2001).

In a situational analysis in South Africa, just over a quarter of all the providers had received any training on sexual assault and about half of them had received the training while they were undergraduates or undergoing basic training. The content of the training concentrated largely on medical treatment and conducting examinations in order to collect forensic specimens. Little attention was paid to addressing provider attitudes, the psychosocial aspects of sexual assault or gender issues (Christofides, Webster, Jewkes et al, 2003).

Facilities that had a designated health care provider for medico-legal services and where there was a considerable case load of relevant cases, service provision was better. (Christofides, Webster, Jewkes et al, 2003) Rohanna Ariffin has documented that services in Malaysia have improved ever since one-stop crisis centres for women became available for medico-legal examination. Malaysia is one of the few Asian countries where standardised kits are available for medico-legal examination (Ariffin, 1997)

A feminist centre providing services to women facing family violence was evaluated to assess whether better provision of preventive health care was linked to more number of women doctors appointed there. Instead it was found that irrespective of the sex of the service providing doctor, the policies, sensitization and women

friendly organization of services were instrumental in better service provision.

Desirable attributes of services from the perspective of women: A study conducted in one rural and one urban site in South Africa among women who had used post-rape services as well as women from the community as potential users of services, found that women preferred facilities which employed a sensitive, trained health care provider who could also provide counseling and where HIV prophylaxis was provided. They did not mind a thorough medical examination for evidence documentation if it provided them better recourse to moving the court procedure. Women were prepared to travel longer distances to access such services and also return for follow-up visits if required especially for counseling. (Christofides, Muirhead, Jewkes, Penn-Kekana, Conco, 2006) In other studies women wanted health providers to be non-judgmental and not to trivialize their problem. (Gerbert et al, 1996; Feder et al, 2006)

Background and rationale for the current study

There has been very little research in India on the response of the health system to violence against women and more specifically sexual violence. A facility based study in Mumbai revealed that over 20 per cent cases visiting the emergency department were definite cases of domestic violence and more than 40 per cent were cases of 'possible violence' More than 25 per cent of pregnant women visiting an ante natal clinic had experienced violence during pregnancy, mostly by family members, indicating that the health system is an important avenue to respond to violence. Yet, the authors of that study noted that doctors are not trained to recognise signs and symptoms of violence, to provide counselling or referral and to document the cases. (Daga, Jejeebhoy, Rajgopal, 2004). While conducting a 'Needs Assessment' for 'Dilaasa', a public hospital based crisis centre for women facing domestic violence, it was found that beyond immediate medical response health professionals felt helpless to respond further. Most did not identify violence as a health issue. Very often hospital staff shared various biases against marginalised social groups, indulged in victim blaming and felt that women provoked violence or were in some way responsible for it. They concur that training and gender sensitisation of staff is an important strategy towards better services (Deosthali, Maghanani, Malik, 2005).

Responding to sexual violence is a complex phenomenon and involves the participation of police, health facilities, forensic laboratories and prosecution. Little is known about how this team work takes place and what procedures are in place for effective response. No national guidelines or protocols regarding care or evidence collection are made mandatory for use (Pitre, 2006). Researchers and women's activists have documented several instances of delayed response, inadequate history taking, lack of sensitivity and health care and incomplete medico-legal evidence collection by health professionals in responding to sexual violence (Prakash 1993; Gudalure M. J. Cherian versus Union of India, 1992; Kulkarni, Jesani, D'Souza, 1997; D'souza, 1998). A study by Shally Prasad on medico-legal response to violence against women, conducted in New Delhi, showed several gaps in services including specifically for Sexual Assault (Prasad, 1999).

Studies also report that health care providers may be judgmental towards victims, may doubt whether that crime has been committed, may give low priority to the crime, make mistakes in documenting evidence and conduct inappropriate medical examinations (Prasad, 1999; Agnes, 2003; Bakshi, 2005). Thus it was felt important to study the procedures followed at the health facility in responding to women and children facing sexual violence and to assess the quality of health care and medico-legal services made available at the health facility.

Goals of the Study

This study aims to explore the procedures followed at the health facility, in responding to women and children facing sexual violence and to assess the quality of health care and medico-legal services made available at the health facility.

Specific Objectives:

1. To map with a gender perspective, the procedures followed when women and

children approach the health facility and the linkages made with referral facilities.

2. To compare the health care, medico-legal services provided at the facilities and gender sensitivity with a model of optimum quality of care.

A model of optimum quality of care is derived from review of literature and legal obligations in India and is used to provide a framework for comparison with existing quality of services. This model is described in detail in Chapter II. The research method used is described in Chapter III. Chapter IV describes the procedures followed. Chapter V analyses the availability of medical supplies in the examination room commonly used for examination, Chapter VI analyses the staff availability, services provided, organisation of services and measures for training. Chapter VII discusses the conclusions and recommendations of the study. We hope this study plays a small part in improving services for survivors of sexual violence.

Blank

Chapter 2

Model of Optimum Quality of Care

There is no pre-defined model of optimum quality of care for victim-survivors of sexual assault available as a reference for health care providers in India. Not only is such a model necessary to guide service provision in the health facility, it can also serve as a tool to monitor quality of services. In order to assess the service provision for women and children facing sexual assault, a review of existing guidance for health care providers was undertaken at the national and international levels. Obligations of the health sector were considered from the perspectives of Medical Ethics, Human Rights and International Law and Legal obligations within national arena. The model of optimum quality of care was informed by these obligations, derived from literature review cited in the introduction and the following:

1. World Health Organisation (2003), Guidelines for medico-legal care for victims of sexual violence, Geneva. This was a collaborative effort between WHO's Department of Injuries and Violence Prevention and Department of Gender and Women's Health. This is a comprehensive guideline for health care practitioners to provide services to victim-survivors of sexual violence.
2. CEHAT (1998 and 2005), Sexual Assault Care and Forensic Evidence Kit, Mumbai: The Sexual Assault Care and Forensic Evidence Kit is the first such kit made in India. It contains a step-wise protocol with body maps to guide examination, documentation and health provision for victim-survivors of sexual assault. It also contains all the material required for a thorough forensic examination and collection of samples. This was developed by Dr.Lalita D'Souza for CEHAT in 1998. It was widely reviewed by experts from the fields of Health, Forensic Medicine, Gynaecology, Law, Women's and Child Rights in 1998. In December 2005, a consultation of Forensic Experts and Gynaecologists was organised jointly by CEHAT and Mumbai Association of Forensic Experts at the Sir King Edward Memorial Hospital in Mumbai where again the protocol and contents of the kit were reviewed and the kit was finalised for use in the Public Health System. The kit has paid special attention to the process and content of consent for examination and presence of a kit and protocol as an indicator of prior readiness of the facility for examination. Issues such as need for a hospital policy to guide provision of services for women and children facing violence and especially sexual violence were discussed at the consultation.

3. Christofides N, Jewkes R, Lopez J, Dartnall E (August 2006): How to Conduct a Situational Analysis of Health Services for Survivors of Sexual Assault, Sexual Violence Research Initiative: Sexual Violence Research Initiative, Christofides N, Jewkes R, Lopez J, Dartnall E (August 2006)- This tool was developed by the South African Gender-based Violence and Health Initiative (SAGBVHI) for a national situational analysis of sexual assault services. The study was undertaken as a collaborative initiative between several partners led by Gender and Health Research Unit, Medical Research Council, South Africa.

Women and children facing sexual violence need a variety of services. Some of these services can be made available by the health facilities themselves and for other essential services, such as legal aid and shelters health facilities can act as referral agencies. The proposed model of quality of care is made up of the following components

1. *Services to be made available*: Provision of health care and medico-legal services are the two direct responsibilities of the health care provider.

    a. *Health care*- As seen in the introduction, victim-survivors of sexual violence can face a variety of health consequences, such as injuries and infections including, sexually transmitted infections and HIV, unplanned pregnancies, short and long term mental health consequences. Irrespective of their wishes to file a complaint, they need:

        i. Immediate mental and physical health care as per requirement
        ii. Assessment and counselling for risk of pregnancy
        iii. Emergency Contraception or Abortion Facilities if required
        iv. Prophylaxis and Vaccination for likely infections
        v. Diagnosis and Treatment for developing infections
        vi. Treatment for long term health consequences- both physical and mental
        vii. Follow up to ascertain delayed health consequences and their treatment

Providing comprehensive health care is an important function of the health facility. In fact, health concerns need to be given priority over medico-legal services.

Table 2.1: Proposed Optimum Model for Health Care Services

Health care parameters
Wound care and care for associated risks
Dressing and other wound care to be made routinely available
Injection Tetanus Toxoid to be given when appropriate, that is, in case of injuries and if woman has not been vaccinated in the last five years
Provision of mental health care
A Psychologist or Psychiatrist or counsellor should be available Alternatively, a staff nurse sensitized and trained to care for survivors and provide mental health support
Reproductive and sexual health care
Risk assessment and counselling to be routinely available for possibility of pregnancy
Emergency contraception provided on case to case assessment
Risk assessment and counselling for Hepatitis B
Diagnostic samples to be taken for Sexually Transmitted Infections routinely
Preventing other possible infections
Counselling for HIV risk and further course of action routinely
Hepatitis B vaccine to be given when appropriate
Follow-up for other health consequences and long term effects
Follow-up for treatment or delayed consequences of assault to be available routinely

Reproductive and sexual health care: Review of literature indicates two kinds of policies recommended to the health facilities. One is to collect diagnostic samples for sexually transmitted infections and suggest treatment based on reports when the woman comes for a follow-up. The other option is to provide antibiotics based on clinical diagnosis and prophylaxis for any infections she may be at risk of. The Centre for Disease Control based in Atlanta, USA recommends prophylactic antibiotics to be given to prevent Sexually Transmitted Infections in every case of sexual assault. In the Indian context and in the context of a complex crime such as sexual assault, women may be prevented from actively following up either for health care or for purposes of court cases. Studies in India show that gynaecological infections are common and highly prevalent and may often be silent in women that is, have no overt signs and symptoms (RCH 2002-03; Bang, Bang et al, 1989; Pandit et al, 2005). They also form an additional risk for transmission of HIV in case of unsafe sexual intercourse. In such a scenario no opportunity should be lost to diagnose and treat STIs. Alternatively, antibiotics may be prescribed to every woman based on clinical assessment.

b. Medico-legal services: The health care provider is assigned with an important task of complete documentation of injuries and collection of samples from the body of the woman or child to aid the investigation of sexual assault. Similar samples need to be collected from the body of the alleged perpetrator. Samples are of the following kinds-

i. Transitory material exchanged during the assault. Example, dried stains of semen on the body of the woman or vaginal epithelial cells found on swabbing the penis of the alleged perpetrator.
ii. Control samples to ascertain the origin of any material. Example, a cut sample of the head and pubic hair of the woman is taken as control to ascertain whether any loose hair found on the body belongs to her or the alleged perpetrator.
iii. Samples to ascertain whether the woman was drugged or given alcohol to assist the assault. Example, blood and urine samples are taken to ascertain drug or alcohol levels when suspected.
iv. Samples to ascertain the identity of the perpetrator or identify to which person any material found on the body belongs. Example, blood sample is collected from both the victim and perpetrator for grouping, analysis of other antigens and if needed for DNA analysis.

It is important to remember that any evidence after sexual assault tends to disappear with time and with daily activities such as bathing, eating, drinking, passing urine and defecating. Therefore the doctor needs to assess which samples would still yield results, based on the history given by the woman, the time delay and intermediate activities such as bathing, and then go ahead and collect relevant samples. This adds to the complexity of assessment and quality of services, since not all samples need to be collected from each woman or child. In addition, care must be taken to protect the samples from tampering or biological degradation. Tampering with samples is prevented by following the chain of custody, which means that only authorised persons are allowed to handle the samples. The samples are properly labelled and sealed after collection, stored in a secure place under lock and key and due receipt is given and records maintained of handing over from one custodian to another. Biological deterioration of samples may occur due to bacterial and fungal growth if samples are allowed to remain in warm and moist conditions. This can be prevented by air drying the samples and refrigeration during storage. Collected body fluids need to be stored in a locked refrigerator. Air dried samples may be stored under lock and key.

Table 2.2: Samples to be collected from the victim-survivor and the suspect

Samples collected from the woman	Samples collected from alleged perpetrator
Transitory material	Transitory material
Clothing Oral Swab and Smear Debris Collection Swab of any body stains, foreign material, dried secretion specimens Fingernail Cuttings Pubic Hair Combings Genital Swabbing Vaginal Swab and Smear Anal Swab and Smear	Clothing Items Oral Swabbing Debris Collection Other Physical Evidence Dried Secretion Specimens Fingernail Cuttings External Penile Swabbing Pubic and Rectal Hair Combings
Control samples	Control samples
Saliva Sample Known Head Hair, Known Blood Samples Known Pubic Hair	Known Saliva Sample Known Head Hair, Known Blood Sample Known Pubic Hair
Other evidence	Other evidence
Photographs of Injuries Bite-mark Impressions	Photographs of Injuries Bite-mark Impressions

Table 2.3: Proposed Optimum Model on Medico-legal examination

Standardised and uniform procedures
There should be standard guidelines and step-wise protocol for examination, collection of samples and documentation
Qualified and trained personnel
Preferably a medico-legally trained doctor / forensic expert / gynaecologist should be available to examine survivors
Doctors involved in medico-legal examination should receive in-service training
Consent for examination
Written consent for examination to be taken by examining doctor
Injury documentation and collection of medico-legal samples
Complete documentation of injuries should be done
Collection of essential samples for investigation should be done (including body stains, oral, vaginal and anal samples, nail clippings, matted hair etc)
Blood and urine samples as required need to be taken
Maintaining chain of custody and protecting samples from degeneration
Examination and documentation to take place in the same room
Labelling to be done by examining doctor in the same room where examination took place
Sealing to be done in the examination room in presence of doctor
Samples to be stored temporarily in lockable cupboard before transportation
Well defined procedure to transport the samples to the forensic laboratory
Samples need to be air dried before sealing to avoid fungal contamination
Arrangement to refrigerate samples in case of delay

Qualified health personnel: In India only doctors are allowed to perform this role and testify in courts. Nurses or other para-medical staffs are not allowed to do so. The WHO guidelines recommend that there should be a medico-legally trained person in-charge of the examination. In India, this would include the doctors who have a post graduate degree in Forensic Medicine and Toxicology or medical graduates who have been specifically trained for such work. Alternatively, the gynaecologist is considered an expert on examination of women and women's reproductive system. Hence whereever possible the gynaecologist is expected to examine the woman.

Consent for examination: Not only is this the basic requirement for any examination, but a written consent is also mandated by the 172nd Law Commission report.

Table 2.4: Proposed Optimum Model on Women sensitive indicators:

Adequate staff to take care of all requirements
Preferably a Female Medical Officer should be available to examine
A Psychologist/ Psychiatrist/ Counsellor should be available
A Social Worker should be available
A Police Constable should be stationed at facility
Privacy, confidentiality and autonomy of the woman to be maintained
The woman needs to be received in a separate room specially made available to take care of survivors
Facilities to maintain privacy
Consent taken in a separate form which adequately explains nature of examination in the local language
Consent includes permission to hand over information to the police for investigation purposes
Avoiding unnecessary referrals, and participation of multiple doctors within and outside the health facility
One doctor takes history and conducts the entire examination including treatment
Entire examination to take place in one room in one department
Preferably not required to refer outside the examining facility/hospital

c. Women sensitive organisation of services: Non-reporting or delayed reporting of sexual assault is one of the foremost barriers to better health care and better investigation. Embarrassment and added humiliation in the process of reporting the crime and getting examined for the same may deter reporting. It is important to organise health services in a manner which will reduce embarrassment to women, increase their control over the process of examination and ensuring privacy and confidentiality in the real sense of the terms.

i. *Adequate staff to take care of all requirements*: The 172nd Law Commission recommends that preferably women doctors should examine women reporting sexual assault. Without a doubt, assaulted women find greater comfort if the examining doctor were a woman. While care should be taken that the medical examination does not get delayed where women doctors are not available, efforts need to be made to ensure their availability whenever possible. A psychologist and counsellor trained to provide mental health care would be most desirable. In addition, a social worker, if available would be expected to ensure safety and security of the woman, finding shelters, liaison with legal aid etc as required. Having a police constable stationed at the hospital is an additional measure available in tertiary care hospitals and civil hospitals. They ensure that it is the investigating agency which will go to the woman if the woman reports directly to the health facility and not vice versa to register the crime.

ii. *Privacy, confidentiality and autonomy of the woman to be maintained*: For informed consent to be meaningful, it should ideally be available in a form in the local language which can be read out to the woman or guardian. All aspects of the examination, including where touching will occur should be explained to the woman and consent obtained to proceed. According to international norms it is essential to ask the woman or guardian's consent to release the information for purposes of investigation.

iii. *Avoiding unnecessary referrals, and participation of multiple doctors within and outside the health facility*: Making services available in a single room/ department with minimal referrals, possibly by one health care provider and these services to be separated from other services.

In some countries, the health and medico-legal components of the service are provided at different times, in different places and by different people. Such a process is inefficient, unnecessary and most importantly, places an unwarranted burden on the victim. The ideal is that the medico-legal and the health services are provided simultaneously; that is to say, at the same time, in the same location and preferably by the same health practitioner. Policy-makers and health workers are encouraged to develop this model of service provision (WHO, 2003).

iv. *Essential medicines, medical supplies, equipment and physical status of the facility:* Cleanliness, auditory and visual privacy are fundamental requirements in the examination facility. The facility should also comply with local safety and health regulations as they apply to fire, electricity, water, sewage, ventilation, sterilization and waste disposal. WHO guidelines specifically explain that the examination room(s) should have walls and a lockable door and not merely curtains.

Table 2.5: Physical Environment of the Examination Room

	Physical Environment of the Examination Room
1.	Separate room with attached or adjacent toilet and bath and lockable door. Separate waiting area. **Desirable**: Separate entrance to the room. Two adjoining rooms, one to be used as waiting room until the examination room is prepared where seating arrangement of the woman or child, relatives and friends is possible or where support person can talk to woman
2.	Adequate light and ventilation
3.	Continuous water supply in room, bath and toilet **Desirable**: Running water in wash basins must be made available with the help of overhead tankers
4.	Services should be accessible, secure, clean and private

Table 2.6: Facilities in waiting and examination room

	Facilities in waiting room	**Purpose**
1.	Chairs	For visitors, friends and family
2.	Clean drinking water	For visitors, friends and family
	Facilities in examination room	Purpose
1.	Presence of examination table with lithotomic position	Aids examination of the genital area
2.	Clean bed linen	For good hygiene
3.	Lockable door, Partition and Curtains	To maintain privacy in room
4.	Adjustable lamp for examination	For better lighting during examination
5.	Lockable cupboard for storing samples transported.	To maintain chain of custody. Samples need to be stored in a secure place until they are
6.	Hospital gown to wear during examination	To facilitate examination
7.	Set of clothes to change into examination	Women's clothes need to be submitted for
8.	Soap to wash hands	For good hygiene
9.	Chairs and table for documentation need to be on-going	Examination and immediate documentation
10.	Labels, sticking plaster and wax	For sealing
11.	Carbon papers, plain papers, pens and pencils copies need to be made.	To aid documentation. At least two carbon
12.	A telephone	For communication
13.	Refrigerator and cupboard, preferably lockable for preservation of samples	To store samples in a cool place.
14.	Information brochure	To inform about the range of services available.

v. *Facilities in examination room:* A high standard of hygiene is required in the provision of any medical service. Adjustable lamp, examination table with lithotomy position, gown and change of clothes for the survivor are essential for a good quality examination.

Not keeping a change of clothes for women not only acts as a dis-incentive to early medical examination but may actually hamper investigation and justice to them. Indira Jaising draws attention to an excerpt from a police enquiry in the Pararia rape case where one of victims of rape was not even allowed to enter the court because she did not undergo a medical examination. The woman is quoted to have said "I don't have another sari to wear if I give this only sari for medical test" (J. Indira, 2001).

vi. *Essential equipment/ medical supplies available in examination room:* All of those listed below are essential for providing a minimum level of service to women, though depending on the circumstances and time lag after the assault, the doctor would have to decide which equipments to use. Nevertheless, all the equipments would need to be stocked for future use.

Table 2.7: General Medical Items and Equipments

	General Medical Items and Equipments	Purpose
1.	Tourniquet	To assist in drawing blood
2.	Needles and Disposable syringes,	To draw blood samples
3.	Plain bulbs	To collect saliva or other samples
4.	Citrate bulbs	To collect blood samples for grouping
5.	EDTA bulb	For Blood grouping & DNA Analysis
6.	Double Oxalate bulb	For drug/alcohol assessment
7.	Sim's / Cusco's speculum	For vaginal examination
8.	Pregnancy test kits	To test for pregnancy
9.	Disposable gloves	Multiple sets as required
10.	Sterile water/ normal saline	As lubricant. No other lubricant is to be used.
11.	Sharps container	To dispose off needles and sharp objects
12.	Proctoscope/ anoscope	For ano-rectal examination

Table 2.8: Forensic Supplies and Equipments

	Forensic Supplies and Equipments	
1.	Standard proforma / checklist Pre-packaged rape examination kit to guide examination and documentation (optional)	
2.	Sterile cotton swabs and containers for	For collecting various samples
	transporting swabs	
3.	Microscope slides	To prepare a slide of vaginal smear
4.	Urine specimen containers	To collect urine sample
5.	Sheet of paper	To facilitate collection of micro evidence on body
6.	Paper bags	For collection of clothes/specimens
7.	Paper envelopes for collecting other samples	All samples to be air dried and stored in paper envelopes
8.	Scissors	To cut control samples of head and pubic hair and any matted hair
9.	Combs	To comb pubic and head hair
10.	Nail cutter	To take nail clippings
11.	Sanitary napkins	If required

Table 2.9: Treatment Items/ Medicines

	Treatment Items/ Medicines (Paediatric dosage forms to be available)	**Purpose**
1.	Painkillers/ Anti-pyretic	To be given as required
2.	Emergency contraception	To be provided on case by case basis
		• If woman comes within first five days of assault • Is at risk of pregnancy • Provided after counselling
3.	Suture Material and Material for dressing injuries	To be used as required
4.	Injection Tetanus Toxoid	To be given if she has not received it in the last five years
5.	Hepatitis vaccination	To be provided on risk assessment and on case by case basis
6.	Antibiotics/ STI prophylaxis	Samples for diagnosis of STI to be sent routinely. Antibiotics to be provided as prophylaxis or on risk assessment and clinical diagnosis.
7.	Tranquilizer	As required
8.	Anti-emetic	As required

Processes to be put in place in order to effectively operationalise the model

Table 2.10: Proposed Optimum Model

	Processes	Effective implementation
a.	Standard Policy and Clinical Guidelines Every health facility should have a policy on comprehensive care for victim-survivors of sexual assault Policy should include clinical guidelines for various services to be provided in various situations	Policy should be made known to all staff, be available on demand to any person, and efforts to make it known to the public through leaflets etc be made
b.	Standard Protocol Every hospital should adopt a standard and uniform protocol for examination and documentation of findings	Copies of Standard protocol must be available in numbers at all times in the facility
c.	Training and sensitisation in ● Concept of Gender, Gender Based Violence and how to incorporate gender sensitivity, Good understanding of local protocols, rules and laws applicable ● Training in comprehensive services for survivors of sexual violence including regular in-service training ● High ethical standards in provision of services, free of bias or prejudices.	● Training manuals and material to provide training to be designed. ● All relevant health care providers to be trained and on-going in-service training to be available. ● Best practises to be evolved and practised.
d.	Inter-disciplinary approach including ● Constructive and professional relationship with other disciplines/ departments/ individuals treating or assisting. Networking with other service providers	● Mechanism for inter-disciplinary approach to be evolved. ● Lists of women's organisations, crisis centres, shelters, free legal aid providers should be readily available and used for referrals
e.	Care should be ethical, compassionate, objective and above-all patient-centered	● This principle to guide delivery of health services
f.	Review and monitoring of services	

2. Policies and procedures to care for women and children facing sexual violence: Review of literature indicates that caring for survivors of sexual assault is a complex task including the participation of multiple departments and multiple health professionals. In such a situation it is recommended that the hospital should adopt a policy covering aspects such as priority to the issue, adoption of standard guidelines and protocols for health care professionals, training and deployment of staff, comprehensive package of services, essential medicines, equipment and facilities, a mechanism of inter-departmental cooperation and networking with other disciplines such as forensic laboratories and the criminal justice system.

