Enhancing the Quality of Response of the Health Care System to Sexual Assault

Dr Lakshmi Lingam, TISS, Mumbai
Dr Sunita Bandewar, FMES, Pune
Ms Sita Mamidipudi, Hyderabad

Funded by

Indian Council for Medical Research and the Department of Health Research, MoHFW, New Delhi, India

(Project Reference No. GIA/8/2014-DHR)

Tata Institute of Social Sciences

Forum for Medical Ethics Society

Mumbai

6 April 2021

Enhancing the Quality of Response of the Health Care System to Sexual Assault

Dr Lakshmi Lingam, TISS, Mumbai
Dr Sunita Bandewar, FMES, Pune
Ms Sita Mamidipudi, Hyderabad

Supported by

Indian Council for Medical Research (ICMR) and the Department of Health Research (DHR), New Delhi, India

(Project Reference No. GIA/8/2014-DHR)

Tata Institute of Social Sciences

Forum for Medical Ethics Society

Mumbai

6 April 2021

Published on April 6, 2021

Enhancing the Quality of Response of the Health Care System to Sexual Assault.

Authors: Lakshmi Lingam, Sunita Bandewar, Sita Mamidipudi

Publishers: Tata Institute of Social Sciences, Forum for Medical Ethics Society

Address of Publisher:
O-18, Nav Bhavna Premises Co-operative Society Ltd.,
422 Veer Savarkar Marg, Prabhadevi,
Mumbai 400 025, India.

Citation:
Lingam, L., Bandewar, S., & Mamidipudi, S. (2021) 'Enhancing the Quality of Response of the Health Care System to Sexual Assault'. Final report submitted to the ICMR/DHR, Ministry of Health & Family Welfare, Government of India, New Delhi.

ISBN : 978-81-955347-0-8 (E-book)

ISBN : 978-81-955347-1-5 (Book)

ACKNOWLEDGEMENTS

The subject matter of this research is close to the hearts of the Principal Investigator and the co-researchers who have been working on the issues of sexual and gender-based violence for several years. We collaborated to carry out this research and complete the report.

Carrying out this research was the most challenging at every step. There were several undue delays at all stages of the research, significant among them being the IRB clearance, approvals from the Directors of Health in Maharashtra and Telangana, approvals from the District Health Directorates and further from each of the health facility head. Our patience and perseverance had helped us at all stages. The report writing and submission has been delayed due to several changes in our personal lives and further the COVID in the year 2020. We mobilised ourselves and completed the report, which holds a lot of value to advocate for strengthening the health systems and build their preparedness through robust infrastructure and capacity building of the health care providers.

This research would not have been possible without the support of the funding from the Indian Council of Medical Research, Department of Health Research, Ministry of Health and Family Welfare, Government of India, which found the proposal important and funded it. Key officials of the DHR office have always been supportive by enabling the administrative process and release of funding.

Dr Ipsita Sapra, Associate Professor, TISS Hyderabad has been instrumental in putting this proposal together and helping out in submitting to the ICMR. We wish to acknowledge the intellectual inputs provided by Ms Amita Pitre in preparing this proposal, in providing inputs and encouraging us to complete this report.

The efforts by Ms K Bhagyashree, Ms Jyoti Dalvi, Ms Shravani Page and Ms Laxmi Damera who had tirelessly carried out the field study and documented the findings meticulously, need special mention and profound thanks.

The able support of researchers, Mr Mausam Kumar in analysing NFHS data, Ms Amruta Bavadekar in translating all the Marathi opened ended questions from the Marathi interview schedules and Ms Rani Unnamalai, in helping out with the editing and sorting out all the references, is warmly acknowledged.

This study has been ably supported by the administrative and finance teams of the Tata Institute of Social Sciences, Mumbai. Our special thanks to them.

Prof Lakshmi Lingam (Prinicipal Investigator)
Dr Sunita Bandewar & Ms Sita Mamidipudi

6th April 2021

Table of Contents

List of Figures

List of Box Entries

List of Abbreviations

1. AH: Area Hospital
2. ANM: Auxiliary Nurse Midwife
3. ASHA: Accredited Social Health Activists
4. CAW: Crime Against Women
5. CEDAW: Convention to End all forms of Discrimination against Women
6. CHC: Community Health Centre
7. CEHAT: Centre for Enquiry into Health and Allied Themes
8. CLA: Criminal Law Amendment
9. CMO: Casualty Medical Officer
10. CrPC: Code of Criminal Procedure
11. DH: District Hospital
12. DM&HO: District Medical and Health Officers
13. DHS: Directorate of Health Services
14. DV: Domestic Violence
15. EDTA Tube: Ethylenediaminetetraacetic acid
16. EML: Essential Medicine List
17. FDC: Fixed-Dose Combinations
18. FIR: First Information Report
19. FSL report: Forensic Science Laboratory report
20. GBV: Gender-Based Violence
21. GoI: Government of India
22. HCF: Health Care