3. Training of health care providers: Rape victims need an unusual degree of professional reassurance, acceptance and understanding in regard to the therapeutic examination and a broad range of skills. (WHO, 2003, pg 31 from reference 37)

To enable health care providers to command this broad range of skills and provide services without being judgmental, they need a comprehensive training and sensitisation programme. This programme should ideally be available to all health functionaries who may be involved in caring for survivors, including doctors, nurses, ward boys and women helpers in the health facility. The training

programme needs to be updated and provided as 'Continued Medical Education' to all health functionaries at regular intervals.

4. Inter-disciplinary, holistic and patient-centric approach: Optimum services for sexual assault involves the police, health facilities, forensic laboratories and any allied services such as support centres, legal aid and shelters, if available. Even within the health facilities different departments such as Casualty, Obstetrics and Gynaecology, Paediatrics, Forensic, Radiology and Psychiatry may be involved in caring for women and children. Therefore adopting an inter-disciplinary, holistic and patient-centric approach should be a principle for providing services rather than services being available in a fragmented manner in different departments. There also needs to be a regular dialogue between the police, health facilities and forensic laboratories to aid optimum services.

5. Review and Monitoring: It is important to review provision of services, upgrade services according to feedback from women's groups and victim-survivors and monitor quality of services.

Blank

Chapter 3

Method and Methodology

The study used primary and secondary sources of data. The secondary source was documentation of cases received by the state-run secondary hospital in the preceding year, that is, from January 2006 to December 2006. Researchers documented case data from the hospital and this was anonymised at source. The other hospitals refused permission to study such data. Primary sources were semi-structured interviews with health care providers and other relevant service providers and an observation of health facility, specifically the setting where the woman or child is examined. The tools used for research were interview schedules for the interviews and an observation check-list for the facility observation. Research participants were primarily health professionals but also included professionals providing complementary services. These were -

- Doctors employed in the Public Health System and who are regularly involved in examination of survivors of sexual assault,
- Senior doctors in administrative capacities,
- Nurses involved in assisting examination,
- Forensic Laboratory personnel who receive and analyze samples,
- Laboratory personnel within health facilities
- Counselors from women's organizations/ centers providing counseling/ support services to women and children,
- Police officers/ sub-inspector who have investigated cases of sexual assault
- Key informants from the medical fraternity who have worked in the health system for many years
- Public Prosecutor

Formulation of research method and tools: The research method was finalized by the research team and reviewed by the Programme Development Committee of CEHAT. It was also tabled at the Institutional Ethics Committee (IEC), set up by the Anusandhan Trust. All the tools of research and proposed letters for consent to participate in the research were also tabled to the IEC. The researchers received valuable feedback from both these processes, and this was incorporated. The recommendations of the IEC regarding safeguarding the confidentiality and anonymity of research participants were implemented. The IEC certified that the research could go ahead.

Method of observation of facility: In some facilities, examinations were carried out in multiple locations, such as the Casualty, Gynaecology Department, Forensic Department and the research team visited all of these. At times, depending on the severity of the condition and time of arrival, the survivor was examined in the Operation Theatre or Labour Room. The researchers were not allowed to observe these facilities. However the main examination was generally carried out in the Gynaecology department/ OPD in most facilities. The findings for this room most commonly used for examination and which was made available for systematic observation are noted.

Each facility was observed at least by two researchers and observations were noted in a pre-designed facility check-list. Some facilities were visited twice to ascertain information. One staff, either a nurse or doctor was requested to accompany us during the facility visit to ask queries and to show supplies stored in cupboards.

The research setting: Currently, according to the dominant practice followed, cases of sexual assault are referred to public hospitals. The universe for

such facilities in Maharashtra is the urban-based Government and Municipal Hospitals, Civil Hospitals in each district, Sub-district hospitals, Rural Hospitals, Community Health Centres and Primary Health Centres. These constitute primary, first referral, secondary and tertiary levels of care. One health institution from each level of the state run health system was chosen to comparatively study the model of health care services provided, the procedures followed and the quality of care at these hospitals. In addition one tertiary facility run by Municipal Government and one centre specialized in medico-legal cases were selected. Health facilities include facilities of the urban and rural health system. Problems faced and recommendations for better services were also documented.

There is no systematic documentation of the procedures and services that women and children who have faced sexual violence may expect. Neither did the researchers find any documentation about how equipped is the health facilities to deliver these services. Since this is an exploratory study, the study was limited to two districts and few institutions within these, which cater to a majority of sexual assault cases. This was designed to give important insights about how sexual assault services are delivered. With this aim in view, the two districts were chosen purposively. Within these districts a State Run Tertiary Care Hospital, a Municipal Run Tertiary care Hospital, a State run Secondary Hospital and a Civil Hospital were chosen based on information about where maximum number of cases in the district are examined.

It was also important to study other components of the rural system such as a Sub-District Hospital and a Primary Health Centre, since very little is known about services delivered at these levels, but they are often the first contact for women and children in rural areas. Since case load data was difficult to obtain their selection was based on easy accessibility, within one of the districts. The district from where facilities of the rural health system were chosen is a tribal dominated district. All components of the rural health system selected for the study namely Civil Hospital, Sub-district hospital and PHC are from this district. The purpose was to study how services for sexual assault are organized at these facilities, the quality of care and constraints they faced and overall to know how equipped they were to provide such services. Though this study is by no means representative, it studies six different kinds of facilities where different models of service delivery are used.

Services for sexual assault are a sensitive matter for the state and research participants. At all levels they cooperated with us with the aim of ultimately improving these services. Therefore protecting their identities was of primary importance. Since health facilities providing these services are few and well known within the districts, the names of the districts and the health facilities are kept confidential.

Introduction to health facilities in the study: For the purpose of the study, six institutions at various levels in the public health system were chosen from two districts of Maharashtra. Table 3.1 briefly summarises the introduction to the facilities. These facilities differ in size, bed capacity, number of departments and staff. Availability of women doctors also vary in the institutions. These institutions have been described below briefly:

Table 3.1: Introduction to health facilities

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Referral Hospital	Civil Hospital	Sub-District Hospital	Primary Health Centre
Type of institution	Tertiary Referral Centre	Tertiary Referral Centre	Medico-legal centre	Secondary Referral Unit	First Referral Unit.	First Contact Centre
Location	Urban	Urban	Urban	Urban but catering to the entire district	Rural	Rural
Number of beds	1352	1416	114	336	100	6
Profile of departments and specialists	Separate gynaecology, paediatric surgery, forensic medicine department and medical social worker department exist	Separate gynaecology, paediatric surgery, forensic medicine department and medical social worker department exist	No separate departments exist. Two of the four medical officers are forensic specialists	No separate departments. Gynaecologists, paediatrician and radiologist available	No departments, No Gynaecologist. One paediatrician present, no radiologist	No gynaecologist No specialist
Women doctors available	Available	Available	Not available	Available	Available	Available

The State Run Tertiary Hospital is a multi-disciplinary hospital attached to a medical college in an urban area. Departments of Obstetrics and Gynaecology, Paediatric surgery, Forensic Medicine and Toxicology are available among others for managing sexual assault cases. Casualty and Radiology department are also present. Departments of social work and psychology are also available. Several women doctors are employed in the department of Gynaecology. A Police station is situated in the hospital compound.

The Municipal run Tertiary Hospital is another multidisciplinary hospital attached to a medical college in an urban area. Casualty, Obstetrics and Gynaecology, Paediatric surgery, Forensic Medicine and Toxicology, are the departments involved in the caring of sexual assault cases. Departments of social work and psychology are also available. Here too, the Gynaecology department employs women doctors.

The State run Secondary Hospital has 114 beds. It works closely with the police to manage several medico-legal cases, apart from being a full fledged hospital. There are no separate departments in the hospital. Four medical officers are employed here, 2 of whom are forensic specialists. There are no women doctors employed full time. Honoraries of various specialities are available, including Gynaecologists, Paediatricians and Psychiatrists.

The Civil Hospital is a 336 bedded, secondary referral hospital based in the urban part of the district. It has a Casualty department and specialists such as Gynaecologist and Radiologist are available. A police *chowky* is present in the

hospital compound. No Forensic Medicine specialist is available.

The Sub-District Hospital is a 100 bedded, first referral centre for primary health centres and rural hospitals in the district, based in a *taluk* place. The institution does not have separate departments but there are specialists, some of them honorary and also women doctors are available. The hospital also has a Casualty. There is no Gynaecologist or Radiologist posted here. A Gynaecologist makes weekly visits. There is no police *chowky* in the premises.

The Primary Health Centre is the first contact point for services and has 6 beds. It is based in a rural area. Two medical doctors are posted, one of which, is a woman doctor. There is a police station quite close to the PHC.

The data collection took place between April 2007 and October 2007. Obtaining official permissions for the research and conducting the actual interviews turned out to be a time consuming process. This is because the heads of institutions and often participants responded only to a doctor or a senior person. Official permission to conduct the research in these institutions was obtained from the Director of Health Services, Maharashtra as well as the heads of the respective institutions. The permission included interviewing health care providers and study of facilities where women and children are examined. The permission to interview doctors was generic and did not include names of specific doctors. The research, including the conduct of interviews was entirely done by the core research team. No research investigators were employed for the purpose because of the sensitive nature of the research.

Health care providers, including doctors and nurses formed the bulk of respondents. The health system is hierarchical in its functioning and health professionals are not willing to participate unless they have specific permissions to participate from the heads of institutions or respective departments. This was a challenge for the study, especially since we did not want the heads of institutions to nominate research participants. This may have introduced a systematic bias in the research. In order to avoid this we visited health facilities after receiving permission, but without prior notice and chose the doctor on duty, who fitted our criterion, example, the gynaecologist in the OPD. If the doctor could not give any time on that day then her/his appointment was sought and the interview was completed later on.

From the selected facilities the heads of institutions (or departments in case of teaching hospitals), gynaecologists, a paediatrician, a forensic doctor, a Casualty Medical Officer, a nurse and medical officers were selected using the above mentioned method depending on staff posted at that facility. To be more specific, the following staffs were selected from each institution (Table No 3.2)

The aim was to get a mix of doctors who were to speak about policy level issues, problems and some doctors who were currently involve in examination.

Table 3.2: Staff selected from each institution

Criterion of staff	State run teaching hospital	Municipal run teaching hospital	State run secondary hospital	Civil Hospital	Sub-district hospital	PHC	Total
Administrators/ HODs[5]	2	3	1	1	1	1[6]	9
Examining doctors	7[7]	Permission not provided	2[8]	4[9]	2	1[10]	16
Nurses	1	Permission not provided	2	2	1	1	7
Laboratory Technician	-	-	-	-	1	1	2
Total health professionals	10	3	5	7	5	4	34

Other facilities and personnel included in the study

One forensic laboratory present in one of the short listed districts was included in the assessment. Interviews of persons in senior administrative position and one senior technician were conducted for the study. The other district did not have a forensic laboratory.

Three Police Inspectors who had investigated cases of sexual assault and posted at police chowky/ station near to three of the six health facilities were also interviewed. A letter to the in-charge of the respective police stations seeking official permission to interview the respondents was given and interviews took place only after receiving the permission.

Three social workers from women's organizations and one from a child rights forum were also interviewed. One public prosecutor is also part of the sample.

Primary data was collected through semi-structured interviews using interview schedules, which were filled by the research team itself. Before commencing the interviews, each respondent was explained the objectives of research and method of conducting the interview. They were then requested to read and sign on the letter of consent. They were assured that their identities as well as those of the health facilities would not be made public. Two copies of the letter of consent were given to each respondent, one for the respondent to keep and one to return along with their written consent for the interview. Only after receiving written consent the interview was conducted and documented. No tape recording was done. Each interview was transcribed by two researchers from the team. The transcriptions were finalized after returning to the work-place. The researchers also maintained field notes of their observations.

The interviews of health care providers gathered the following information:

- Profile of sexual assault cases seen and approximate case load
- How do cases approach the hospital and their journey through the hospital setting
- Procedures followed at health facility level for medico-legal examination
- Provision of health services to the women and children

[5] Heads of Departments
[6] Medical Officer in charge of PHC
[7] 1 Associate Professor, 4 Lecturers, 1 Casualty Medical Officer, 1 Senior Resident
[8] Medical Officers
[9] 3 Medical Officers, 1 Casualty Medical Officer
[10] Medical officer

- Indications and facilities to conduct age estimation
- Problems faced while providing services
- Experiences of testifying in court
- Details about the last case seen
- Training to provide services
- Recommendations

The interviews with counselors gathered the following information:

- Profile of sexual assault cases seen, mode of approaching the facility, services they provide and their inter-linkages with the health system.
- Women's experiences with the health system
- Problems faced in providing services
- Problems faced in liaison with health facilities and recommendations to improve services

The interviews with Police gathered the following information:

- Procedure of investigation, medical examination and procedure of liaison with health facilities
- Their expectations from the health facility and the examining doctor and the extent to which they are satisfied with existing services
- Problems faced and recommendations to improve them

The interviews with forensic laboratories gathered the following information:

- Procedure of liaison with police and health facilities
- Modes of inter-disciplinary coordination and training for examining doctors
- Expectations from the health facility and satisfaction with the same
- Problems encountered and recommendations to improve services

All the respondents we approached for an interview, except one doctor, agreed to give an interview. We had to approach the facilities several times before getting an official permission to conduct interviews and also visit some respondents multiple times to conduct interviews. Table 3.3 provides the profile of the sample.

Table 3.3: Profile of sample included:

	Total	No. of women
Total number of doctors interviewed	25	9
Total number of nurses	7	7
Total number of laboratory staff in health facilities	2	1
Total number of forensic laboratory staff	2	1
Total number of counselors	4	4
Total number of police personnel	3	0
Key informants (doctors)	2	1
Public Prosecutor	1	0
Total number of participants	46	23

The sampling framework was designed to include personnel in certain administrative capacities, such as heads of institutions and others with certain specializations, example, Gynaecologists and assigned certain relevant tasks such as that of Casualty Medical Officers. This limited the opportunity to maintain gender parity in the sample. Example, all Casualty Medical Officers on duty during sampling were male doctors. Heads of most of the institutions and departments were male doctors. This in itself is an indication of the fewer number of women found in medico-legal service provision and positions of power in the health system. For example, no women doctors were posted as Casualty Medical Officers except in the Sub-district Hospital where this duty was carried out by all Medical Officers on rotation. No women doctors specialized in forensic medicine were found to be posted in any health facility. Indeed we were told that there are very few

women doctors overall who have taken a degree in forensic medicine. Very few women doctors were posted in the paediatric surgery department in the two tertiary hospitals. A sex wise break up of the sample will thus help understand the profile of doctors interviewed and also the paucity of women doctors to provide services (Table 3.4).

Table 3.4: Specialties, designations and sex of doctors included in study

Designations/ Specialities*	Total	Women
Heads of Institutions/ Departments	9	3
Gynaecologists	7	6
Forensic Doctors	4	0
Paediatric Surgery[11]	4	0
Paediatrics	2	2
Casualty Medical Officers	3	0
Total (from table above)	25	9

**There is an overlap in some designations and specialties and thus numbers add up to more than total doctors in sample.*

Table 3.5: Profile of doctors included in sample:

	Range	Median
Age group of doctors ranged from	25 years to 54 years	37.5 years
Years of experience ranged from	1 month to 28 years	11 years
Number of cases seen range from	1 case to 200 cases seen	10 to 15[12]
Number of times given court testimony ranged from	Never testified to testified many times	Median is not relevant[13]

Data Analysis

Comparative analysis of procedures followed and services available: The model of optimum quality of care describes indicators and parameters of services for women and children for

- Provision of medico-legal services
- Provision of health care services and
- Sensitivity of services to women's concerns

Each of these indicators is made up of specific indicators, indicating example whether all components of a medico-legal examination were covered or if a chain of the custody was maintained. These were used to do a comparative analysis of the existing facilities, procedures followed and services provided. These are explained in Table 3.7 to 3.10

Comparative analysis of facilities: Similar to analysis of procedures the facilities were scored for stocking of essential medicines, essential equipments and medical supplies, facilities and status of the room where examination took place. These form the indicators for facility assessment. Availability of each medicine was assessed according to the availability in the examination room (deemed satisfactory) which indicated readiness of the facility to provide services at one place or provided elsewhere (deemed partially satisfactory). Equipment was assessed for availability in the examination room at that point of time when the research team visited. The

[11] Paediatric surgery is a specialized branch of surgery where doctors specialized in general surgery further specialize in paediatric surgery. Male children facing sexual abuse are referred to them. Very few female paediatric surgeons were posted in the two tertiary facilities which had a post.
[12] Only 20 respondents answered this question reliably. This is the 10th and 11th answered in an ascending order of representation.
[13] Very few doctors had ever testified in court.

method of scoring for both of these is similar and is given below.

Scoring of indicators: Each of the parameters was scored on a scale of 0 to 2, where 0 indicated unsatisfactory performance, 1 indicated partially satisfactory and 2 indicated satisfactory performance.

For example, in the parameter of medico-legal doctor or gynaecologist being available for examination,

- Facilities where there was routine possibility of either qualified doctor to be available were scored 2
- Facilities where only half of the examining doctors had the required qualification were scored 1
- Facilities where there was very remote possibility of either qualified doctor to be present were scored 0

While scoring facilities in the above respect, aspects such as the policy of deploying staff for examination as well as posting of specialists in the health facility were both considered.

The facility score where a particular parameter could not be scored was not affected, as it was removed both from the numerator and denominator of the scoring. There are very few such facilities, which could not be scored on certain parameters. The final scores were added up to come to the score of the indicator. The scores of the indicators were then converted into percentages.

Example, if a facility scored 12 out of 26, then considering 26 as 100 per cent score, the facility would be scored 46 per cent for its 12 marks in that indicator. This was done so that the various scores become comparable. Further the percentages of scores were converted into rating of quality of services.

Ratings:

- 80% and above- Very Good
- 60 to 80%- Good
- 40 to 60%- Fair
- Less than 40%- Poor

The mean final scores of the indicators were the scores allocated to facilities in that respect. The scores and their analysis can be found in chapter III.

Table 3.6: How were the ratings calculated?

Scoring of individual parameters (on a scale of 0 to 2)	0 - unsatisfactory 1 - partially satisfactory 2 - satisfactory
Scoring of indicators	By adding individual scores of parameters
Converting these to percentages	Each indicator has a score in percentage
Converting these to rating	Each indicator has rating of Poor, Fair, Good or Very Good
Score and rating of the entire facility	Mean of indicator score-percentages and then their conversion to ratings

Parameters for services provided in health facility

Table 3.7: Provision of medico-legal services

Specific indicators (Maximum score)	Parameters (Maximum score possible for each parameter in bracket)
Standardised and uniform procedures (4)	The hospital has a written policy for management of sexual assault (2) Standard protocol/proforma for examination, collection of samples and documentation is available (2)
Adequate, qualified and trained staff (4)	Preferably a medico-legally trained doctor/ forensic expert/ gynaecologist is available to examine survivors (2)
	Doctors involved in medico-legal examination receives in-service training (2)
Consent for examination (2) Injury documentation and collection of medico-legal samples (8)	Written consent for examination is taken by examining doctor (2) Complete documentation of injuries is done (2)
	Collection of essential samples for investigation is done (including body stains, oral, vaginal and anal samples, nail clippings, matted hair etc) (2)
	Blood and urine samples as required need to be taken (2)
Maintaining chain of custody and protection of samples from biological deterioration (10)	Labelling is done by examining doctor in the same room where examination took place (2)
	Sealing is done in the examination room in presence of doctor (2)
	Samples are stored temporarily in lockable cupboard before transportation (2)
	Arrangement to refrigerate samples in case of delay (2)
	Well defined procedure to transport the samples to the forensic laboratory (2)
	Samples need to be air dried before sealing to avoid fungal contamination (2)

Table 3.8: Health Care Provision

Wound care and care for associated risks (4)	Dressing and other wound care is made routinely available (2) Injection Tetanus Toxoid is given when appropriate (2)
Provision of mental health care (2)	A Psychologist/ Psychiatrist/ counsellor is available (2)
Reproductive and sexual health care (10) of pregnancy (2)	Risk assessment and counselling is routinely available for possibility
	Emergency contraception provided on case to case assessment (2)
	Risk assessment and counselling for various sexually transmitted infections routinely (2)
	Diagnostic samples is taken for STI routinely (2)
	Counselling for HIV risk and further course of action routinely (2)
Preventing other possible infections (2)	Hepatitis B vaccine is given when appropriate (2)
Follow-up for other health consequences and long term effects (2)	Follow-up for treatment (2)

Table 3.9: Women sensitive indicators

Adequate staff to take care of all requirements (8)	Preferably a Women Medical Officer is available to examine (2)
	A Psychologist/ Psychiatrist/ counsellor is available (2)
	A Social worker is available (2)
	A Police constable is stationed at facility (2)[14]
Privacy, confidentiality and autonomy of the woman to be maintained (8)	The woman is received in a separate room specially made available to take care of survivors (2)
	Facilities maintain privacy (from facility checklist). (2)
	Consent taken in a separate form which adequately explains nature of examination in the local language (2)
	Consent includes permission to hand over information to the police for investigation purposes (2)
Avoiding unnecessary referrals, and participation of multiple doctors within and outside the health facility (8)	Making of case paper and examination documentation takes place in the same room (2)
	One doctor takes history and conducts the entire examination including treatment (2)
	Entire examination and treatment takes place in one room in one department (2)
	Preferably not required to refer outside the examining facility hospital (2)

[14] Police constable stationed at the hospital is meant to make filing of any MLC easier for the woman, so that she does not have to go to the police station.

Table 3.10: The parameters for the stocking of facilities were as under

Essential medicines	Essential equipment/ medical supplies	Facilities in examination room	Status of examination room
Pregnancy test kit	Sheet of paper	Examination table	Waiting room near the examination room
Emergency contraception	Sterile cotton swabs	Optimal Clean bed linen	Separate room for examination
Treatment for Physical injuries (e.g. dressing material)	Envelopes / bags for collection of clothes/ specimens	Bed linen changed daily or after each examination	Optimum cleanliness
Painkillers,	Scissors	Adjustable lamp for examination	Privacy well maintained
	Combs	Lockable cupboard for storing samples	Wash basin
	Sim's / Cusco's speculum	Gown stored there for examination purposes	Continuous water supply in room
	Needles and Disposable syringes	Change of clothes available	Facility for washing hands with soap
	Appropriate bulb (For Blood grouping & DNA Analysis)		Toilets attached or very close
	Appropriate bulb for drug/alcohol assessment		Optimum cleanliness in toilets
	Disposable gloves		Water in toilets
	Nailcutter		Table and chairs for documenting and labeling evidence
	Sharps container (to dispose off needles and sharp objects)		
	Sanitary napkins		
Total score possible(12)	Total score possible (26)	Total score possible (14)	Total score possible (22)

Challenges: Sexual assault is a sensitive issue for the state and local governments. Media reports on low quality of care often put the administrators in a defensive position and there is resistance to any form of enquiry. Overall there is lack of accountability and transparency in this field. At the beginning of the research itself it was clear that health facilities would not allow us to scrutinize records, though this was initially planned as a part of the research. The Municipal Run Hospital denied us permission to speak to those who conduct hands-on examination and we were allowed to speak only to the department heads. We were not allowed to observe the facility where examinations take place. Multiple gate-keepers need to be approached for official permissions at various levels, such as Director of Health Services for the rural health system, the Civil Surgeon for civil hospital as well as sub-district hospital, the District Health Officer for the PHC, Deans of Medical Colleges in case of a teaching institution and other heads of institutions. This considerably delayed the research.

Ethical concerns; The main concern for this research was to maintain confidentiality of not merely the participants but the health facilities too. Consequently the districts where research was conducted are not named. The main aim of this research is to improve services for survivors and not to show health facilities in bad light. Therefore the identities of health facilities as also districts involved in the research cannot be made public. The other rights of the research participants such as informed consent and anonymity were protected.

Limitations of this study

Though the study is informed by a broad definition of sexual violence and the authors recognise a wide range of contexts in which it occurs, the doctors spoke to us in the context of 'Rape', 'Attempt to Rape' or 'Molestation' and 'Child Sexual Abuse', which are the crimes for which survivors are brought to the hospital for a medico-legal examination. The other vast majority of sexual violence is far more invisible to the health professionals. Sexual violence in the context of conflicts is another area that was not specifically dealt with in this research.

The other limitation of the study is that information was procured from the service providers themselves and not those who received services. Given the constraints of time, cost and thus the research method chosen it was not possible to include victim-survivors themselves in the study. Thus assessment of service provision depends on what was 'reported' by service providers. Some amount of political correctness, cautiousness or need to show the facility in good light may have influenced the answers they gave. Where ever possible, objective criterion were chosen to assess services. Example, criterion such as whether counsellors, social workers or psychologists were posted at the facility was chosen to indicate whether counselling actually takes place.

How services are organised and profile of cases was also known in a nuanced manner only during the analysis of this data. Thus it was found that medical assessment of the need of the patient influences the provision of services. Example, if the woman arrives too late in the facility the opportunity to provide emergency contraception may be lost and collection of evidence may not be possible. This also made the assessment difficult. Hence some services such as reproductive and sexual health care have not been rated.

These are the limitations of the study. Since this study was exploratory in nature, we hope that it still contributes to the very limited knowledge base in India on services available to women and children facing violence. We also hope that this provides valuable information for future studies.

Chapter 4

Procedures Followed at the Health Facility and Allied Systems

We studied among other things, the common procedures followed when a case of sexual assault is registered or approaches the health facility. The response of the facility depends on mode of presentation, the model of health care followed, departments, speciality of staff and facilities available.

Profile of cases seen by health facilities: Studying the profile of sexual assault cases seen by the health facilities was not the main aim of the research. But questions such as age groups and sex of survivors of sexual assault were asked to the providers along with the mode of presentation. Table 4.1 provides the age profile of victim-survivors as told by doctors.

A majority of doctors (10) reported that 16 to 30 years was the age group in which most sexual assault cases were reported, and 7 doctors (the next highest number) reported that 11 to 15 years was the maximum reporting age group. Four doctors reported that 6 to 10 years and three doctors said that 0 to 5 years was the age group where maximum number of assaults was reported. Most of the doctors reporting two latter responses were paediatric specialists, which explain the difference in reporting. Four doctors said about 50 + age group and 1 doctor said that 30+ age group rarely reported sexual assault.

Table 4.1: Age profile of victim-survivors as told by doctors

	0 to 5 yrs	6 to 10 yrs	11 to 15 yrs	16 to 30 yrs	31 to 50 yrs	More than 50 yrs	Total
Number of health professionals who reported this age group approached with maximum frequency	3(2 answering doctors were paediatric specialists)	4(3 answering doctors were paediatric specialists)	7	10	Nil	Nil	24

Health professionals conveyed that maximum reported cases were of women and girl children. Very young boys and boys living on the street also reported with sexual assault but with much lesser frequency than girls. One of the police officials interviewed also confirmed that not more than 5 per cent cases were male. He said that boys and men don't report because *'unke ijjat ka sawal ban jata hai'* (It becomes a matter of ego and shame for them).

The State Run Secondary Hospital shared with us records of case documentations of the year 2006. A total of 239 cases were seen by this facility in the year 2006, clearly indicating that of the sampled facilities this was preferred by the police for medical examination. Such data was not made available by any other facility. Even so, preliminary analysis of this data is valuable to understand the profile of cases seen by the health facilities. Table 4.2 show-cases the profile of these cases.

Table 4.2: Profile of cases seen by State Run Secondary Facility in the year 2006

Table 4.2.1: Sex wise profile

Total number of cases	239	100%
Female cases	229	96%
Male Cases	10	4%

Table 4.2.2: Age group wise profile

Age groups	Total	%
0 to <=5 yrs	10	4%
> 5 yrs to <= 10 yrs	15	6%
> 10 yrs to <= 15 yrs	54	23%
> 15 yrs to <= 20 yrs	116	49%
> 20 yrs to <= 25 yrs	24	10%
> 25 yrs to <= 30 yrs	7	3%
> 30 yrs to <=50 yrs	9	4%
> 50 yrs	1	0.40%
Missing data	3	1%
Total	**239**	**100.4**

Total is above 100% due to rounding up of decimals

Table 4.2.3: Profile of offenders

Known offender	168	70%
Unknown offender	35	15%
Unspecified	34	14%
Missing data	2	1%
Total	**239**	**100%**

Decimals have been rounded up.

Case load: The various facilities differed considerably on account of case loads. Given below is an approximate range of cases seen in those facilities every year as told to us by principal examining doctors. Table 4.3 shows the yearly case load as reported by doctors.

Table 4.3: Yearly Case Load

State run tertiary	Municipal run tertiary	State run secondary hospital	Civil Hospital	Sub-district hospital	PHC
12-24 cases	10 -12 cases	200 cases	60 cases	4 to 5 cases	1 to 2 cases

It is clear from the above table that the State Run Secondary Facility received the maximum number of cases. The State run tertiary facility used to receive a fair number of cases earlier and have asked cases to be sent instead to be sent instead to other health facilities.. They now receive much lesser number of cases as indicated here. Analysis of 239 cases from the State Run

Secondary Facility revealed some common trends from the brief history which was mentioned. An attempt to define cases with the help of these commonalities is made here and frequency of these presentations mentioned.

Profile of cases from case records of State Run Secondary Health Facility

Not all cases which were documented were clear cases of sexual assault (Table 4.4). Some were of sex workers presumably brought by the police after a raid and who did not give any history of sexual coercion. Some girls did not give any history of sexual coercion at all, while other cases were of kidnap and physical abuse but there was no history of sexual abuse. Though there is no clear history, sexual abuse in the above cases cannot be ruled out. Even so these cases were set aside and the rest of the cases were grouped to define certain recurring profiles of sexual assault. Thus only 215 cases are used to generate these profiles. The documentation of histories was found to be very poor, in barely one or two phrases and thus puts a lot of limitations to the analysis.

Table 4.4: Profile of cases derived from available history of case

Profile of case	Number	%
Child sexual abuse which was defined as sexual assault/ abuse under the age of 12 years by known or unknown person	38	18%
Manifestation of teenage sexuality where girls under the age of 16 years have eloped by consent and had consensual sexual contact. The complaint is generally lodged by parents.	93	43.00%
Girl gave consent to sexual intercourse because the boy gave a promise of marriage which he did not keep	7	3%
Sexual assault by a known person, where the assaulted person is above the age of 12 years	43	20%
Sexual assault by an unknown or unspecified person, where the assaulted person is above the age of 12 years	23	11%
Forced into prostitution	11	5%
Total	**215**	**100%**

Profiles were generated only of 215 cases as clear history was available only for these records.

The above categories also provide a working definition used for the classification. Cases of child sexual abuse, defined as all cases of abuse found in children under the age of 12 years, were 18 per cent of the cases. Twenty per cent of the cases were sexual assault above the age of 12 years by known persons and 11 per cent was by unknown persons or where information about the known/unknown status is not known. Three per cent of the girls had consented to sexual intercourse because the boy promised to marry them but reneged on the promise. Five per cent of cases were by women who were forced into prostitution.

Teenage sexuality: The largest chunk of cases (43 per cent) were those concerning teenaged girls under the age of 16 who presumably eloped with their childhood sweethearts and had consensual sex with them. Cases where the girl indicated that though she ran away with her friend she did not consent to sexual intercourse are not included in this category. Researchers also made an attempt to separate these cases from other cases of sexual coercion by lovers. Many girls in this category had already married their boy friends. The complaints were generally lodged by the family and since the girls were under aged, it is also 'statutory rape' according to current laws. Such a profile of cases is not unique to the said facility, but was described by health care providers in other facilities as well as the police personnel interviewed. These cases draw attention to the concept of teenage sexuality, largely ignored in

analysis. It is strange that in India society and parents push a large chunk of girls into early marriage and expect them to perform sexually while in other cases such as these, girls are not supposed to be sexual beings until they dramatically attain sexual maturity at the age of 16, the legal age of consent.

Teenage sexuality is recognised in some rape laws in other countries (example some states in the US), where if the difference in age between the girl and the boy is small (example not more than 5 years), the boy is not penalised and it is not considered an offence provided the girl is above a certain age (example 13 years) and gives a statement that she had consented. In India, the history given by the girl and her statement has little value when parents make a complaint. Since the offence is non-compoundable meaning there cannot be an out of court settlement, once the complaint is filed, the parents too cannot withdraw it. There may be a delay of 4 to 6 months in filing of these rape cases. This seems to strengthen the idea that late reporting is often false reporting.

Recognition and sociological analysis of these cases is important as these cases are seen by health care providers as well as police, directly or indirectly affecting their perception of the crime, priority given to it and provision of services. These cases were described by the police as 'Technical' rape cases, meaning they would not be called rape but for the age of the girl. 'Technical' rape according to the police also includes cases where the girl initially consented because the boy had promised to marry her, but this second category has been marked separately here. Some health care providers termed them as 'not real' cases of rape, hinting at false reporting. This may be one missing piece in the puzzle which women's rights activists encounter constantly, that of service providers making allusions to 'false reports', the rest of the puzzle made of the varied myths attached to rape as a crime.

The fall-out of it, as told by the police is that often the girl becomes hostile in court and does not cooperate. Eventually, when the girl attains maturity she may marry the person she is in love with and finally none of the family is interested in pursuing the case. Since the laws do not recognise the phenomenon of 'teenage sexuality', these cases are often used to site how women 'falsely complain' of rape and the dominance of 'technical' rape in the profile of rape cases. Cases of women marrying their rapists may also be quoted. There needs to be more research on who reports rape or on whose behalf rape is reported and who does not. From the earlier review of literature it is clear that most cases of rape and sexual assault go unreported. It is possible that genuine cases of rape are not being reported and reporting of teenagers in love may be distorting the profile of rape cases.

From the point of view of health care, teenagers may be in urgent need of health care, information and resources to understand and control their sexuality, though they may not be interested in pursuing the legal aspects.

Modes of presentation to the health facility

Given below is a brief account of modes of presentation of women and children to health facilities (Details in annexure 3.2).

Generally accompanied by the police: Women and children are generally escorted to health facilities for medical examination by the police. A woman police constable (WPC) always accompanies the woman. There is also one or more other police personnel and they travel in a police vehicle. Health Professionals in civil hospitals and sub-district hospitals told that this add to greater visibility and identification as a 'rape victim' for the girl. One of the key informants told us that this is a 'humiliating' experience for the woman.

This also means that a police complaint has already been made. In the case of State Tertiary Hospital and Civil Hospital, other hospitals- for whom these facilities are referral units- tend to refer women and children facing sexual assault. Thus it is also clear that probably due to lack of some facilities women and children need to visit more than one hospital, and such referrals are not uncommon. In these cases too they are accompanied by the police. Multiple referrals accompanied by police in police vehicle causes a lot of gossip, especially in rural areas.

On probing, facilities agreed that sometimes women and children may come directly to the hospital. It is more probable for abused children, rather than adults to be brought directly to the OPD (Out Patient Department) by their families. One senior gynaecologist at the State Run Tertiary Hospital told us that cases of marital rape are also brought directly by families.

Registering the crime is mandatory before examination: A police request for examination or a registration of crime with the police is necessary before examination at any of the health facilities. Two doctors, one gynaecologist working with the State Tertiary Hospital and a forensic doctor working with the Municipal Tertiary Hospital said that police involvement was mandatory only for medico-legal examination and not for treatment. Though this may be true we found no systematic procedure to ask the woman whether she would like to report the crime or only seek treatment. The other doctors answered that once they discovered that the women had faced sexual assault, cases were not accepted by hospitals unless a police complaint was registered. An exception was made where emergency medical treatment was required, which was provided immediately. In the cases of children though, many times sexual assault was suspected when children approached the doctor in the OPD. Where there was no grievous hurt involved the families were advised to report the cases but the decision was left to the families whether to report the case or not. Doctors told us of both scenarios where sometimes families promptly report cases and sometimes they decide not to. The doctors talked about their helplessness to go beyond advising the family.

Delay in reporting is common: Cases which are brought immediately or within 72 hours are termed as 'fresh' cases and possibility of documenting medical evidence is high in such cases. Doctors told us that delay in reporting was common. Delay ranged from 8 to 10 days to a few months. Sometimes the abuse came to light only when the girl became pregnant.

> One case was pertaining to pregnancy as a result of rape. The magistrate had requested for an abortion of the under aged girl and asked for the abortus to be sent for DNA examination. The samples of the accused were also sent for DNA. (Told by gynaecologist at state run tertiary hospital)

Delay in reporting may be due to various reasons.

> 80 per cent of cases come from the slum where sexual assault is a stigma on the woman for life and hence she is reluctant to report. Only about 20 per cent of cases come early (Lecturer in State Run Tertiary Facility).

Procedure followed in case of direct reporting: During instances where the abuse is discovered by the doctor in the health setting, the family is immediately asked to make a police complaint. Where a policeman is posted at the health facility, they are expected to come to the hospital and register the complaint. In many instances the woman herself has to go to the police chowky or station to register the case.

Table 4.5:

State run tertiary	Municipal run tertiary	State run secondary hospital	Civil Hospital	Sub-district hospital	PHC
Police constable is posted	Not Posted	Not Posted	Police constable is posted	Not Posted	Not Posted
Police Constable is called to come and register a police complaint	Woman is sent to the nearest police station.	Woman is sent to the nearest police station.	Woman may be sent to the police chowky on the premises or the police constable may be called to the hospital.	Woman is sent to the nearest police station.	Relatives are sent to the nearest police station or the police are called to PHC.

On probing whether an FIR (First Information Report) is necessary before examination could proceed, we were told that 'Registration of Crime' was mandatory before examination. Subsequently, it is the responsibility of the police to come to the hospital and take the statement of the woman or child or guardian of the child. Doctors can proceed with the examination once they are provided with a CR (Crime Registration) number. Doctors indicated that families take time to come to the decision of filing a complaint. Necessity to register the crime may also act as a deterrent to visit a health facility.

> A 65 year old woman came complaining of rape. We called the police but she left before the police could come. Such is the social stigma associated with rape. Women often do not report. (Told by Medical officer at PHC)

Procedures at the hospital level: Most procedures are considered from the point of view of women and children. Though not all facilities are available in all institutions, the most common procedures generally followed for medical examination in the bigger institutions like State Run Tertiary Hospital, Municipal Run Tertiary Hospital and Civil Hospital, in cases of sexual assault is given below. After the initial introduction, there will be an introduction to procedures followed at other hospitals. Subsequently, procedures employed for children, both girls and boys will be discussed.

Flowchart I: Procedures at Health Facilities

Procedures commonly followed in health facilities

Step 1: Woman or child brought to the casualty by woman police constable

↓ (With police memo/police letter)

(If woman comes directly she is sent to the police chowky or police is called to the hospital)

Step 2: OPD paper is made by CMO. It records personal details such as name and age. Identification mark and right/ left hand thumb impression is taken.

↓

Step 3: Consent of the victim is obtained for examination

↓ *(History, inspection and documentation of injuries by casualty medical officer)*

Step 4: Findings of physical examination and injuries are noted on Medico Legal Case register (MLC register) and Carbon Copy is made on OPD paper

↓

Step 5: Referred to Gynaecologist for examination

↓

Step 6: Survivor is examined in Gynaecology Unit

(Examination takes place in presence of a female nurse)

↓

Step 7: Forensic samples are collected.

↓ *(History and internal examination, findings are noted)*

Step 8: Diagnosis and treatment may be provided as per requirement

↓

Step 9: Sent to X-ray department for x-rays if age estimation is required

↓ *(This may take place on the next day)*

Step 10: Samples sealed and labelled in casualty/medical records department

↓

Step 11: Handed over to the police *sepoi* and taken to Forensic Laboratory

(There may be delay in handing over samples to police especially if the woman is admitted)

Role of health professionals providing services

1. *Casualty Medical Officer (CMO*) - The Casualty or Emergency department is the first place where the woman or child is taken to within the hospital. The Casualty is present in all health facilities studied except the State Run Secondary Care Hospital and Primary Health Centre. The Casualty Medical Officer is generally a graduate medical officer and is expected to look after all the cases that come to the Casualty. These cases include all emergencies, all medico-legal cases and all other cases which may come when the Out Patient Department (OPD) is closed, thus making it a very crowded and busy place. The Tertiary Hospitals and Civil Hospital have specially appointed CMOs, but in the sub-district hospital, the duty of CMO is taken up on rotation basis by all medical officers. Mostly CMOs are found to be male doctors, though there is no such stated rule. All of the three CMOs we interviewed were male doctors.

The Casualty Medical Officer is generally assigned with the following roles concerning victim-survivors of sexual assault.

a. Registration of a medico-legal case in the Medico-legal Case Register or Emergency Police Register (MLC register)
b. History[15] taking and Physical Examination by inspection
c. Documenting the history, and external injuries in the MLC register.
d. Treatment of external injuries
e. Referral to gynaecology department for gynaecological examination
f. Sealing samples and handing over to the police
g. Issuing an injury certificate for purposes of prosecution

In case a woman or child reports directly to the health facility, they are sent from the OPD, where generally they are 'discovered' on history taking and sent to the Casualty Department. It is the responsibility of the CMO to notify the police and get the crime registered, before any examination can proceed.

The CMO records the case in the Emergency Police Register (EPR), and makes a carbon copy of the details on the case paper. He also records the thumb impression of the woman and her identification mark. Being escorted by multiple police, recording the thumb impression and recording identification mark may make the woman feel like a criminal herself.

2. *Gynaecologist*: A gynaecologist is preferred for the next step of examination, i.e. internal examination, irrespective of whether the gynaecologist is male or female. A gynaecologist (including female gynaecologist) was available at the two tertiary hospitals and civil hospital. A gynaecologist makes a weekly visit at the sub-district hospital. There were no gynaecologists in the rest of the facilities, including the state run secondary hospital which also functions as a medico-legal centre and where the maximum number of sexual assault cases were seen, among the sampled facilities. A gynaecologist is expected to perform the following role

a. Take a brief history
b. Document injuries on genital area
c. Conduct an internal examination and document findings
d. Collect forensic samples and send to the Casualty Department
e. Take decisions as per diagnosis and treatment related to reproductive and sexual health
f. Make any further referrals
g. Findings are sent to the Casualty Department to assist in making the final Injury Certificate.

[15] History is the standard term used in medical language to give account of what happened. Here it means the narration of the assault incident and the complaints.

The nurse labels the samples and puts a temporary seal. The samples are sent to the Casualty (State Run Tertiary and Civil Hospital) or Medical Records Department (Municipal Tertiary Hospital) for permanent seal.

Hospitals such as Municipal Tertiary Facility and Civil Hospital make an attempt to admit the woman or child. Apparently this seems a positive step as within the hospital system if the patient is admitted specialists are expected to visit the admitted person and not vice-versa. On the other hand, when referrals are made on OPD basis the patient has to move around to respective departments. But women and families are generally not ready for admission. The flip side became apparent when the research team visited hospitals. Admissions often delay the examination and are more for the convenience of doctors than patients. Often senior doctors who are also expected to examine or provide inputs may come only on the next day.

Procedures followed in case of children: The definition of a child varies in varied contexts. For purposes of medical examination, the definition of child used for hospital purposes and age at which a person can give consent for medical examination are relevant.

The classical definition of a child followed by the medical community is someone who is less than 12 years of age. Internationally the definition of child for medical purposes has been revised to less than 16 years in some places and less than 18 years in others. One paediatrician told us that though this is so, it has not been adopted in India for hospital procedures, because then the question of a separate male and female ward in paediatrics department would arise. Currently, the paediatrics departments in all hospitals have only one ward for both sexes. Therefore practically all those under the age of 12 years are 'children' for the hospital system.

Standard textbooks of Forensic Medicine which also define legalities pertaining to medicine mention the age of consent for physical examination as 12 years. But this is not what is practised in the hospital system. Practically, all the doctors we interviewed told us that only a girl above the age of 18 years can give consent for medical examination which is required when the crime is registered. Consent was said to be obtained from the family, guardian or at times from the police while examining all those under the age of 18 years.

Unless the children were very young, example, less than 10 years, the same hospital procedures were followed in cases of sexual assault.

Presentation to the hospital in cases of child abuse: As mentioned earlier it was much more probable for children to be brought directly to the hospital as compared to adult women. Generally, girl children are brought by their family but abused boys are more likely to be living on the street and brought by police. In many cases families had first sought treatment in private hospitals and then were referred to public hospitals for medico-legal documentation.

In cases of young children too, once the abuse was discovered, it was advised to make a police complaint. Sometimes families did not agree to make a complaint and the children were sent home after treatment.

> There was one case of an 8 year old female child. She was brought by her parents; both mother and father were there. They complained of vaginal bleeding and abdominal pain. History given was of fall, but this did not seem consistent with the complaints. I took the opinion of gynaecologist. The child was very uncooperative. She did not allow examination. We prepared her psychologically for the examination. Mother was approached and counselled. We felt that she was hiding something. We informed the police but she was not ready to lodge a complaint. She was admitted for a day. She left secretly against medical advice. The perpetrator, most probably was the father (Told by paediatrician at sub-district hospital).
>
> In one of the cases, it was a 5-6 year old girl. She was referred from gynaecology department. At first the mother feigned

no knowledge, but later very unwillingly admitted that the father had abused the girl. It is very difficult to get a history in such cases. We took history with the help of social workers (Told by Head of Paediatrics Department, Municipal Tertiary Facility).

Sometimes 8 to 9 year old girls are brought. They have a stunned look on the face. Also have loss of weight. Their behaviour suddenly changes. 'Achanak shant hotat'. (They become very quiet.) They are on the threshold of adolescence. They are aware that something is wrong. In such cases I alert the mother. I have also seen two cases of vaginal bleeding in such 8 to 9 year old stunned and quiet girls. These were most probably cases of sexual assault but the family is not ready to talk (Told by paediatrician at sub-district hospital).

Doctors said that they found it difficult to take history of very young children, especially because children do not have adequate vocabulary to narrate what happened. Most children who can talk describe the incident as '*ganda kaam kiya'.* The bigger hospitals take the help of child psychologists and social workers to get the history.

Doctors also reported that sometimes the family was more concerned about their reputation and the child's future and preferred not to pursue the complaint.

> Parents of young children often request to make report of sexual assault negative (means to show that rape did not take place), to discourage negative reactions from the society. (Medical Officer at State Run Secondary Facility)

Flowchart II: Procedures in case of children

Procedure Followed In Case of Children

Young Male Children
↓
OPD paper is made by CMO
↓
CMO conducts physical examination, Inspection and Documentation
↓
Sent to Paediatric Surgery Department if present in hospital. If not then the CMO or doctor on duty examines and treats
↓
Paediatric Surgeons take care of medico-legal examination, collection of forensic samples
↓
Surgical treatment if required
↓
May be referred to Paediatrics department And X-ray facility, Forensic Department for age estimation

Young Female Children
↓
OPD paper is made by CMO
↓
Referred to Gynaecology Department
↓
Psychologist or Social Worker may be called to help in taking history
↓
Gynaecologist conducts the Gynaecological examination, collection of forensic samples,
↓
May be referred to Paediatrics department or paediatric surgery for treatment if required and available
↓
X-ray facility, Forensic Department for age estimation

1. Paediatrics department: A paediatrics department is present in State Run Tertiary Hospital, Municipal Hospital and a paediatrician is present also in the Civil Hospital and Sub-district hospital. There is no paediatrician available at State Run Secondary facility and PHC. The paediatrics department employees doctors who have a post graduate degree in paediatrics, i.e. they are child specialists. But irrespective of this little girls who are suspected of sexual abuse are taken to the gynaecology department or to the gynaecologist and not the paediatrician. The gynaecologist is responsible for the gynaecological examination and collection of forensic samples. The paediatrician is called to provide medical treatment in case it is required. When the case comes directly to the Paediatrics department, which is not uncommon, they in turn refer it to the Gynaecology department.

4. Paediatric surgery: Young boys when brought to the health facility are referred to the Paediatric Surgery Department. This department is present only in the two tertiary care centres. Paediatric Surgery employs doctors who have specialised first in General Surgery after their basic graduation and then further specialised in Paediatric Surgery. They conduct examination in cases of very young male children. They may be called to assist in surgical treatment for young girls, but the principal responsibility rests with the gynaecologist.

5. Forensic Department: The forensic department is present in the two tertiary hospitals and forensic doctors are employed also with the State Run Secondary Health Facility. They are responsible mainly for age estimation and examination of the accused. Age estimation is an important examination in the context of sexual assault, as any sexual intercourse with a girl under the age of 16 years is statutory rape according to the Indian Penal Code. Though the rationale of the test is clear, we received different responses to the question of when was the test asked for. Some of the answers included-

- In every medico-legal case we send for age estimation. This is done irrespective of any documentary proof available.
- Below 18 years
- In every case above the age of 10 years, unless she tells her age to be well above the legal age of consent
- When she is suspected to be minor or around 16 years of age
- When the police request for the same. If birth certificate is available and the age is obvious then the test is not done.
- When age of the survivor is unknown and no proof of age is available.

It seems that at least in facilities such as State Secondary Facility, age estimation takes place in every case, though maybe the entire battery of tests may not be employed. This is corroborated by records of the State Secondary Facility where age is marked as 16 to 17, 10 to 11 in every case and not as one figure told by the patient.
Age estimation involves

- Measurement of height and weight
- Breast development and examination for development of secondary sex characters such as hair in arm-pits and pubic hair.
- Dental examination for eruption of teeth
- X-rays of joints such as hip, knee, elbow, shoulder, wrist and jaw bone for ossification of bones.

Clearly, it is an estimation which requires physical examination. In the State Run Tertiary Facility this examination is carried out in the Seminar Room of the Forensic Department! The female laboratory technician is asked to be present during examination. The research team visited this Seminar Room. The room was organised like a regular seminar room with a huge table in the centre and chairs around it. It had big glass windows, but no curtains! There was no place for a complete physical examination.

Multiple X-rays are also needed subjecting her to radiation.

We were told that documentary evidence of age is not sought before conducting age estimation. It appears that documentary evidence procurement involves the following problems-

- It is not the job of the doctor to procure it
- It may not be reliable
- Courts do not rely on it

Providing the Injury Certificate: The Injury Certificate is the summary of findings of the medical examination and is given by the Casualty Medical Officer on plain paper in a day or two after the examination. Immediately after the examination, the police are given only the samples of evidence collected to deliver to the laboratory. This is accompanied by a printed form filled for the Chemical Analyser or Forensic Laboratory. A receipt that the police have collected the samples is taken from them. The Casualty Medical Officer compiles the notes of the gynaecologist and any other expert within the hospital who has examined and summarises these findings in the Injury Certificate. There may be delay in both handing over the samples and injury certificate. The examining doctors are not expected to give any opinion regarding the medical examination, except in the case of age estimation. They are expected to record their observations and answer the queries made by the police.

Procedures differ in health facilities where a number of departments do not exist. They are given in short here.

In the State run secondary referral hospital, the police brings the survivor to the Medical Records room where consent is taken by the clerk (!). The clerk also takes the left/ right hand thumb impression of the woman. They are then taken to the medical officer who conducts the physical and gynaecological examination, collects forensic samples, documents injuries and findings in the examination room. Survivor is sent to the radiologist for x-rays if age estimation is to be done. For any diagnosis and treatment, the woman is referred to another institution. Step 1, in the flow-chart pertaining to the examination by Casualty Medical Officer is skipped in this facility and the role of the Casualty Medical Officer as well as Gynaecologist (step 5 and 6) is performed by the Medical Officer on duty. Step 8, i.e. diagnosis and treatment also does not happen in the hospital. This is because though it is a full fledged hospital, for purposes of police cases it functions only as a medico-legal centre. They refer all cases requiring diagnosis, treatment and ultra-sonography. The ward boy labels the samples and seals it in front of the clerk in the Medical Records room. The clerk is in charge of the hospital seal.

In the Sub-District hospital, the survivor is first brought to Casualty by police, where case paper is made. Again an identification mark is noted and thumb impression is taken. The woman is not examined or inspected in Casualty. Honorary Gynaecologist (if available, first preference) or Woman Medical Officer (second preference) examines the survivor in presence of a female nurse, collects samples and documents the findings. The nurse seals and labels the samples and it is handed over to the police to be taken to the Forensic laboratory. As Radiology department is not present, women are referred to civil hospital for age estimation.

In the Primary Health Centre**,** the medical officer on duty examines the woman or child, collects samples and documents the findings. The medico-legal certificate is handed over to police a day or two after examination. Survivor is referred to Sub-District or Civil Hospital for X- rays (if required), diagnostic tests and treatment if required. As this is the smallest facility, most of the steps in the above flowchart are not followed. Generally, most cases are directly referred from the PHC to the referral facilities due to lack of expertise and facilities.

> Last case was of a 15 year old girl, who came after 8 days, so the possibility of finding anything was much reduced. I had referred the case to ****** hospital, so that she could be examined by a gynaecologist, but they sent her back here. They said if the case happened in this area, it had to be examined in the same place. So I examined her finally. I studied some books before examination (Told by PHC Medical Officer)

The above case highlights that not only are cases referred to other hospitals as peripheral facilities do not have facilities, but patients may be referred back or to other facilities. Referral in matters as sensitive as sexual assault not only means loss of

time and evidence, a dis-incentive to report and higher visibility as she travels with the police in the police vehicle, but also that the woman has to open up and tell her story to multiple service providers.

Police Procedure

As sexual assault is a medico-legal case, police is involved in recording the complaint, filing an FIR, investigation, charge sheeting and cooperating with the courts throughout the trial. The various stages of police procedure in a case of sexual assault are explained below by the way of a flowchart. The police procedure is derived both from what the police told us and what the doctors told about the interface with police.

Profile of cases as told by the police: One police officer said that there were three kinds of cases reported.

1. **Technical Rape:** A lot of cases of sexual assault are the ones where the girl goes along with the boy with her consent, but the parents make the complaint. Here the girl may be underage and thus technically it is rape since she cannot give consent. Also there are cases where the boy refuses to marry the girl. Here the girl is consenting initially since she believes that he will marry her. These cases, as they are usually old cases are difficult to prove.
2. **Rape in Violent, Isolated situation:** Sometimes girl is kidnapped and taken to isolated place and raped or gang raped. These are cause for concern. It is entirely against her wishes. Sometimes the victim is pressurised by blackmailing and photographing. Child's consent is not a valid consent. Even the guardian cannot give consent on behalf of the child for this.
3. **Marital Rape:** The law also has provision for marital rape, but generally nobody complains. There is no discrimination in law between stranger rape and marital rape, but it is not taken seriously.

More or less the same descriptions were given by the other police officers interviewed. There is clearly a discrepancy in the fact that criminal law does not recognise marital rape except for girls less than 15 years of age, but the police reported as above.

When a complaint is made the First Information Report is filed in the woman's own words or as told by the family in case of children. Sections are defined here by the Investigating Officer. Generally the person in charge of investigation is of Police Inspector level, but those assigned with hands on work include junior officers, up to the level of constables. Among the police officials interviewed one Police Inspector had worked for 30 years but had not investigated a single case of sexual assault. Another officer had an experience of twenty two and half years and had investigated only 3 to 4 cases. Of these cases some were handled when he was a sub-inspector, under the team led by an Inspector. The third Police Inspector interviewed had 19 years of experience and had investigated 7 cases, all as sub-inspector. From the information we received it appears that many police personnel are promoted to the position of PI after about twenty years of service and each may have investigated few or no cases of sexual assault. We were told that there was no special cadre to look after crime detection.

According to one police officer, 60 per cent FIRs are filed immediately after the crime is committed, in the rest there is a delay of 1 or 2 days and technical rape may be filed up to 4 to 6 months later. Here again 'technical' rape is considered as a category apart.

Flowchart III:

Procedures Commonly Followed At the level of Police

FIR is filed (version of the complainant told in the complainant's own words). **Sections are defined here** by the **Investigating Officer.**

↓

Victim's and witnesses **statement is taken**

↓

Spot *panchnama* done at the site of the incident with two *panchas*. **Circumstantial evidence** searched for.

↓

(Delay occurs here as it is difficult to get panchas)

Clothes collected from the woman

↓

Woman sent for a **medical examination** in police vehicle with a woman police constable and **police memo** [which has some pertinent questions addressed to the examining doctor]

↓ *(Delay occurs here if woman constable is not available)*

If the **accused** is known/found then **identification parade** is organized by jail authorities

↓

He is also taken for a **medical examination**

↓

Samples and injury report handed to the police by hospital

↓

Samples handed over to the **Forensic Science Laboratory** by Investigating Officer (reports usually come within 2 months)

↓

Jail custody is asked for the accused. This application has to be made to the **Special Executive Magistrate**

↓

Chargesheet is filed within 90 days of filing the FIR, provided an accused is identified. The reports of the forensic laboratory help in finalizing charges

↓

Interaction with **public prosecutor** (which evidence to highlight etc)

Panchnama: An attempt is made to locate the spot of crime and spot *Panchnama* is made. A *Panchnama* is the document where the crime scene description is written, list of things found on the crime scene taken into custody and documented and statements of any witnesses are taken in the presence of two *Panchas or* witnesses. An adult, more than 18 years of age, who does not have any criminal record on him, can become a witness or a *panch*. The *panch* has to be present when samples are sealed and have to sign on police papers. This procedure is called *Panchnama*. The witnesses also have to come to the court for the hearing. *Panchas* are required to endorse documents at every stage such as when the crime scene is photographed, if a weapon is found, at the time witnesses give a statement. A total of upto 10 *panchas* could be required for each investigation. Sometimes the police have to make-do with only one instead of two *Panchas* at each point as people are reluctant to become a witness. This is also a cause for delay as people have to be approached and convinced to become a *Panch*.

Sometimes the spot of crime cannot be determined and then spot *Panchnama* is not done. Circumstantial evidence such as ruffled or disturbed

bed or marks of force used such as broken window or door through which the person entered is noted. Though one police officer conceded that generally signs of use of force are not found, his next sentence was-

> But if there is no willingness, no consent how can it happen without the use of force? Without use of force Sexual Assault is impossible. (Police officer interviewed)

After this the police visit the girl or child's house to collect clothes worn during assault and send these to the forensic laboratory. Clothes are wrapped in brown paper. Clothes are collected even if they have been washed, as there is still some possibility of recovering evidence by the forensic laboratory. This could be a place where there is further delay. There is no provision of change of clothes at the police station if the woman has come in person to file the case. Neither is there any provision of change of clothes at the hospital if the woman goes directly to the hospital. One police officer told us that registration of crime and filing of First Information Report, Panchnama and collection of clothes takes about 3 to 4 hours, after which she is taken for a medical examination. This seems to be an under-estimate. Clearly medical examination is not carried out immediately.

Collection of Medical Evidence: The police do not always escort cases to the nearest hospital, as would be expected. In the district where the State Secondary Facility was located most cases were taken there for examination irrespective of location of complaint filed, though some were taken to other facilities. In the other district women and children were taken for Medical Examination preferably to bigger hospitals, mostly Civil Hospital, but are also taken to the sub-district and rural hospitals. Medical Examination is carried out in all cases of sexual assault. The police told us that doctor's know about the procedure of examination. Queries are also given by the police. Queries quoted by police and doctors were:

- *Whether it was rape?* (*Balatkar zhala ka?)*
- *What is the time lapse after the event? (This is asked in case of late reporting)*
- *Did intercourse take place?*
- *Was force used?*
- *What is the age of the victim? (all cases)*

Queries made to the forensic laboratory are

- *Is the blood found human blood or animal blood?*
- *If hair is found, is it human? Of which part of the body it is?*
- *Does the blood match? Does the semen match?*

Another police officer told, "Generally we expect to see injuries, genital injuries, bleeding, semen stains on clothes and such things. If there are semen stains DNA can prove the identity of assailant." (Police officer interviewed)

On being asked about procedures followed if it is suspected that drugs or alcohol were used, one police officer said:

> I have not investigated any case where drug/ alcohol was used. If the accused is drunk or under the influence of alcohol, he will not be able to do the crime, because he can't apply force. Force is essential for the crime to happen. (Police officer interviewed)

The charge sheet is the document where charges are systematically framed for purposes of the court trial. All cases where accused is identified, charge sheet is mandatory within 90 days. In case bail is granted to the accused by the court then the charge sheet has to be filed within 180 days. Charge sheet contains FIR No, complainant's name and address, articles seized particularly of accused, personal details of accused, bail details, date of arrest, co-accused details if available and relevant. It also contains a list of witnesses such as the *Panchas*, witnesses, Medical Officer, Chemical Analyser (at Forensic Laboratory), Special Executive Magistrate (SEM), Police Investigating Officer (IO). In the end charges are framed and signature of IO, Police station in-charge and Assistant Commissioner of Police (ACP) is taken. Each charge sheet has to be signed by ACP. If no accused is found then case is termed as "True but undetected" case or 'True versus Unknown'

case and the final summary report of such case is sent to court.

Police officers told us that though it is ideal to be in touch with the forensic laboratory while trying to solve a case, it is not practical. The only interaction is when a case is important and high profile, when they request the forensic laboratory to give the results of tests earlier than scheduled. They said that generally the laboratories complied with such requests. Generally the forensic laboratory results are obtained within two months. The report is appended to the charge-sheet. In addition he told us that in the designation of hierarchies the Director of Forensic Laboratory has a higher designation. It is possible therefore that this hinders the dialogue process.

On the other hand, they said that they maintained a good dialogue with the Public Prosecutor in order to strategise regarding which evidence to highlight in the case.

The police said that they do not refer cases to the Special Cell for Women and Children as they do not see any role to be played by them. Juvenile offenders and children and women who have nobody to take care of are sent to remand homes and home for women and children respectively.

Forensic Laboratory

Forensic Laboratories receive samples through police and then analyse them. The clerk receives the samples from the police and then hands it over to the Reporting Officer. The Reporting officer with his team analyses the samples, and sends in the report to the police in two months.

Overall the forensic laboratory staff seemed satisfied with the condition of samples being sent from health facilities. Lab personnel told that they reject samples if they are not properly sealed or if they arrive too late (15 to 20 days) after collection. This indirectly tells us that such cases do occur. Technicians talked about the need to train the Medical Officers on preservation of samples. "Once a vaginal smear was wrapped directly in Johnson's tape and was destroyed!"

There is no feedback mechanism for health professionals to know whether the samples they are sending and the bulbs in which they are preserved and sent are appropriate. The forensic laboratories have not conducted any training for the health personnel. One technician commented on training of doctors- "It is very important. But hard to carry out since doctors think they're experts too!"

Researchers have noted the discrepancies they found in the expectations of the laboratory and procedures followed at the hospital level.

Table 4.6: Evidence collection

Requirements of Laboratory	Ground reality in health facilities
All samples need to be air dried	Sometimes, especially in monsoon samples are not completely dry. Moisture encourages growth of microbes and samples are destroyed
Survivor should be medically examined immediately	Survivor reports late and evidence is lost in 80% cases (as reported by technician)Sometimes there is delay if no woman police constable is available to take survivor to health facility
Samples collected should be preserved in ice Cold chain not adhered to in hospital	Samples are not preserved in ice. Handed over to police for transportation to the forensic laboratory, even in case of time lag. Samples should be sent to laboratory immediately after collection
as well as police station	Delay in handing over samples occurs both at health facility level and police level

Examining doctors need to read the laboratory report before testifying in court. E.g. If vaginal swab has been sent to the laboratory the doctor benefits from knowing whether sperms could be identified on the swab, when she testifies in court. Doctors do not uniformly get to see laboratory reports. Many times they see reports directly in the court room.

Problems told by counselors: Many women's counselling centres focus on domestic violence. Conversations about sexual violence happen much later with the counsellors, and that is generally restricted to sexual violence within marriage. This is primarily because there is no mechanism to refer women and children facing sexual assault to these centres for emotional, social and legal support. Counsellor from Special Cell for Women and Children told that though they worked within the police system, none of the cases of sexual assault were referred to them. This was confirmed by the police in their interviews. A women's support centre is located within the Civil Hospital, but doctor's at the Civil Hospital too said that there was no protocol to refer cases to this centre. Three centres also felt that technique to deal with sexual violence and especially children's requirements needed to be developed amongst them too. Medical social work departments exist in the bigger State run tertiary and Corporation run tertiary hospitals, but they are "*not very effective*" as put by one of the doctors. They exist to provide monetary support in cases where patients can't afford to pay for services. But there is no aspect of care giving or counselling.

Problems articulated by health personnel: Several problems which affect their functioning were recounted by doctors in various facilities.

Forensic doctors felt that Health Care Facilities do not give adequate priority to medico-legal work. Their priority is to save lives and medical treatment. Thus there is inadequate attention to provide for facilities required for medico-legal work.

On the other hand, Gynaecologists from the State Run Tertiary Facility felt that they had a huge load of clinical work and hence they could not do justice to the work. They felt that this work should be given to designated persons or hospitals in a well coordinated manner and all doctors should not be expected to do it. There were a lot of referrals to this Facility from other hospitals regarding treatment, diagnostic procedures and lack of woman doctor to examine.

Doctors told us about problems that occur between departments, example, Gynaecology department and Paediatrics about who should examine very young girls. The entire system in all hospitals except the State Run Secondary Facility functions with the understanding that Gynaecologists are best suited for examination. The Gynaecologists at the State Run Tertiary Facility were not very happy with this and would prefer if other departments and specific medical officers would take up this job instead.

Sometimes two doctors are involved in examination. The lecturer examines and Resident Doctor writes the notes. In such and other cases the names and designations of examining doctors are not clearly written and legible on the documentation. It then becomes difficult to trace doctors for the court testimony when the court summons come.

Several equipments/ medical supplies required to provide standard services were not available. These were-

- Standardised forms used to document were adopted by some hospitals but were not always available. This caused delay in examination.
- Swabs and such material required for examination was not stocked.
- Child Psychologists who could be especially helpful in children's cases were not available. The State Run Tertiary Facility told that their child psychology unit has closed down due to lack of funds! It was supported through external funds and was of great help in such cases but has closed down since those funds are not available now.
- No counselling and psychological support is provided, especially in facilities other than tertiary facilities and to adult women.
- Bigger hospitals such as tertiary hospitals and Civil Hospital complained that the

> smaller facilities acted as '*traffic policemen'* directing women and children to the bigger facilities. This was because they were ill-equipped to provide all services.

There is no practical training provided to doctors to conduct medico-legal work. The training provided in the second year of MBBS is not enough. As one doctor put it-

> In the second year nobody takes interest in such matters (Casualty Medical Officer at Sub-district hospital).

Some heads of institutions and departments make attempt at their level to procure training for staff, but there is no institutionalised procedure and plan. There is no orientation from the forensic laboratory. Especially there is no sensitisation to handle a crime of this nature and to the emotional support that is required.

Doctors said that they felt ill equipped to take history when very young children came for examination. They also felt ill equipped to provide emotional support. In fact a paediatrician said that the cases caused emotional disturbance for the health professional herself and they were not trained to cope with it.

Samples are not refrigerated, though recommended. There is delay in handing over of samples and handing over Injury Certificate.

Women Gynaecologists from the Civil Hospital said that they were called to court several times and made to feel embarrassed in the courts while giving testimony. But this was a minority opinion. Most doctors said they had no problems in courts. Orientation to how to formulate an opinion and face courts or what the courts expect from doctors is not provided in the doctor's training. They learn from experience. Such training was felt necessary. The courts are also not oriented to ask doctors pertinent questions.

Maybe as a result of all of the above, many times doctors on duty do not want to examine cases. They try to wriggle out of this work by saying that they are posted somewhere else. One key informant who did not support such behaviour told us that they call this attitude '*batting*', that is if the ball of responsibility comes to a doctor, she will '*bat*' it to someone else, like the cricket bat hits the ball away!

Recommendations by doctors:

1. Send cases to specialised medico-legal centres. Chain of specialised hospitals to be created to provide immediate decentralised care. Otherwise there can be a special senior Medical Officer for medico-legal work designated in the facility.
2. MBBS doctors can provide services. They should be trained to do so. No need of a Gynaecologist.
3. Women doctors to be made available.
4. Paediatrician to be present in cases of young children
5. Guidelines, protocols are important. Printed guidelines to be displayed in the examination room. Standard form of examination is required, so that uniformity is maintained.
6. Practical training/ orientation should be provided to students in their internship.
7. Police should provide on-going counselling services.
8. Home ministry should take responsibility to improve infrastructure
9. Cases should come faster in court. This would facilitate same examining doctor to appear in court. In cases of delay the examining doctor has been transferred or may have left the service.
10. There should be better quality of documentation by doctors.
11. Interaction between medical people, police officials and forensic science laboratory should increase.
12. There should be training of all Medical Officers in providing medico-legal services and there should be on-going orientation, probably through Continued Medical Education.

Chapter 5

Essential Medicines, Equipment, Medical Supplies and Status of Examination Room

One of the aims of this research was to study the examination facilities at the health institutions where examination and evidence collection from the survivor is done; and compare them with a model examination facility to enable us to know where each of the facility stands and to give specific recommendations. Towards this we divided the model facility into indicators which cover essential internationally recommended parameters.

Examination Facilities: In the State Run Tertiary Facility and Civil Hospital examination is generally carried out in Gynaecology ward. In the State Run Secondary Hospital it is carried out in the dressing room. In the Sub-district Hospital it takes place in the Gynaecology OPD. In the PHC it takes place in the Labour Room. In the Municipal Run Tertiary facility we were told that examination takes place in the receiving room of the Gynaecology ward but we were not allowed to visit the facility, and hence this facility is not scored here.

Only medicines, equipment and facilities found in the examination room are marked as available. It must therefore be noted that all these observations pertain to the supplies found in that particular room on that particular day when we visited the facility. The equipments and medicines were also examined only in this room. An attempt was made in case of medicines to find out whether they were made available elsewhere and this has been noted.

Method of data analysis: Table 5.1 gives the final scores of indicators and the facility. Tables 5.2 to 5.4 give the details of findings of observation. Each institution has been scored on a scale of 0 to 2, with 0 score indicating unsatisfactory performance, 1 score indicating partially satisfactory and 2 indicating satisfactory performance. The sum of parameters within the indicator gives the score of the indicator, which is then converted to a percentage. The average of these scores is the final rating for the institution.

Table 5.1: Comparative Analysis of Essential Medicines, Equipments, Medical Supplies and Status of Examination Room

	State Run Tertiary Hospital	State Run Secondary Facility	Civil Hospital	Sub-District Hospital	PHC
Essential Medicines Made Available	Fair (50%)	Poor (38%)	Fair (50%)	Poor (33%)	Poor (25%)
Essential Equipment/ Medical Supplies available in examination room	Good (77%)	Good 67%)	Good (67%)	Good (73%)	Poor (8%)
Facilities in Examination Room	Fair (50%)	Fair (43%)	Fair (43%)	Poor (29%)	Poor (7%)
Status of Room For Examination	Very Good (91%)	Fair (59%)	Very Good (91%)	Fair (59%)	Poor (36%)

We were not permitted to observe the examination facility at Municipal Tertiary Facility and hence it is not included her.

Overall, the State Run Tertiary Facility seems to be doing relatively better on most counts and the PHC fares 'Poor' on all counts. This is expected as the two facilities are on two sides of the spectrum of health facilities in the public health system. Given below is an indicator wise analysis of the facility.

Analysis of Essential Medicines (Table 5.2): Each medicine was scored on the basis of whether it was physically present in the room or whether it was being provided elsewhere.

Most facilities did not have the essential medicines stocked in the examination room. The exception was dressing material which was stocked in the examination facilities of State Run Secondary Facility and Civil Hospital. It is obvious that there is no concept of all care to be provided in one room and the same place where examination takes place. All facilities provide treatment of injuries and painkillers, irrespective of whether the examination room has the provision for it.

The State Run Tertiary Facility provides all the medicines used as indicator here. It was not clear whether the Civil Hospital and Sub-district Hospital provided Emergency Contraception and Pregnancy Tests routinely[16]. The State Run Secondary Facility and the Primary Health Centre do not provide these services to rape cases on a routine basis. In the overall assessment for this indicator, the State Run Tertiary Facility and Civil Hospital fared 'Fair', while all the other facilities fared 'Poor'.

Table 5.2: Essential Medicines Available and Observed in Examination Room[17]

Maximum marks if found satisfactory	**State Run Tertiary Hospital**	**State Run Secondary hospital**	**Civil Hospital**	**Sub-District Hospital**	**PHC**
Treatment for Physical injuries (e.g. dressing material) (2)					
Present in room (1)	No (0)	Yes (1)	Yes (1)	No (0)	No (0)
Provided elsewhere (1)	Yes (1)	Provided in same room (1)	Provided in same room (1)	Yes (1)	Yes (1)
Painkillers (2)					
Present in room (1)	No (0)	No (0)	No (0)	No (0)	No (0)
Provided but elsewhere (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)	Yes (1)
Emergency contraception (2)					
Present in room (1)	No (0)	No (0)	No (0)	No (0)	No (0)
Provided elsewhere (1)	Yes (1)	No (0)	Unclear (Not scored)	Unclear (Not scored)	No (0)
Pregnancy test kit (2)					
Present in room (1)	No (0)	No (0)	No (0)	No (0)	No (0)
Provided but elsewhere (1)	Yes (1)	No (0)	Unclear (Not scored)	Unclear (Not scored)	No (0)
Subtotal (8)	4 (50%)Fair	3 (38%)Poor	3 (50%) Fair	2 (33%) Poor	2 (25%) Poor

[16] Routinely means that assessment for these services to be part of package provided routinely.
[17] No clear information about use of or stocking of tranquilizers and anti-emetics (to prevent vomiting) was available and hence these were not included in the analysis.

Essential Equipment/ Medical Supplies available in examination room (Table 5.3): The State Run Tertiary, State Run Secondary, Civil and Sub-District Hospitals score 'Good' here, while the primary health centre fares 'Poor'. The Primary Health Centre was clearly ill-equipped to examine.

Paper envelopes for collection of samples are not used in the facilities we studied. This is a cause of concern, since the technician from forensic laboratory emphasized the importance of air drying of samples and using paper envelopes to keep samples dry. He told us that moist samples are a problem in the monsoon months due to excess humidity. Moisture can cause degeneration of body fluids and destroy DNA from it. In each facility a few of the examination equipments were missing. If they are available in the institution, time is spent in getting them together and then starting the examination or these are not used at all. Sheets of paper for the survivor to stand while undressing, bag for collection of clothes and sanitary napkin were missing in all institutions. In the general procedures followed, it was found that collecting clothes from women is the responsibility of the police, and not the doctor. Due to various barriers to reporting, women generally report late, and doctors may not have required to collect clothes or the sanitary napkin for evidence. But with improvement in reporting of cases, this could be major lacunae in supplies. Also a sanitary napkin should be considered a basic necessity where gynaecological examination of women takes place.

Table 5.3: Essential Equipment/ Medical Supplies available in examination room

Availability of	**State Run Tertiary Hospital**	**State Run Secondary hospital**	**Civil Hospital**	**Sub-District Hospital**	**PHC**
Sheet of paper (2)	No (0)	No (0)	No (0)	No (0)	No (0)
Sterile cotton swabs (2)	Yes (2)	Not ready. Swab stick and cotton available. (2)	Yes (2)	Yes (2)	No (0)
Envelopes / bags for collection of clothes/ specimens (2)	No (0)	No (0)	No (0)	No (0)	No (0)
Scissors (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Combs (2)	Yes (2)	Yes (2)	Yes (2)	Not clear (Not scored)	No (0)
Sim's / Cusco's speculum (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Needles and Disposable syringes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Appropriate bulb (For Blood grouping & DNA Analysis) (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Appropriate bulb for drug/alcohol assessment (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Disposable gloves (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Nailcutter (2)	Yes (2)	Not clear (Not scored)	Not clear (Not scored)	Not clear (Not scored)	No (0)
Sharps container (to dispose off needles and sharp objects) (2)	Yes (2)	No (0)	No (0)	Yes (2)	No (0)
Sanitary napkins (2)	No (0)	No (0)	No (0)	No (0)	No (0)
Total score possible (26)	20 (77%) Good	16 (67%) Good	16 (67%) Good	16 (73%) Good	2 (8%) Poor

Table 5.4: Facilities present in examination room

	State Run Tertiary Hospital	State Run Secondary hospital	Civil Hospital	Sub-District Hospital	PHC
Examination table	Present with lithotomy position (2)	Present without lithotomy position (1)	Present with lithotomy position (2)	Present with lithotomy position (2)	Present without lithotomy position (1)
Optimal Clean bed linen	Moderate (1)	Moderate (1)	Moderate (1)	Moderate (1)	No bed linen (0)
Bed linen changed daily or after each examination	Daily (2)	Weekly irrespective of examinations (1)	Weekly (1)	Once in three days irrespective of examinations (1)	No linen used (0)
Adjustable lamp for examination	Yes (2)	Yes (2)	Yes (2)	No (0)	No (0)
Lockable cupboard for storing samples[18]	No (0)	Yes, but not used for storing samples (1)	No (0)	No (0)	No (0)
Gown stored there for examination purposes	No (0)	No (0)	No (0)	No (0)	No (0)
Change of clothes available	No (0)	No (0)	No (0)	No (0)	No (0)
Total score possible (14)	7 (50%) Fair	6 (43%) Fair	6 (43%) Fair	4 (29%) Poor	1 (7%) Poor

Facilities in Examination Room (Table 5.4): On these parameters, Sub-District and Primary Health Centre fare 'Poor', while other three institutions are 'Fair'. The State Run Tertiary Institution faring the best among all, has only 50 per cent of the required facilities.

Lack of basic facilities, such as lockable cupboard and non-availability of linen for daily change points to the general pauperization of the public health system. There is also no gown stocked for examination purposes and none of the facilities provide a change of clothes if required. A nurse at State Run Secondary Facility told us that they provide a sheet to the woman to cover the exposed parts while examining, but not a gown. This may also obstruct a thorough general examination that needs to be conducted to document injuries from all over the body. Not providing a gown may make the examination embarrassing for the woman.

[18] All the facilities told us that samples are given away immediately to the police and not stored at the facility. Hence there is no arrangement to store samples.

Table 5.5: Status of Room for Examination[19]

	State Run Tertiary Hospital	State Run Secondary hospital	Civil Hospital	Sub-District Hospital	PHC
Waiting room near the examination room	Common Waiting area (0)	Common Waiting area (0)	Common Waiting area (0)	Common Waiting area (0)	Common Waiting area (0)
Separate room for examination	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Optimum cleanliness	Yes (2)	Moderate (1)	Yes (2)	Moderate (1)	Moderate (1)
Privacy well maintained	Yes (2)	Yes (2)	Yes (2)	No (1)	Yes (2)
Wash basin	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Continuous water supply in room	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Facility for washing hands with soap	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Toilets attached or very close	Yes (2)	No (0)	Yes (2)	Yes but locked. Opened only for ANC OPD (1)	Yes (2)
Optimum cleanliness in toilets	Yes (2)	Not Applicable (0)	Yes (2)	Not seen. Toilet was locked. Opened only for ANC clinics. (0)	No (0)
Water in toilets	Yes (2)	Not Applicable (0)	Yes (2)	Not seen. Toilet was locked.(0)	No. Water tank was present outside. (1)
Table and chairs for documenting and labeling evidence	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)
Total possible score (22)	20 (91%) Very Good	13 (59%) Fair	20 (91%) Very Good	13 (59%) Fair	8 (36%) Poor

On the above parameters, State Run Tertiary and Civil hospital fare 'Very Good'. State Run Secondary and Sub-District Hospital were 'Fair'. Primary Health Centre fares 'Poor'. In three of the five facilities there was no clean toilet. Of these the State Run Secondary Facility does not have a toilet close by or in the same corridor. The toilet in the Sub-district Hospital was locked and inaccessible and the one in the PHC was unclean.

None of the facilities had a separate waiting room near the examination room for the girl, child or family to wait. None of the facilities provided a bathroom to take bath or warm water to wash, though this was not included in the scoring.

Overall the uniform absence of a private waiting room, bathroom, warm water to wash, gown, change of clothes and sanitary napkin in all the facilities when the concerned examination is of an intimate nature indicates that facilities are unfriendly to specific gender concerns. Some facilities also do not have a clean and thus functional toilet, making the facility un-friendly for women.

[19] Some parameters such as cleanliness are based on researchers' subjective judgements. It was based on common sense notions of acceptable cleanliness.

Blank

Chapter 6

Health Services, Medico-legal Services and Sensitivity

This study looked at the provision of services in health facilities for management of sexual assault and compare them with a model set of procedures. The analysis is based on three indicators- medico-legal examination services, health care services and women sensitive performance. These cover essential, nationally and internationally recommended parameters.

Methodology: Table 6.1 gives the overall score of the facilities. Tables 6.1 onwards give the parameters on which the scores were calculated. The left side of the table provides the indicators and parameters of measurement. Each institution has been scored on a scale of 0 to 2, with 0 score indicating unsatisfactory performance, 1 score indicating partially satisfactory and 2 indicating satisfactory performance. The response of those health care providers who were assigned the responsibility to provide the service was considered. The sum of parameters within the indicator gives the score of the indicator, which is then converted to a percentage. Table 6.1 gives the final scores of all indicators. The average of these scores is the final rating for the facility.

Some parameters are repeated across the indicators. For example, consent is part of the medico-legal work, while the manner in which consent is taken, is a parameter for sensitivity towards women and children. This does not affect the overall score since each indicator stands independent and the grading is not aggregated but an average calculated.

Table No. 6.1: Comparative Analysis of Provision of Services and Sensitivity in Provision of Services

Institutions → **Indicators ↓**	**State Run Tertiary Hospital**	**Municipal Run Tertiary Hospital***	**State Run Secondary Hospital**	**Civil Hospital**	**Sub-district Hospital**	**PHC**
Medico-legal examination	Fair (46%)	Fair (50%)	Fair(46%)	Fair (46%)	Fair (46%)	Poor (39%)
Health care	Good(60%)	Fair (44%)	Poor (15%)	Poor (11%)	Poor (11%)	Poor (10%)
Sensitivity towards women	Fair (42%)	Poor (27%)	Poor (33%)	Poor (33%)	Poor (33%)	Poor (38%)
Average score of each institution	Fair (50%)	Fair (40%)	Poor (31%)	Poor (30%)	Poor (30%)	Poor (29%)

**The research team was not permitted to visit the examination facility at the Municipal run tertiary hospital, and hence some of the parameters could not be gauged. For this reason, parameters which required information regarding the facility, have not been scored for this institution. These were removed both from the numerator and denominator and hence the final scores are not affected.*

Key to Scores: Very Good- 80% and above, Good- 60 to 80%, Fair- 40 to 60%, Poor- Less than 40%

All facilities were geared to provide a minimum of evidence collection as expected by the police. Beyond this, the survivor's health concerns appear to have been marginalised and concerns as a human being and a woman neglected. This is also substantiated by experiences of researchers while interviewing.

The provision of medico-legal services followed set norms and procedures and it was easy to get information about who provides services, from where, etc. But there did not seem to be set norms and practices in place for health care. Health care in the Civil and Sub-district Hospital and PHC fared the poorest (Table 6.1).Facilities indicating sensitivity towards women were also generally poor except in State Run Tertiary Hospital. Overall, the State Run and Municipal run tertiary care facilities were better placed at providing the range of services that are expected to care for women and children. They are rated as 'Fair'. The rest of the facilities are 'Poor'. In the tertiary care hospitals the required facilities existed but comprehensive care was not routinely given. (Table 6.1).

1 Provision of Health Care services

Table 6.2: Wound care and care for associated risks

	State Run Tertiary Hospital	**Municipal Run Tertiary Hospital***	**State Run Secondary Hospital**	**Civil Hospital**	**Sub-district Hospital**	**PHC**
Dressing and other wound care is made routinely available (2)	Reported provided (2)	Reported provided (2)	Reported provided (2)	Reported provided (2)	Reported provided (2)	Reported provided (2)
Injection Tetanus Toxoid to be given when appropriate (2)	Reported provided (2)	Not permitted to interview CMO. (Not scored)	Not Reported (0)	Not Reported(0)	Not Reported (0)	Not Reported (0)
Subtotal	4 (100%)	2 (100%)	2 (50%)	2 (50%)	2 (50%)	2 (50%)

Wound care and care for associated risks (Table 6.2): All the facilities were found to prioritize immediate medical emergencies and needs. Wound care was assessed by way of reporting by health care providers, whether basic dressing material was available (observation of facilities) and whether injection Tetanus Toxoid (Inj. TT) was given or risk assessed for the same. All facilities but the municipal institutions were equipped for basic injury care. But none of the health professionals apart from the Casualty Medical Officer (CMO) at the State run tertiary facility mentioned providing Injection Tetanus Toxoid. In the Municipal facility we could not meet the CMO so they are not scored on this parameter.

Table 6.3: Provision of mental health care and other support

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital*	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
A Psychologist/ Psychiatrist/ counsellor should be available (2)	Mixed responses. (1)	Available but services are not sought routinely (1)	Psychiatrist available as honourary, but called only to ascertain mental state of the woman (1)	Not available (0)	Not available (0)	Not available (0)
A Social worker should be available (2)	Mixed responses. (1)	Available but services are not sought routinely (1)	Not posted (0)	Posted but services not used (0)	Not posted (0)	Not posted (0)
Subtotal (4)	2 (50%)	2 (50%)	1 (25%)	0 (0%)	0 (0%)	0 (0%)

Provision of mental health care (Table 6.3): Mental health services were assessed on the basis of whether a psychologist, counsellor or social worker was posted at the facility and whether they were routinely asked to offer services. Counsellors were not posted at the Civil Hospital, Sub-district Hospital and PHC. A women's organization is based in the Civil Hospital, but women and children facing sexual assault were not referred to them. A psychiatrist or psychologist is posted at the State run tertiary as well as Municipal tertiary hospital, but services were not accessed routinely as was evidenced by a mixed response. There is an honorary psychiatrist at the State Run Secondary Hospital. Here too psychiatric referral is not provided routinely, but for '*assessment of mental status*' where consent for sexual act itself may be in question or for obvious conditions of mental illness.

Of the 239 case documentations studied in the State Run Secondary Facility, only five case referrals to the psychiatrist were noted. Of these, three were for psychiatric assessment. We also spoke to four counsellors in women's organizations, one of which works with the police and two are based in public hospitals. All of them confirmed that victim-survivors of sexual violence were not referred to them for services.

Reproductive and sexual health care (Table 6.4): Provision of reproductive and sexual health care were difficult to assess. This is because decisions have to be made on a case to case basis. Delayed presentations, whether the woman was menstruating at the time of examination, clinical presentations, nature of assault may have a bearing on risk of pregnancy and various sexually transmitted infections. We did not score facilities on this count. Even so, some salient points emerge from the information we received.

Table 6.4: Reproductive and sexual health care

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Risk assessment and counselling to be routinely available for possibility of pregnancy	Reported provided when required.	Reported provided when required.	Not provided	Not clear	Mixed responses	Not provided
Emergency contraception provided on case to case assessment	Provided when required	Advised but not prescribed or provided	Not given	Not clear	Mixed responses	Not provided
Diagnostic samples to be taken for STI routinely	Reported provided	Reported provided	Not provided	Mixed response	Not answered	Not provided
Counselling for HIV risk and further course of action routinely	Is advised	Is provided	Mixed response	Mixed response	Not answered	Not provided

- The tertiary facilities were obviously better equipped to provide optimum services with a gynaecological department, diagnostic laboratory and a Voluntary Counselling and Testing Centre (VCTC) for HIV. But there are no uniform guidelines followed such as if the woman comes within a certain time span she should be given a certain set of services. Survivors do not seem to be assessed systematically for all health risks possible.
- The State Run Secondary Hospital receives the maximum number of cases among all the facilities studied. Yet, it does not provide any reproductive and sexual health care at all. Women are referred to the tertiary facility for diagnosis and treatment of any medical condition, and this too is rare. Of the 239 cases documented for 2006, only six victim-survivors were referred to another hospital for gynaecological examination and treatment. Of these three were under the age of nine years. Only one woman who told that she had missed her period was referred for a pregnancy test.
- Provision of diagnosis for infection and counselling for HIV were all dependent on individual doctor's initiative. There was no protocol to be followed.
- One health professional at the Civil Hospital told us that STI tests are done if patient reports being 'habituated to sex and white discharge'. Samples are then sent for VDRL Test (Venereal Disease Research Laboratory Test).
- The PHC we studied also had a laboratory but was not utilized for collection of samples for diagnostic purposes. Only national health programmes related samples were analysed there.
- Summarising the scenario, a key informant told us that in the health system 'there is very little insistence on quality of care', especially for survivors.

Risk of HIV infection (Table 6.4): Review of literature indicates that risk of HIV infection after assault depends on many factors such as overall rates of HIV infection in the population, the severity, frequency and duration of abuse and

whether the perpetrator or the victim belonged to a high risk group. The incidence of contracting HIV from a single episode of sexual assault is believed to be similar to that faced by health professionals from pin prick injuries. HIV infection also has a window period[20] and thus without systematic assessment of risk and follow-up it would be difficult to track HIV contracted from sexual assault. We found that there is almost no follow-up conducted after sexual assault examination, except for obvious medical reasons. One of the paediatricians told us that it is extremely difficult to speak of an HIV infection to the families of traumatised children who have been sexually assaulted. Another paediatrician reported two cases of child sexual abuse resulting in the children contracting HIV infection.

> A four year old boy came to Hematology OPD in 1994. He complained of bleeding which would not stop. He was suffering from Thrombocytopenia or a very low blood platelet count. A senior doctor along with me examined the case. In the differential diagnosis he mentioned the possibility of HIV. He insisted that we do the boy's HIV test. The result of the test turned out positive. I was quite shocked. This was because, but for the insistence of my senior colleague we would not have diagnosed, at least initially the condition. Both father and mother were also tested by the department, and both of them turned out HIV negative. So the most obvious cause of the infection was ruled out. There was no history of transfusion of blood or of any cut or of unsafe injections/ IV fluids. So the next obvious was also ruled out. Then we decided to take a detailed history about possibility of exposure to risk. Upon asking the mother about such incidents that could cause risk of infection, she said that no such incident had taken place. Mother could not tell about possibility of sexual abuse. We tried to ask the child but he could not follow what we were saying. Then we referred him to a social worker. She used special methods to extract a history from him. The fact of sodomy by neighbour then came out. (Reported by Head, Paediatrics, Municipal Tertiary Facility)

Table 6.5: Preventing Hepatitis B infection

Hepatitis B vaccine to be given when appropriate (2)	Not given (0)	Not given (0)	Not given (0)	Not given (0)	Not given (0)	Not given (0)
Subtotal	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Prevention of Hepatitis B (Table 6.5)- None of the health facilities provide risk assessment, prophylaxis or vaccination for Hepatitis B.

Table 6.6: Follow-up for other health consequences and long term effects

Follow-up for treatment (2)	Not routinely asked (0)	Not routinely asked (0)	Not routinely asked (0)	Not routinely asked (0)	Not routinely asked (0)	Not routinely asked (0)
Subtotal	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Follow-up (Table 6.6): None of the institutions follow-up routinely with women and children for treatment or delayed consequences of trauma.

[20] Window period is the time period between the entry of the HIV virus in the body and the possibility of this showing in the diagnostic tests. This could range from 3 to 6 months.

2. Provision of Medico-legal services

Table 6.7: Standard protocol and proforma used for examination and documentation

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
The hospital should have a standard step wise protocol/ proforma for management of sexual assault and injury documentation	Proforma is used, but its availability is variable. Researchers could not access a copy. (1)	No standard proforma (0)	Standard proforma is used. Readily made available to researchers. (2)	No standard proforma (0)	Standard proforma is used. Readily made available to resear-chers. (2)	No standard proforma (0)
Subtotal (2)	1 (50%)	0 (0%)	2(100%)	0(0%)	2(100%)	0(0%)

Use of standard proforma (Table 6.7): Three hospitals, the State Run Tertiary Hospital, State Run Secondary Hospital and Sub-District Hospital have adopted a standard proforma for examination and documentation of survivors of sexual assault. But the State Tertiary Facility reported that this had to be procured from another facility which meant delays in examination and inconvenience to the survivor and the examining doctor. No copies were available for examination. The services were rated as partially satisfactory.

The State Run Secondary Facility was routinely using a proforma. The Sub-District Hospital has gone out of the way to access the standard protocol used by a state run facility and has made it available to staff for documentation. A standard protocol or proforma is not mandated by the state and is not used in most facilities.

Table 6.8: Adequate, qualified and trained staff

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Preferably a medico-legally trained doctor/ forensic expert / gynaecologist should be available to examine survivors (2)	Available (2)	Available (2)	Some medical officers are forensic doctors (1)	Available (2)	No (0)	No (0)
Doctors involved in medico-legal examination should receive in-service training (2)	No in- service training provided (0)	No in- service training provided (0)	No in- service training provided (0)	No in-service training provided (0)	No in - service training provided (0)	No in-service training provided (0)
Subtotal	2 (50%)	2 (50%)	1 (25%)	2 (50%)	0 (0%)	0 (0%)

Qualified staff (Table 6.8): The Tertiary Facilities and Civil Hospital had qualified staff, i.e. a gynaecologist available for examination. Some of the medical officers appointed at the State Run Secondary Hospital are also medico-legal experts. The rest of the facilities fare 'Poor' on this count.

No in-service orientation (Table 6.8): There is no specific training in any of the facilities to deal with medico-legal cases or caring for survivors though doctors are expected to be competent from day one. Medico-legal experts were regularly invited to train staff in conducting post-mortems but not for other medico-legal activities. A standard policy on in-service training was absent.

Table 6.9: Consent for examination

	State Run Tertiary Hospital	**Municipal Run Tertiary Hospital**	**State Run Secondary Hospital**	**Civil Hospital**	**Sub-district Hospital**	**PHC**
Written consent for examination to be taken by examining doctor (2)	Taken by examining doctors (2)	Taken by examining doctors (2)	Taken in the Medical Records room by the clerk (0)	Taken by examining doctors (2)	Taken by examining doctor (2)	Taken by the medical officer (2)
Subtotal	2 (100%)	2 (100%)	0 (0%)	2 (100%)	2 (100%)	2 (100%)

Written Consent (Table 6.9): A written consent is taken in all the institutions, but there is much wanting in content of consent taken and manner in which it is taken. In the State Run Secondary Hospital, consent is reduced to a mere technicality and is taken by the clerk in the hospital.

Injury documentation and collection of medico-legal samples (Table 6.10): All hospitals document injuries. Though, some essential samples are collected by all institutions, samples like body stains, oral and anal samples are not collected routinely by all institutions. This was not considered while giving ratings as collection of samples is also dependent on time lag after incident, whether the woman has eaten, drunk fluids, bathed or defecated. Blood samples are taken routinely. Though doctors may decide which samples to collect depending on the time lapse of the case and the history given, there did not appear to be a clear understanding of why some samples were taken routinely and others not. Despite these shortcomings, all facilities score a high of 83 per cent (very good) on this count.

Table 6.10: Injury documentation and collection of medico-legal samples

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Complete physical examination and documentation of injuries should be done (2)	Reported Done (2)	Reported Done (2)	Reported Done (2)	Reported Done (2)	Reported Done (2)	Reported Done (2)
Collection of essential samples for investigation should be done (including body stains, oral, vaginal and anal samples, nail clippings, matted hair etc) (2)	Samples, were reportedly collected routinely (2)	Samples, were reportedly collected routinely (2)	Samples, were reportedly collected routinely (2)	Samples, were reportedly collected routinely (2)	Samples, were reportedly collected routinely (2)	Samples, were reportedly collected routinely (2)
Blood samples as required need to be taken (2)	Blood samples collected (2)	Blood samples collected (2)	Blood samples collected (2)	Blood samples collected (2)	Blood samples collected (2)	Blood samples collected (2)
Subtotal	6 (100%)	6 (100%)	6 (100%)	6 (100%)	6 (100%)	6 (100%)

Table 6.11: Protecting samples from biological dengeration

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Samples need to be air dried before sealing to avoid fungal contamination (2)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)
Arrangement to refrigerate samples or store in ince in case of delay (2)	Never refrigerated (0)	Never refrigerated (0)	Never refrigerated (0)	Never refrigerated (0)	Never refrigerated (0)	Never refrigerated (0)
Sub Total (4)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

Protecting samples from biological degradation(Table 6.11): None of the facilities reported either refrigerating or air drying samples for long preservation or storing them under ice. The standard procedure is to hand over the samples immediately to the police to take to the forensic laboratory which reportedly is often delayed. The forensic samples often get ruined especially in the monsoon months due to high humidity.

Table 6.12: Maintaining chain of custody

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Labelling to be done by examining doctor in the same room where examination took place (2)	Labelling done by nurse (1)	Labelling done by nurse (1)	Labelling done by ward boy (0)	Labelling done by nurse (1)	Labelling done by nurse (1)	Labelling done by nurse (1)
Sealing to be done in the examination room in presence of doctor (2)	Samples brought to the casualty from the gynaecology examination room, and sealed by ward boy in presence of casualty medical officer (1)	Not permitted to see the facility (Not scored)	Sealing done in the examination room by the ward boy/clerk, without the presence of doctor (1)	Sealing done in the examination room by nurse/ward boy, without the presence of doctor (1)	Sealing done in the examination room by nurse/ward boy, without the presence of doctor (1)	Sealing done in the examination room by nurse, without the presence of doctor (1)
Samples to be stored temporarily in lockable cupboard before transportation (2)	Lockable cupboard not present (0)	Not permitted to see the facility	Samples are stored in medical records room (2)	Lockable cupboard not present (0)	Lockable cupboard not present (0)	Lockable cupboard not present (0) (Not scored)
Well defined procedure to transport the samples to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)	Police collects them and carries to the forensic laboratory (2)
Subtotal	4 (50%)	3 (75%)	5 (63%)	4 (50%)	4 (50%)	4 (50%)

Maintaining chain of custody (Table 6.12): None of the doctors follow the rule that the specimens are not to be left unattended until they are sealed. In most places temporary sealing and labelling is done by nurses and sealing with wax is left to the ward boys in absence of the doctor. There is no arrangement to temporarily store the specimens in a lockable cupboard. Although it is the responsibility of the police to transport the specimens to the laboratory the State Run Secondary Facility reported that the police only collect samples twice a week. As a result some samples may be delayed as long as three days before they reach the forensic laboratory where they are examined. All facilities, except the Municipal Tertiary Facility score between 40 to 60 per cent (Fair) in this indicator.

Standard equipment like refrigerators are not adequately used, but mostly hospitals do take medico-legal work seriously. The PHC is the most handicapped (score Poor) lacking trained staff and standard proforma or guidelines.

3. Women Sensitive services

Table 6.13: Adequate staff to take care of all requirements

	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Preferably a Female Medical Officer should be available to examine (2)	Yes (2)	Yes (2)	No (0)	Yes (2)	Given second preference after gynaecologist (1)	Yes, one of the two medical officers is a woman (1)
A Psychologist / Psychiatrist / counsellor should be available (2)	Available but services are not sought routinely (1)	Available but services are not sought routinely (1)	Available as honourary but services used only when mental state of the woman is to be checked (1)	Not available (0)	Not available (0)	Not available (0)
A Social worker should be available (2)	Available but services are not sought routinely (1)	Available but services are not sought routinely (1)	Not available (0)	Not available (0)	Not available (0)	Not available (0)
A Police constable should be stationed at facility (2)[21]	Yes (2)	No (0)	No (0)	Yes (2)	No (0)	No (0)
Subtotal	6 (75%)	4 (50%)	1 (13%)	4 (50%)	1 (13%)	1 (13%)

Adequate staff (Table 6.13): Woman-friendliness of a hospital in terms of staff deployed was assessed on whether a woman doctor, psychologist or counsellor, social worker, policeman was posted at the health facility . The State Run Tertiary Hospital scores a high of 75 per cent (Good) in staff deployment and the other Tertiary Hospitals and Civil Hospital 'Fair'. The rest of the facilities score poorly. Though there was no policeman posted at the State Run Secondary Hospital and PHC, there was a police station close-by.

For women who have suffered any form of sexual violence, it is important to have a woman doctor conduct physical examination. The State Run Tertiary Hospital, the Municipal Hospital and Civil Hospital could all make women doctors available routinely. In the Sub-district Hospital and PHC

[21] Police constable stationed at the hospital is meant to make filing of any MLC easier for the woman, so that she does not have to go to the police station.

women doctors were available for about half the time. In the State Run Secondary facility which examines the maximum number of cases no women doctors were posted. The four women gynaecologists posted as honoraries are not expected to examine these cases. Sometimes the lack of a woman doctor was the reason to 'refer'[22] the woman when she specifically requested to be examined by a woman.

Generally the urban facilities and bigger facilities do have women gynaecologists available for examination. But here too it is the CMO who conducts the first examination and the probability of the CMO being a male is high. The three CMOs we interviewed for the study were all male doctors. There is no woman doctor in the other urban based facilities such as the State run secondary hospital, where the highest number of survivors were being examined.

On the other hand, the rural and smaller facilities have a serious dearth of women doctors. In the districts where the rural health system was studied, of the 106 Class II Medical Officers (MBBS) in the rural health system, only 22 were women doctors. Among the 91 Class III (BAMS) Medical Officers, only 12 were women doctors.[23] A blanket policy that women doctors should examine can result in delays in examination and this would not be in the interest of the woman. The concept of informed consent should include information of how delays could affect services, so that women can make a truly informed decision.

Even otherwise there was no explicit preference for women except in the sub-district facility that gave it second preference, after a gynaecologist. Preference is given to a gynaecologist even if he is a male doctor, since they are the experts in gynaecological examinations. A trained, experienced male doctor may be preferable to a novice woman doctor. We were told that a woman nurse was always present in all institutions when a male doctor examined.

A social worker is expected to ensure safety and security of the woman, finding shelters, liaison with legal aid, etc as required. Having a police constable stationed at the hospital is expected to ensure that it is the investigating agency that will go to the woman to register the crime. No social workers were posted except in the two Tertiary Hospitals and respondents told us that social workers were involved only in the case of patients who faced monetary difficulties and came for major medical interventions. They seem to play minimal or no role in the case of women who have faced assault.

Privacy, confidentiality and autonomy of the woman to be maintained (Table 6.14): All health facilities score poorly on this count. Most facilities had curtains as well as a lockable door and were conscious of maintaining audio and visual privacy for the woman in the examination room. But on all other counts the facilities fail women. All facilities are scored 'Poor'. There is no place to directly receive a woman or a child, so very often they have to wait along with other patients for their turn to be examined. In the bigger Tertiary Hospitals and Civil Hospital this place is the Casualty Medical Officer's room or ward where all medical emergencies, accident and trauma cases are examined. Life threatening and 'serious'[24] cases are prioritized in the Casualty and it is not possible to pay personal attention to all cases which do not come under this category. In the Sub-district Hospital the women are received in the Gynaecology OPD. In the State Run Secondary Hospital and PHC women are received in the OPD where again all other patients are also examined. There is no place for the survivor's family or friends to wait away from the public gaze.

An informed consent is an important part of ensuring autonomy for the woman. None of the facilities have an information sheet or form where such information will be provided to the woman in the local language. Interviews with doctors indicated that a one liner 'I give free and full

[22] Refer is put in inverted commas to underline the fact that a mere reference for a woman who has faced sexual violence, actually means a loss of time and probably evidence, along with having to tell her story to another set of professionals and again go through the procedure of making a case paper, giving consent etc.

[23] Information accessed on 07/09/07 from the District Health Officer's office

[24] In the casualty setting serious is understood as life threatening, potentially disability causing, serious infections and such conditions.

consent to examination', written by the doctor in English on the in-patient paper (IPD paper) or sometimes by the woman in her own handwriting is considered sufficient. There seems little clarity that examination, documentation and release of documentation for purposes of investigations are three separate processes and consent would be required for each of these. In fact, since the woman has no way of knowing her rights she may feel that she has no choice but to acquiesce to the examination. Sexual violence affects not only women's bodily integrity, but her sense of control on her life and agency as well. She may often experience a similar erosion of autonomy and replay of power in the health set-up as well.

Table 6.14: Privacy, confidentiality and autonomy of the woman to be maintained

	State Run Tertiary Hospital	**Municipal Run Tertiary Hospital**	**State Run Secondary Hospital**	**Civil Hospital**	**Sub-district Hospital**	**PHC**
The woman needs to be received in a separate room specially made available to take care of survivors (2)	Received in Casualty[25]. No separate room. (0)	Received in Casualty. No separate room. (0)	Received in Medical Records section. (0)	Received in Casualty. No separate room. (0)	Received in Casualty. No separate room. (0)	Received in medical officer's room. (1)
Facilities to maintain privacy (from facility checklist). (2)	Privacy well maintained. Visual and auditory privacy can be maintained, lockable door present. (2)	Not permitted to see the facility	Privacy well maintained. Visual and auditory privacy can be maintained, lockable door present. (2)	Privacy well maintained. Visual and auditory privacy can be maintained, lockable door present. (2)	Privacy well maintained. Visual and auditory privacy can be maintained, though the door could not be locked. (1)	Privacy well maintained. Visual and auditory privacy can be maintained, lockable door present. (2)
Consent taken in a separate form which adequately explains nature of examination in the local language (2)	No separate form adequately explaining procedure (0)	No separate form adequately explaining procedure (0)	No separate form adequately explaining procedure (0)	No separate form adequately explaining procedure (0)	No separate form adequately explaining procedure (0)	No separate form adequately explaining procedure (0)
Consent includes permission to hand over information to the police for investigation purposes (2)	Not included (0)	Not included (0)	Not included (0)	Not included (0)	Not included (0)	Not included (0)
Subtotal	2 (25%)	0 (0%)	2 (25%)	2 (25%)	1 (13%)	3 (38%)

[25] Casualty is a place where all emergency cases e.g. accidents and medico legal cases are attended to. Cases of minor ailments too are seen when the OPDs are closed. It is typically a very crowded place with little personalized care possible.

Table 6.15: Avoiding unnecessary referrals, and participation of multiple doctors within and outside the health facility

Making of case paper and examination documentation to take place in the same room (2)	Case paper is made in casualty. Examination and documentation takes place in casualty, gynaecology and sometimes also in forensic department (0)	Case paper is made in casualty. Examination and documentation takes place in casualty, gynaecology and sometimes also in forensic department. (0)	Case paper is made in Medical Records room. Examination and documentation in examination room. (1)	Case paper is made in Casualty. Documentation takes place in casualty and gynaecology (0)	Case paper is made in Casualty. Examination and documentation in gynaecology OPD room. (1)	Case paper and documentation in doctor's room. (1)
One doctor takes history and conducts the entire examination including treatment (2)	At least two doctors, a CMO and Gynaecologist are involved in history taking and examination (0)	At least two doctors, a CMO and Gynaecologist are involved in history taking and examination (0)	One doctor takes history and conducts the entire examination. (2)	At least two doctors, a CMO and Gynaecologist are involved in history taking and examination (0)	Gynaecologist/ Lady Medical officer takes history and conducts examination (2)	One doctor takes history and conducts the entire examination.(2)
	State Run Tertiary Hospital	Municipal Run Tertiary Hospital	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Entire examination to take place in one room in one department (2)	Minimal two (casualty and gynaecology) and sometimes multiple departments/ rooms involved. (0)	Generally two (casualty and gynaecology) departments/ rooms involved. (0)	Examination in one room (dressing room) (2)	Examination and treatment takes place in at least two (casualty and gynaecology) rooms (0)	Examination done in one room (gynaecology OPD room) (2)	Examination done in one room (labour ward) (2)
Preferably not required to refer outside the examining facility hospital (2)	Examination, treatment, tests done in the same facility. (2)	Examination, treatment, tests done in the same facility (2)	Referred for treatment. Referred also when the woman does not want to be examined by a male doctor. (0)	Examination, treatment, tests done in the same facility, unless severe trauma requires referral (2)	Referred to Civil Hospital for age estimation (1)	Referred to Sub-District and civil hospital for examination, treatment, age estimation. (0)
Subtotal	2 (25%)	2 (25%)	5 (63%)	2 (25%)	6 (75%)	5 (63%)

Avoiding unnecessary referrals, and participation of multiple doctors within and outside the health facility (Table 6.15):

The Sub-District Hospital and PHC score well (Good) in this respect simply because they do not have many departments to which women can be referred. For anything that is not available at these facilities, e.g. age estimation, the woman or child has to be referred to the Civil Hospital. The State Run Secondary Hospital scores 'Fair' because it does not have multiple departments and age estimation also takes place at the same place.

On the other hand, the two tertiary facilities and Civil Hospital fare 'Poor' in this respect, because examinations routinely take place in at least two places, the Casualty and Gynaecology department and consequently involve at least two medical officers, the Casualty Medical Officer and the Gynaecologist. Thus even the benefits of having a woman gynaecologist could be eroded if the woman is examined by other medical officers. Hypothetically (based on actual stories) references could be as many as five from the Casualty, and these are Gynaecology, Paediatrics, Forensic Department (Radiology instead in Civil Hospital), X-ray and Psychiatry. Apart from the obvious difficulty of moving around to various departments, without comprehending the necessity for it, this also necessitates the survivor to tell her story to multiple professionals and get undressed for more than one examination

The CMO at the state run facility told us that they do comprehensive injury documentation, including 'inspection'[26] of the genital area. The woman is then referred to a gynaecologist for a complete gynaecological check-up. It is difficult to understand the need for inspection of genital area (by a male doctor) when a complete gynaecological examination is to follow.

The municipal hospital has tried to reduce internal referrals by setting up a mechanism to admit the woman and give calls to various specialists rather than send the woman to various departments. But they have not been able to circumvent standard medico-legal procedures where all medico-legal cases are first examined by the Casualty Medical Officers. As mentioned before in Chapter IV, it is not clear whether admissions help reduce hardship or cause delay in examination.

Where the woman has to be referred to another facility altogether, other issues of time spent, delay in services and again telling her story to and 'convincing'[27] a new set of professionals is involved. Providing services at one point would avoid a number of referrals within hospitals, considerable discomfort to the woman to tell her story and be examined in more than one place and lack of coordination in various services that need to be offered.

Policies and protocols for management of sexual assault

Hospital Policy for Addressing Concerns of Violence against Women:
None of the hospitals studied had a policy to deal with medico-legal cases or address issues of violence faced by women. Consequently, there is no policy on Sexual Violence. Thus issues such as priority, preference of staff for examination, procedure to be followed, resolution of complaints and interface between departments or staff of the facility and agencies outside such as police and forensic laboratory are not adequately clear to the staff. The ideal set-up to conduct examinations or minimum essential equipments or medicines is not adequately discussed or known. Many procedures are followed simply because they are the norm without understanding the rationale. For instance, doctors did not give any reason why every adult case of sexual assault is regarded as a medico-legal case but not those of children.

Special requirements of Children: Interaction with health professionals indicated a lot of sympathy for children who face sexual assault. But this is not matched with specific tools,

[26] Inspection is a method of examination along with palpation and percussion taught to medical students.
[27] This refers to the difficulties which women face in terms of a judgmental attitude, suspicion and disbelief when they approach professionals and public services as articulated in the introduction.

techniques, facilities, training or sensitisation to equip health professionals to better deal with needs of children.

No protocol specific for children: Signs and symptoms of abuse in children can be very different from adults. Some unusual presentations were described by health care providers.

- The complaint was of foul smell emanating from the body. Detailed examination revealed a safety pin in the vagina and consequent infection. (Paediatrician at State Run Tertiary Facility)
- Adhesion of outer genitalia (labia majora) which may or may not be due to abuse and consequent infection. (Gynaecologist at Municipal Tertiary Facility)
- Two cases of HIV infections due to abuse were found only due to senior doctor's experience and initiative. (Paediatrician at Municipal Tertiary Facility)
- Cases of stunned and quiet young girls or vaginal bleeding where the story given of fall did not match the findings. (Paediatrician at sub-district facility)

There is no checklist or protocol to follow in the case of children.

No special tools and techniques: A uniform complaint from health care providers was the inability to get the story of what happened or 'history' from the child. Child psychologists were better able to accomplish this. Apart from a child psychologist available at the Municipal Tertiary Facility, none of the other facilities offered these services. The State Run Tertiary Facility also had a child psychologist who according to the staff interviewed did valuable work, but the department has since closed down due to lack of funds. Clearly this service is not recognised as an essential facility within the public health system. The Paediatrics Departments in the two tertiary hospitals had play rooms and child psychologists used play therapy with children. None of the other facilities employed special tools or techniques to relax the child for better communication, examination or treatment.

Training and Sensitisation: It may not be possible to have designated staff at each facility due to the overall reduced budgets, shortage of staff and specialists in the public health system. This can be mitigated to a certain level by good quality training and sensitisation to various issues via in-service trainings. No such trainings and sensitisation sessions were conducted for the staff.

Emotional Needs of Children Neglected: The literature indicates that children may face long standing development problems as well as personality problems as a result of the abuse. The above scenario indicates that emotional needs of children may not be addressed adequately.

No awareness of services available at public facilities: Some children who faced more severe abuses were generally taken to a private doctor for treatment by families and then sent to the public facility for medico-legal purposes. This may be due to general lack of faith in the public health system, greater faith in the private medical system or because of a known physician or a lack of awareness of services needed in such circumstances. Families also need time, information and counselling to make decisions regarding reporting the cases. This leads to delay and loss of evidence. Health facilities have the added responsibility to generate awareness about the need for health care and medico-legal documentation to take place as soon as possible and provide information on services available. This also aids primary and secondary prevention of such incidents.

Training and Sensitisation of Health Professionals

Training of Medical Officers: All the medical officers who answered the query of where they received their training (24) reported that their basic training to provide medico-legal services was during the II year of MBBS course. Only four doctors who had a post graduate degree said that they received additional training during their higher studies.13 doctors told us that the training they

received was adequate, but 14 doctors said that medical graduates did not feel equipped to examine victim-survivors.[28] Most doctors acknowledged that they learnt through hands-on experience and guidance by senior doctors and that specific training would greatly enhance the quality of services. Many felt that in-service training, standard protocols and guidelines would definitely help. The following analysis emerged after piecing together what health professionals told us about their training.

Medical Education: It appears that theory and practical exposure on the topic are divorced from each other. Doctors told us that they learn the theory of medico-legal examination for sexual assault in the II year of MBBS curriculum in subject of Medical Jurisprudence and Toxicology. Students don't give it too much importance as they feel that they will never need to care for rape survivors. Two gynaecologists said that practical orientation is provided in the III year of undergraduation under the topics- 'Genital Injuries' and 'Social Aspects: Case of Unmarried Primy'. These topics obviously do not deal with the subject in a holistic manner. One paediatrician reported that there is a chapter on 'Child Abuse' which also covers sexual abuse. A key informant told us that there is no mention of 'Examination of Sexually Assaulted Woman' as a topic in the curriculum or a chapter on sexual assault in the under-graduate Obstetrics and Gynaecology textbooks and neither is there any training module. The superintendent of the sub-district hospital told us that there is too much emphasis on genital or vaginal examination and importance of other evidence is not emphasised in their training. Specifically doctors are not trained in how to provide emotional support, how to formulate an opinion and how to face the courts.

The divorce between theory and praxis continues as forensic doctors who are supposed to be trained in medico-legal aspects rarely examine the woman. The examination is conducted generally by a gynaecologist or a graduate medical officer. The exception is the State run secondary hospital, where two of the four medical officers are post graduate in Forensic Medicine.

The Medical Superintendent of the sub-district hospital told us that Medical Officers need specific training to handle medico-legal cases, such as sexual assault.

> MO becomes panicky……MOs join immediately after completion of their training. They have no experience or training at that time to handle medico-legal cases. But they are expected on day one to be able to work as well as any experienced MO. So training should be provided either in internship or just before joining as MO (Told by Medical Superintendent of Sub-district Hospital).

One nurse at the same facility told us that young doctors don't know how to examine and sometimes nurses need to orient them. A medical officer working in the PHC said that their knowledge was limited and a specialist is required for examination and documentation. There are also no guidelines available or standard protocols in most facilities to guide the novice.

The superintendent of the sub-district hospital told that Forensic Doctors had formulated a good training module on orientation to Medico Legal Work, which included caring for survivors. It was recommended by Maharashtra State Gazetted Medical Officer's Organisation (MAGMO) for all MOs. The training was to be implemented during the 'Maharashtra Health Systems Development Project' (MHSDP). But it never took off. According to him, the MHSDP set the 'hardware' in place (infrastructure of health facilities) but neglected the 'software', i.e. training of doctors. He hoped that the Maharashtra Government would include it under the National Rural Health Mission.

No training of nurses and other para-medical staff: A key informant and nurses themselves expressed the need for training of nurses and other para-medical staff. Currently there is no

[28] The numbers do not add up because some doctors who said that training was adequate also said that medical graduates did not feel equipped to examine.

provision for this. The topic is not included in formal nursing curriculum as they are not expected to independently examine or care for survivors.

Thus the principle that only medico-legally trained staff can conduct examination and documentation may not be applicable in the current health system, where forensic doctors are found only in teaching institutions, gynaecologists may not be available at the periphery and most other doctors have no training. Capacity building at the primary health care setting onwards is required.

No review or monitoring of services: There is no process to review and monitor existing services.

Blank

Chapter 7

Conclusion and Recommendations

1. **Medico-legal services**: The provision of medico-legal service provision is prioritised over health services and gender sensitivity in services in all facilities. But the quality of these services is wanting. There is no in-service orientation and no orientation from forensic laboratories. There are no mechanisms for feedback from the forensic laboratory and dialogue with the police regarding requirements of the case.

2. **Health Care Services**: The health requirements of women and children, especially reproductive and sexual health care and emotional support are neglected. There is no age group wise guidelines for clinical care (example regarding which services to be provided to which age group) and presentation wise guidelines (example when victim-survivors approach within 72 hours, or after 72 hours and very late). Doctors have no training in providing emotional support and specialised staff is not available to all survivors and in all facilities.

3. **Gender Sensitivity in Services**: Women have to face insensitive procedures such as being escorted by police, thumb impression of the woman procured irrespective of her ability to sign, inadequate consent procedures and mandatory police reporting. The lack of a separate, private room well equipped with bathroom, toilets, change of clothes, sanitary napkins and such material to carry out examination as well as treatment may discourage rather than encourage reporting to health facilities. No attempt is made to link women to organisations that can provide emotional support, shelter and legal aid.

4. **Inadequate training**: There is no special training and continued in-service training for health professionals in all categories to equip them to address requirements of victim-survivors such as information on their rights, adequate services, examination and collection of evidence, gender sensitivity and emotional support.

5. **Limited resources in the public health system**: The public health system has limited resources in the form of specialists such as medico-legal experts and gynaecologists, support staff such as psychologists and social workers, women doctors, equipped facilities and essential drugs. The sub-district hospital and PHC were worse off in these parameters due to rural context and being placed lower in the hierarchy of the public health system.

6. **Lack of planning to effectively utilize existing services**: In spite of the lack of resources, it is to be noted that most services that women and children need are not resource intensive. Fragmented services such as multiple examinations, medico-legal services and health services being provided by different health providers, women doctors not made available in facilities where this is possible and lack of prior preparation to provide all services in one place is a major lacuna.

Overall it appears that health care facilities do not make an attempt to make assaulted women and children feel welcome at the facility. Since this is an important avenue of reporting violence, unprepared facilities can, in fact, hamper reporting.

Recommendations

Following are some recommendations emerging from this study.

1. **Policy to respond to victim-survivors of gender based violence:** The State Government must formulate a policy for responding to women and children facing violence, which includes services to be made available at health facilities. Every health facility must adopt a policy for responding to gender based violence which takes into account the obligations of health providers and legal requirements. The policy will deal with how optimum services can be made available in that facility. The following recommendations can be incorporated in the hospital facility.

2. **One room to be equipped for caring for survivors:** Every health facility must have at least one room equipped with a bathroom with provision for warm water, towels, change of clothes, sanitary napkins and all other facilities required for examination and initial treatment of victim-survivors of gender based violence. Standard Sexual Assault Evidence Kits may be made available to aid examination. The room must be equipped with all requirements for sexual assault care as well, according to the 'Model of Quality of Care'. Preferably it should have an adjoining room which can be used as a waiting room by the family as well as if more than one woman needs care. The room must be clean and hygienic. This facility would be situated in one corner of the health facility, away from the public gaze. Case paper and medico-legal documentation should take place in the same room. The team of health professionals should visit the woman in this room except for certain examinations, example, X-ray examination.

3. **Essential medicines and medical supplies to be available**: Services such as pregnancy test, emergency contraception, injury care, injection Tetanus Toxoid if required, pain-killers, medicine to avoid vomiting (anti-emetics) if required should be stocked in the room.
4. **Other requirements in the room**: The room should have a lockable cupboard to temporarily store samples.

5. **Standard Protocol to guide examination and documentation:** Every health facility should adopt a uniform and standard protocol to guide examination and documentation. The protocol will also contain a consent form which helps the provider to provide information on all aspects of consent. Consent will include consent for examination and documentation as well as handing over documentation to investigating officers for investigation purposes.

6. **Adopt Clinical Guidelines:** Every health facility should adopt standard clinical guidelines to provide care in differing profiles of sexual violence. These must be displayed in the examination room for easy reference.

7. **Training of staff**: All health care professionals including doctors, nurses and other para-medical staff must have a basic orientation to sexual assault services, communication with women and children and emotional support. Casualty Medical Officers, Gynaecologists, Paediatricians, Forensic Doctors, Women Doctors, Psychologists and Social Workers must be given special training to respond to victim-survivors of violence. Regular orientation to be provided to all staff. Training to include:
    a. Gender sensitisation
    b. Provision of emotional support
    c. Model of Optimum Quality of Care
    d. Estimation of age
    e. Standard examination and documentation procedure
    f. On what counts to provide opinion and how
    g. How to testify in court
    h. Regular orientation to be obtained from forensic laboratories

8. **Staff deployment:** All graduate Medical Officers must be able to examine and provide essential services including reproductive and sexual health care. Women health care providers must be preferred for examination of women and children where possible, e.g. in urban areas but such institutions may be in minority in rural areas. Only one doctor to conduct the entire examination. Team of doctors to be designated and trained beforehand. Preference to designated staff may be as under:
    a. Trained and experienced woman doctor
    b. Trained and experienced male doctor
    c. Any woman doctor available
    d. Any male doctor available

    It is important to employ counsellors and social workers to provide emotional and other support to all women and children facing violence.

9. **Facility for examination**: All health care facilities including Primary Health Centres must be made equipped to provide services.

10. **Psychological support**: Psychological support should be provided to each and every woman and child who approaches the facility with a history of sexual assault. It must not be restricted to women and children who have obvious signs of psychological disturbance. Basic emotional support and counselling for risk of various infections such as HIV must be included in the training of doctors and nurses.

11. **Interdisciplinary approach**: Every health facility must make formal linkages with women's organisations providing counselling and social support, crisis centres, free legal aid groups and shelters. Lists of these should be available in the form of booklets, leaflets and on display. Health Facilities should seek feedback from forensic laboratories regarding quality of samples.

12. **Special services for children**: A small part of the facility should be converted into a play room with bright posters, crayons, chart papers and toys for children. Special tools and techniques need to be learnt and developed to help communicate with children. Where possible child psychologists and social workers should be employed and their assistance sought.

Blank

References

Agnes, Flavia. (2005). '*To whom do experts testify? Ideological challenges of feminist jurisprudence*', in 'Review of Women Studies*', Economic and Political Weekly,* Vol. 40, No. 18, April 30 - May 6.

Ahmad, M., Ghani, T. (2007): *A Research Study on the Medico-legal Sector in Karachi*, Aahung, Pakistan

Amey, A. L., & Bishai, D. (2002): 'Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey', *Annals of Emergency Medicine, 39*, 631-638, Accessed on 06/02/07

Arrifin, R. (ed) (1997): *Shame, Secrecy and Silence: A Study of Rape in Penang*, Penang, Women's Crisis Centre

Azikiwe, N., Wright, J., Cheng, T., & D'Angelo, L. J. (2005). 'Management of rape victims (regarding STD treatment and pregnancy prevention): Do academic emergency departments practice what they preach?' *Journal of Adolescent Health, Vol. 36,* pp 446-448.

Bacchus, L., Mezey, G., Bewley, S. (2003): 'Experiences of seeking help from health professionals in a sample of women who experienced domestic violence', *Health Soc Care Community*, St George's Hospital Medical School, Department of Forensic Psychiatry, London, UK, Jan, Vol. 11(1), pp 10-8.

Bachman, R. (1993): 'Predicting the reporting of rape victimizations: Have reforms made a difference?' *Criminal Justice and Behavior*, Vol. 20, pp 254-270.

Baxi, P. (2005): 'The Medicalisation of Consent and Falsity: The Figure of the Habitue in Indian Rape Law' In Kannabiran, K. (Ed.), *The Violence of Normal Times: Essays on Women's Lived Reality*, Women Unlimited, New Delhi.

Campbell, J., Pliska, M., Taylor, W., Sheridan, D. (1994): 'Battered women's experiences in the emergency department', *J Emerg Nurs.* Aug, Vol. 20(4), pp 280-8.

'Carnage in Gujarat: A Public Health Crisis' (2002): Report of the investigation by Medico Friend Circle, Pune

CEHAT (1998): *Sexual Assault Care and Forensic Evidence Kit*, Mumbai.

Christofides, N., Jewkes, R., Lopez, J., Dartnall, E., (August 2006): *How to Conduct a Situational Analysis of Health Services for Survivors of Sexual Assault*, Sexual Violence Research Initiative, South Africa.

Christofides, N., Muirhead, D., Jewkes, R., Penn-Kekana, L., Conco, D. (2006): 'Women's experiences of and preferences for services after rape in South Africa: interview study', *BMJ*, January 28; 332(7535), pp 209–213.

Christofides, N., Jewkes, R., Webster, N., Penn-Kekana, L., Abrahams, N., Martin, L. (2005): 'Other patients are really in need of medical attention—the quality of health services for rape survivors in South Africa', *Bull World Health Organ,* Vol. 83, pp 495-502.

Christofides, Nicola., Webster, N., Jewkes, R., Penn-Kekana, L., Martin, L., Abrahams N., Kim, J. (October 2003): 'The state of sexual assault services: findings from a situation analysis of services in South Africa', *Criminal Justice and Behavior*, Vol. 30, No. 1, pp 6-38

Ciancone, A., Wilson, C., Collette, R., Gerson, L. (2000): 'Sexual Assault Nurse Examiner programs in the United States', *Annals of Emergency Medicine*, Vol. 35(4), pp 353-357.

Crime in Maharashtra (2006): Maharashtra State Criminal Investigation Department www.mahacid.com Accessed 20th November'07.

Daga, Jejeebhoy, Rajgopal (2004): 'An investigation of Domestic Violence Using Hospital Casualty Records' In Jesani, Deosthali, Madhiwalla (Eds), *Preventing Violence Caring For Survivors*, Kalpaz Publishing House, Mumbai.

Dickens, B. M., Cook R. J., Kismodi, E. (2006): *Reproductive Health, Case Studies with Ethical Commentary*, UNESCO Chair in Bioethics, Israel.

Deosthali. P., Maghnani. P., Malik, S., (2005): *Establishing Dilaasa Documenting the Challenges*, CEHAT, Mumbai.

D'Souza, Lalitha. (1998): *Sexual Assault of Women and Girl Children: A Manual and Evidence Kit for the Examining Physician*, Mumbai, CEHAT Publications.

Feder, G., Hutson, M., Ramsay, J., Taket, A. (2006): 'Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies', *Arch Intern Med*, Jan 9; Vol. 166(1), pp 22-37

Fisher, B., Daigle, L., Cullen, F., Turner, M. (2003): 'Reporting Sexual Victimization to The Police And Others: Results From a National-Level Study of College Women', Gerbert, B., Johnston, K., Caspers, N., Bleecker, T., Woods, A., Rosenbaum, A. (1996): 'Experiences of battered women in health care settings: a qualitative study', *Women Health*, Division of Behavioral Sciences, University of California-San Francisco 94111, USA. Vol.24(3), pp 1-17.

Guidelines for Medico-Legal Care for Victims of Sexual Violence (2003), WHO, Geneva.

Houry,D., Feldhaus, K., Nyquist, S., Abbott, J., and Pons, P. (1999): 'Emergency department documentation in cases of intentional assault' *Annals of Emergency Medicine*, 34, pp 715-719 in *Proposed WHO documents to strengthen health sector response to sexual violence: Policy guidance for the provision of adequate services* (November 12, 2001).

International Institute of Social Sciences (IIPS) (2007): *National Family Health Survey-3*, India 2005-06, Mumbai.

Jejeebhoy, S., Bott, S., (2003): 'Non-consensual sexual experiences of young people: A review of the evidence from developing countries', Population Council, New Delhi.

Jesani, A. (1998): 'Violence and Health Care Professional in India: Towards a campaign for medical neutrality', *Radical Journal of Health,* Volume III, No. 3, July-September 1998, pp. 143-156.

Jewkes, R. (2002): 'Sexual Violence', in *World Report on Violence and Health,* World Health Organisation, Geneva.

Kacker, L., Varadan, S., Kumar, P. (2007): *Study on Child Abuse*, Ministry of Women and Child Development, UNICEF and Save The Children, New Delhi.

Kelly, L., Regan, L. (2003): 'Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations : A Briefing Paper for the Daphne Strengthening the Linkages Project', Child and Woman Abuse Studies Unit, London Metropolitan University

Koss, M. (1994): 'The negative impact of crime victimization on women's health and medical use' In A. J. Dan (Ed.), *Reframing women's health: Multidisciplinary research and practice* (pp. 189-200). Thousand Oaks, CA: Sage Publications, Inc.

Koss, M., Woodruff, W., Koss, P. (1991): 'Criminal victimization among primary care medical patients: prevalence, incidence, and physician usage', *Behavior Science Law*.

Kulkarni S., Jesani, A., D'Souza, L. (1997): 'Sexual Assault Of A Deaf Mute Juvenile In Observation Home, Umerkhadi', Mumbai, Forum Against Child Sexual Exploitation.

Kumar, P., Dagar, R. (1995): 'Atrocities against Women in Punjab', Institute for Development and Communication, Chandigarh pp.56.

Law Commission of India (2000); *One Hundred And Seventy Second Report* on Review of Rape Laws March. http://www.lawcommissionofindia.nic.in/rapelaws.htm Accessed 20th November 2007

Logan, T., Evans, L., Stevenson, E., Jordon, C. (2005): 'Barriers to Services for Rural and Urban Survivors of Rape', University of Kentucky., Accessed on 06/02/07

McGregor, M., Le, G., Marion, S., Wiebe E. (1999): 'Examination of sexual assault: Is the documentation of physical injury associated with laying of charges?' *Canadian Medical Association Journal,* June, Vol. 160, pp 1565 – 1569.

McGregor, M.J., J, Du Mont., Myhr, TL. (2002): 'Sexual Assault Forensic Medical Examination: Is Evidence Related to Successful Prosecution?'*Annals of Emergency Medicine*, Vol. 39 (6), pp 639-47

McFarlane, J., Malecha, A., Watson, K., Gist, J., Batten, E., Hall, I., Smith, S. (2005): 'Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes', *Obstet Gynecol,* Texas Woman's University, College of Nursing, Houston, Texas, USA, Jan, Vol. 105(1), pp 99-108

National Crime Records Bureau (2005) Ministry Of Home Affairs, http://www.ncrb.nic.in Accessed 5th December'07.

Noorani, A. (2002): 'Human rights in Kashmir', *Economic and Political Weekly,* Vol. XXXVII (12), March 23 pp 1081-1082.

Patel, V. and Andrew, G. (2001): 'Gender, sexual abuse and risk behaviours in adolescents: a cross-sectional survey in schools in Goa', *The National Medical Journal of India*, Vol. 14 pp 263–267.

Prakash, P., George, A., Panalal, R. (1993): *'Focus issue, patients rights', The Indian Journal of Social Work, Vol. LIV, No. 2, April , pp.199-201.*

Prasad, S. (1999): 'Medicolegal response to violence against women In India', in *Violence Against Women*. Vol. 5 No. 5, May, Sage Publications.

Pitre, Amita. (2006): 'Caring For survivors of sexual assault', In *Indian Journal of Medical Ethics,* Vol III, No 3, July- September.

Rennison, Callie Marie. (2002): ' Rape and sexual assault: reporting to police and medical attention, 1992-2000', Washington, DC: USGPO. NCJ 194530.

Sansone, R., Wiederman, M., Sansone, L. (1997) : 'Health care utilization and history of trauma among women in a primary care setting', *Violence and Victims*, 12 pp 165-72;

Sarkar, S., Lalwani, S., Rautji, R., Bharadwaj, D., Dogra, T. (2002): 'A Study of Victims of Sexual Offences in South Delhi' AIIMS, New Delhi.

Schei, B., Sidenius, K., Lundvall, L., Ottesen, G. (2003): 'Adult victims of sexual assault: acute medical response and police reporting among women consulting a center for victims of sexual assault' *Acta Obstet Gynaecol Scand,* 82 pp 750-755

Shepherd, J., Shapland, M., and Schully, C. (1989): 'Recording of violent offences by the police: an accident and emergency department perspective' *Medical Science and Law*, 29 pp 251-257;
Kruger, J., Butchart, A., Seedat, M. and Gilchrist, A. (1998): 'A Public health approach to violence prevention in South Africa' in Eeden, R. and Wentzel, M. (Eds.) 'The dynamics of aggression and violence in South Africa', Human Sciences Research Council, Pretoria pp. 399-424;

Sievers, V., Murphy, S., & Miller, J. (2003): 'Sexual assault evidence collection more accurate when complete by sexual assault nurse examiners: Colorado's experience', *Journal of Emergency Nursing, 29,* 511-514.

Singh, K. (2004): 'Violence against Women and the Indian Law', In Goonesekere, Savitri. (Ed.) Violence, Law and Women's Rights in South Asia, Sage Publications India Pvt. Ltd, New Delhi

Soutoul, J., Froge, E., Bizouarne, C., Pierre, F., Aglan, A. (1988): 'Importance of the initial examination after a rape in considering the criminal penalty and indemnification of the victim in a civil suit. Review of the documents from one Court of Assizes over 11 years', *Gynecol Obstet Biol Reprod,* Paris, Vol. 17(7), pp 811-24

Stacey, B., Plichta, T., Clements, Houseman. (2007): 'Why SANEs Matter: Models of Care for Sexual Violence Victims in the Emergency Department',
Journal of Forensic Nursing, Vol. 3 (1), pp 15–23

Suffla, S., Seedat, M., Nascimento, A. (2001): 'Evaluation of medico-legal services in Gauteng: implications for the development of best practices in the after-care of rape survivors', South Africa Medical Research Council, Tygerberg, South Africa, (Policy Brief), Accessed on 06/02/07

The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): http://www.un.org/womenwatch/daw/cedaw/index.html, Accessed 4th December'07

'Voices From The Silent Zone: Women's Experiences of Incest And Childhood Sexual Abuse' (1999) RAHI, New Delhi.

Wiebe, E., Comay, S., McGregor, M., Ducceschi, S. (2000): 'Offering HIV prophylaxis to people who have been sexually assaulted: 16 months' experience in a sexual assault service', *CMAJ*, Department of Family Practice, University of British Columbia, Vancouver Mar 7, Vol. 162(5), pp 641-5
'World Report on Violence and Health' (2002) WHO, Geneva.

Winter,9(1) pp85-96 in 'Proposed WHO documents to strengthen health sector response to sexual violence: Policy guidance for the provision of adequate services', (November 12, 2001).

World Health Organisation (2003), Guidelines for medico-legal care for victims of sexual violence, Geneva

Blank

Annexure I

Analysis of procedures followed at the hospital level

	State Run Tertiary	Municipal Run Tertiary	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Cases are generally brought by	Generally brought by police. Rarely is this hospital the first contact. Often referred from other hospitals.	Generally brought by police. If trauma is severe may be brought directly to hospital but generally not brought directly.	Always brought by police	Always brought by police. Many times referred from peripheral health facilities but brought by police.		Police
Sometimes brought by	Relatives, specially in cases of children.	Relatives, specially in cases of children.	Never brought by others.	Not mentioned.		Come on their own with relatives.
Specific present-ation regarding children	One doctor told us that girl children are brought by families and boys, specially street boys are brought by police.	May be detected directly in OPD.	Not mentioned.			Not mentioned.
Is an FIR required to be filed before examina-tion?	Crime needs to be registered. Either FIR number or Police Registration number is required.	Police case needs to be registered.	Crime registration is mandatory before examination.			Yes
Is FIR filed before or after the examina-tion?	Always crime is registered before examination.	Police need to be informed before examination.	Police request is obtained before examination.			

	State Run Tertiary	Municipal Run Tertiary	State Run Secondary Hospital	Civil Hospital	Sub-district Hospital	PHC
Do cases come directly to the hospital?	Rarely, except in case of children.	Yes, they come.	Never come directly.	Only one doctor said that cases may come directly but they still need to make a police case before examination at the hospital.		Occasionally
What is the procedure followed in these cases?	Sent to the casualty to register a Medico-legal case. Police stationed at the hospital registers the case and informs the relevant police station.	Sent to the casualty to register a Medico-legal case and inform the police.	Cases are not accepted without police request for examination.	Cases are not accepted directly at the hospital. Sent to the casualty from where they are sent to the police chowky in the premises of the hospital for crime registration.		Relatives are sent to the police station housed close by or police is informed on phone. They generally come immediately.

Annexure II

Interview Schedule for Health Care Provider

Schedule no: _____ **Date of interview:** _____

Name of interviewer: _____

Informed consent: (In writing/ verbal)

I) Personal Information

1.1) Name
1.2) Age
1.3) Sex
1.4) Education/ Specialty
1.5) Designation
1.6) Department
1.7) Years of Service

II) General Information about Cases

2.1) How many cases of sexual assault were referred for examination at this hospital, in the last three months?

2.2) Approximately how many cases of sexual assault are referred for examination at this hospital, in a year?

2.3) What is approximately the age distribution? Rank the age groups in descending order of frequency.

0 to 5 yrs
5 to 10 yrs
10 to 16 yrs
16 to 30 yrs
30 to 50 yrs
More than 50 yrs

Any Additional Comments on the age distribution:-

_____

2.3) Approximately how many such examinations have you conducted until now?

_____

2.4) What is the procedure generally followed for examination in the hospital? (open ended)

_____

2.5) Cases are referred:

a) Generally by _____

b) Sometimes by _____

c) Also by _____

2.6) Do any cases come directly to the hospital?

a) Never come directly ☐

b) Sometimes/rarely come directly ☐

c) Always come directly ☐

2.7) If cases come directly to the hospital, and FIR or police request is not present what is the procedure followed?

_____

2.8) Is filing of FIR compulsory before cases are accepted for examination?

Yes ☐ No ☐

2.9) Is there a policeman/ constable always stationed at the hospital?

a) Yes, always
b) Sometimes absent
c) Not present

2.10) Does he complete the procedure of filing of FIR? _____

2.11) Which department is the survivor first brought into when she/ he comes to the hospital for medical examination?

_____

2.12) Who examines the survivor in the above mentioned department?

a) Designation: _____

b) Department (if other than the above mentioned department)

_____

2.13) Is there some preference given to who should conduct exam:

a) Male doctor _____
b) Female doctor _____
c) No such thing _____

2.14) What is the role played by this department in examination?

_____

2.15) How is consent obtained for examination?

_____

2.16) Do you have any form for obtaining consent? Will you share it with us?

_____

2.17) How do you define minors for the purpose of consent?

_____

2.18) How is consent sought in case of minors?

_____

2.19) Who signs as a witness ? What is the role of the witness?

_____

2.20) Are any referrals made from this department?

Yes ☐ No ☐

2.21) If yes, which are the departments to which referrals are made?

_____

2.22) Do you have a checklist or a printed form to follow for examination?

Yes ☐ No ☐

2.23) If yes, can you share the details of the checklist with us? (Collect a copy of checklist if available)

_____

2.24) What is your role in handling cases of sexual assault?

_____

2.25) What are the problems you face in functioning within this role?

_____

2.26) What are your suggestions to improve your functioning?

III) Medical Examination of child survivors of sexual abuse:

3.1) Are cases of child survivors referred to this department in this hospital?

Yes ☐ No ☐

3.2) If yes, what approximately is the age distribution of the survivors? (rank the age groups in descending order)

0-5 years
5-10 years
10-16 years

Additional comments on the age distribution

_____

3.3) Who examines cases of child survivors in the above mentioned department?

a) Designation: _____

b) Department (if other than the above mentioned department)

_____

3.4) Are there any referrals made to other departments?

Yes ☐ No ☐

3.5) If yes, which departments are referrals made to?

_____

3.6) Is there any specific checklist (other than the general one) used for child survivors of sexual abuse?

Yes ☐ No ☐

3.7) If yes, will you please share the details of the checklist with us?

_____

3.8) Are there any specific tools and/ techniques used while questioning and/examining the child survivor of sexual assault?

Yes ☐ No ☐

3.9) If yes, please share in detail about the tool and/ technique used and reasons for the same?

_____

3.10) Have you handled cases of child survivors of sexual assault?

Yes ☐ No ☐

3.11) If yes, what is your role in handling cases of child survivors of sexual assault?

_____

3.12) What are the problems you face in handling cases of child survivors?

_____

3.13) What are your recommendations to improve functioning while handling cases of child survivors?

IV) General information about how cases are handled in the hospital setting:-

Facilities available for examination

4.1) Where are cases of sexual assault examined?

_____

4.2) How is privacy of the survivor ensured during the examination?

_____

4.3) Can you enlist the equipments you require for examination?

_____

4.4) Are all these available at one place in the hospital?

_____

4.5) If yes, where? If yes, are all departments similarly equipped?

4.6) If no, how much time does it take to gather all the equipment and be ready to examine? If such preparation is required, who does it? Who guides the preparation?

4.7) When do you conduct age estimation? Where is it conducted?

4.10) Please list the routine tests involved in age estimation?

4.11) Have you ever testified in court regarding a case of sexual assault?

Yes ☐ No ☐

4.12) If yes, how many times and for what purpose?

4.13) Please describe the problems you faced while testifying in the court?

4.14) Are you informed by the police/ court on the outcome of legal case?

Yes ☐ No ☐

4.15) What is the relationship between documentation of injuries and/ medical evidence collected with legal outcome in cases of sexual assault?

V) About Specific Case:

5.1) When was the last time you examined a case?

5.2) What was your role in the management and examination of the case?

5.3) Can you describe the case and the management of it at the hospital level?

a) Who referred the case to you?

b) Did the case come directly to hospital or was she referred here from elsewhere?

c) If the case was referred, who referred the case?

d) How much was the time lapse before the case was brought to the hospital?

e) Was an FIR filed?

Yes ☐ No ☐

f) If yes, was it filed before or after examination of the case?

g) How many doctors were involved in the examination process?

Designation:

Department:

h) If more than one doctor examined, how was this accomplished?

i) How was the examination divided between doctors?

j) Were referrals to other departments made?

Yes ☐ No ☐

k) If yes, to which departments were referrals made and why?

Department referral made to _____

Reasons: _____

Department referral made to _____

Reasons: _____

Department referral made to _____

Reasons: _____

5.4) Age of the survivor:

5.5) Sex of the survivor

5.6) Marital status: Married ☐

Unmarried ☐

Divorced ☐

Widowed ☐

5.7) Was the accused known or unknown to the survivor?

5.8) If known, what was the relationship between the accused and the survivor?

5.9) Was she brought to this health facility directly or was she referred here from elsewhere?

5.10) If referred, where was she referred from and who referred her?
Organization/Department:

5.11) If the survivor was referred, was there a time lapse in between?

Yes ☐ No ☐

5.12) If yes, how much was the time lapse?

_____

5.13) What was the reason for the time lapse?

_____

5.14) Had the survivor:

Bathed or washed ☐

Brushed or washed mouth ☐

Eaten ☐

Drunk fluids ☐

Changed clothes/ washed the clothes she was wearing during the incident ☐

Passed stools and voided urine ☐

If nails were cut, were they freshly cut: Yes ☐ No ☐

5.15) Were you the only doctor examining?

Yes ☐ No ☐

5.16) If more than one doctor was involved, how was it accomplished?

_____

5.17) What was the procedure of examination?

_____

5.18) Where did the examination take place?

_____

5.19) How was the examination divided between doctors?

_____

5.20) In case the doctor is male, was a female present at the time of examination?

Yes ☐ No ☐

5.21) Who signed as witness?

a. Male relative
b. Female relative
c. Female Nurse
d. Other

5.22) Was there a social worker or counselor to help talk with the woman during the examination?

Yes ☐ No ☐

5.23) How much time did the examination take?

_____

Quality of examination

5.24) Did you complete or skip any of the following-

	Please tick if you completed all these in your last examination	Give reasons if you did not	Please tick if you usually complete them	Give reasons if you do not
Counseling and initial comfort (who gave?) Ensuring Privacy Informed consent				
History taking in patients own words				
Collection of specimen for treatment purposes				
Collection of clothes. How did you collect?				
Recording physical injuries. How did you record?				
Which details of the injuries did you record? Please list				
Did you record the following				
Location, size, shape, duration, (filled with/ contaminated with) and possible cause of injury				
Which samples did you take for forensic examination? Please list.				
Did you take any of these samples				
Oral sample				
Stains on the body				
Four vaginal samples				
Anal samples				
Urine sample				
Blood sample for bld group/ drug alcohol estimation				
Blood sample for alcohol/ drug estimation				
Blood sample for DNA				
Nail clippings				
Matted hair if any				

5.25) What were your findings on examination?

_____

5.26) What was your opinion after that examination?

_____

5.27) Who carried the samples to the laboratory? When?

Designation: _____

Department: _____

When carried: _____

Diagnosis and Treatment

5.29) Were diagnostic tests for STD done? _____

5.30) If yes, which? Please specify _____

5.31) Did you treat her for injuries or infection?

Yes ☐ No ☐

5.32) If yes, please specify treatment _____

5.33) Did you give her emergency contraception?

Yes ☐ No ☐

5.34) If yes, please specify _____

5.35) If delayed examination, was a urine pregnancy test conducted?

Yes ☐ No ☐

5.36) Was she given a discharge card?

_____

5.37) Did you call her for a follow up examination?

Yes ☐ No ☐

5.38) If yes, when did you call her for a follow- up?

_____

5.39) What was the reason for a follow-up?

_____

5.40) Did you tell her that she may be at risk of pregnancy, infections like STD, Hepatitis B or HIV?

	Yes	No	Treatment / Prophylaxis given	Follow up
Injuries				
Pregnancy				
Infections like STD				
Hepatitis B				
HIV				

5.41) Were referrals to other departments made?

Yes ☐ No ☐

5.42) Were you shown the reports from forensic laboratory?

Yes ☐ No ☐

5.43) If, yes, did it help your final opinion?

5.44) Generally are you expected to give a final opinion based on laboratory reports?

5.45) What are the problems faced in providing services to survivors of sexual assault?

5.46) What are your recommendations to improve the facilities/ quality of services provided to the survivors of sexual assault?

VI. Examination of the Accused

6.1) Are you involved in the examination of the accused?

Yes ☐ No ☐

6.2) If yes, please list the kind of examinations that you conduct on the accused?

6.3) If no, who conducts the examination, please share the details:

6.4) Is there some preference given as to who should conduct exam:

- Male doctor
- Same doctor who examined victim
- Same facility who examined victim
- No such thing

6.5) What are the problems faced by the examiner while conducting medical examination of the accused?

6.6) What are your recommendations to overcome the problems/ improve the quality of examination of the accused?

VII) Training:

7.1) What training have you received for examination of cases of sexual assault?

_____

7.2) How would you rank the usefulness of the training received? (VU- very useful, MU- Moderately useful, RU- Rarely useful, NU- Not useful at all)

_____

7.3) What are the problems with the training offered?

_____

7.4) Please share your recommendations on how to improve the quality of training for efficient collection of medical evidence/ According to you what should be included in the training so that it equips medical professionals for efficient collection of evidence?

Thank You For Your Time

Blank

Annexure III

CHECKLIST FOR HEALTHCARE FACILITIES

QUALITY OF CARE FOR SURVIVORS OF SEXUAL ASSAULT

Date of administering the checklist: Date _____

Time : _____

Schedule No. _____

Name of the interviewer (s) _____

Note:

· *Kindly put a tick mark (Ö) against the option applicable in the question given. In cases where more than one answer is applicable, please tick mark against the options applicable. If required, you may write out any other answers that may not have been enlisted in the options given.*

General Information:

1. What type of a facility is it?
   - Primary care hospital
   - Secondary care hospital
   - Tertiary care hospital

2. Name of the facility _____

3. District/Area in which facility is located: _____

4. Total number of villages/zones covered by the facility _____

5. Name of the officer-in Charge _____

6. Designation of the respondent (If more than one respondent, circle the number against all respondent)
   - Gynaecologist
   - Paediatrician
   - Forensic expert

- Casualty Medical Officer
- Nurse
- Any other

7. Years of service: _____

8. Years of service at the hospital: _____

Staff position:

9. Do the facility/ department have the following staff? (For Civil Hospital)

Sr.no	Designation	Sanctioned	Filled Post	Vacant post
1	Civil Surgeon			
2	Specialist Medical Officers Honorary			
3	Sister in Charge			
4.	Social workers/counselors			
5	Staff Nurses			
6	X – Ray Technician			
7	Laboratory Technician			
8	Pharmacist			
9	Driver			
	Any other			

10.Does the Teaching Hospital Department have the following staff?

Name of department: _____

Sr.no	Designation	Sanctioned	Filled Post	Vacant post
1	Head of Department			
2	Professors			
3	Associate Professors			
4	Assistant professor			
5	Lecturers			
6	Resident Medical Officers			
7	Honorary			
3	Sister in Charge			
4.	Social workers/counselors			
5	Staff Nurses			
6	X – Ray Technician (Fill up once for the hospital)	-	-	-
7	Laboratory Technician			
8	Pharmacist			
9	Driver			
	Any other			

11. Does the facility/ department have the following staff? (For Other Facilities)

Sr.no	Designation	Sanctioned	Filled Post	Vacant post
1	Head of Facility			
2	Medical Officers Honorary			
3	Sister in Charge			
4	Social workers/counselors			
5	Staff Nurses			
6	X – Ray Technician			
7	Laboratory Technician			
8	Pharmacist			
9	Driver			
	Any other			

12. Is there a female medical doctor at the facility?

Yes ☐ No ☐

13. If yes, how many and of what speciality? _____

14. Is there a designated medico-legal officer? _____

15. If yes, is he on-call for 24 hrs? Yes ☐ No ☐

16. Who are the specialists currently posted at the facility?

- Paediatrician Yes ☐ No ☐ If yes, how many? _____
- Gynaecologist Yes ☐ No ☐ If yes, how many? _____
- Surgeon Yes ☐ No ☐ If yes, how many? _____
- Anaesthetist Yes ☐ No ☐
- Any other specialists in position (specify) _____

Building:

17. Is a designated government building available for the health facility?

Yes ☐ No ☐

18. If there is no designated government building, then where does the health facility function from?

- Rented premises ☐
- Other government building ☐

- PHC ☐
- Any other (specify)_____

19. What is the present observed state of the building of the health facility? *(OBSERVE)*

Complete ☐ Incomplete ☐

- Leaking ☐
- Dilapidated ☐
- Water logged sections ☐
- Building is in good condition ☐
- Adequate space/ rooms/ facilities ☐
- Any other observation ☐

20. What is the present observed state of the premises? *(obsertvation)*
    - Quite clean
    - Somewhat dirty
    - Very dirty
    - Any other observations

21. What is the total bed capacity?

22. How many wards are there?

23. Do women have separate wards?

24. Is there a waiting room with seating arrangement for clients using the facility?

Yes ☐ No ☐

25. Is the waiting area sheltered and/or covered?

Yes ☐ No ☐

Separate room for examination

26. Do you have separate rooms/area for examination of cases of sexual assault?

Yes ☐ No ☐

27. If yes, can visual/auditory privacy be maintained in the room or area?

28. Is the examination room available for 24 hours?

29. Does the room have facility to lock the door to maintain privacy?

30. Is there adequate light in the room/area?

Yes ☐ No ☐

31. Is there a working angle lamp in the examination room?

32. Does the facility have one or more toilets? (attached or very close) _____

33. Do the toilets appear clean? _____

34. Is water available in the toilets? _____

35. Is the bed linen clean?

Very clean _____, Moderately clean _____, Dirty _____

36. Is the bed/ examination table linen changed after each examination? _____

Waiting area for examination room

37. Does the examination room have a waiting area for support person to talk to the patient? _____

38. Essential facilities

	Yes	**No**	**Intermittent supply (please specify)**
Continuous water supply			
Uninterrupted electricity supply			
Refrigerator			
Working Telephone line			
Generator/ Inverter			
Vehicle			

39. If referred to a higher level health care facility, how is the patient taken there?

- Free transport by hospital ambulance ☐
- By hospital ambulance, but fuel and other charges have to be made by the patient ☐
- Private/ personal conveyance ☐
- Any other _____

Requirements for examination :

40. Are the following available for the examination of sexual assault cases at the Hospital? Write yes/ No or specify)
    - Separate room for examination _____
    - Lockable door _____
    - Partition for privacy _____
    - Consent form for Examination _____
    - Examination table with lithotomy position _____
    - Examination table without lithotomy position _____
    - Gown for examination _____
    - Spare clothing _____
    - Facility for washing hands with soap _____
    - Facility for having bath _____
    - Table and chairs for documenting and labeling evidence _____

41. Does the examination table allow the doctor to be positioned on the right of the patient? ___

42. Equipments specific to examination and collection of medical evidence in cases of sexual assault?

Equipment	Present	Not Present	Alternative Equipment If Used
Sheet of paper			
Sterile cotton swabs			
Envelopes / bags for collection of clothes/specimens			
Scissors			
Combs			
Sim's / Cusco's speculum			
Needles and Disposable syringes			
EDTA bulb (For Blood grouping & DNA Analysis)			
Double Oxalate bulb for drug/ alcohol assessment			
Disposable gloves			
Nailcutter			
Sanitary napkins			
Colposcope			
Pregnancy test kit			
Sharps container (to dispose off needles and sharp objects)			
Pre-packaged rape kit			
Others (specify)			

43. What facility is available to seal and package the collected evidence? _____

44. Are information leaflets/ booklets available to patients telling them about available services and medication? _____

45. Diagnosis and Treatment:

	Available in the room/ facility (specify)	Provided elsewhere	Not Provided	If provided, type of test/ drug	Time duration
Diagnostic tests for STI/RTI					
RTI/STI's					
HIV rapid test kit					
HIV Prophylaxis					
Pregnancy test kit					
Emergency contraception					
Treatment for Physical injuries					
Painkillers,					
tranquiliser,					
anti-emetics					

46. If the patient has to pay for some drugs and/ or services, what are those?

- Purchase of drugs ☐
- Purchase of cotton, syringe, etc ☐
- Bribes to doctor, nurse, sweeper, etc ☐
- Transport ☐
- Any other (specify) _____

47. Are surgeries carried out at the facility?

Yes, always ☐ Yes, sometimes ☐ No, never ☐

48. If surgeries are carried out at the facility, then please tick mark the type of surgeries being conducted here against the availability of the services.

- Minor surgeries (e.g. stitches on wounds, drainage of abscess, etc)

Yes, always ☐ Yes, sometimes ☐ No, never ☐

- Major surgeries (e.g. vaginal wall repairs etc)

Yes, always ☐ Yes, sometimes ☐ No, never ☐

49. Is the X-ray facility available in this facility?

Yes, always ☐ Yes, sometimes ☐ No, never ☐

50. Are the blood tests done regularly in this facility?

Yes, always ☐ Yes, sometimes ☐ No, never ☐

51. What facilities are available for storage of the following samples collected from cases of sexual assault? (Refrigerator or lockable cupboard)

- Swabs
- Blood samples
- Urine samples
- Head hair samples
- Pubic hair samples
- Clothing
- Nail cuttings/scrapings

52. Is the storage facility lockable? (*observe*) _____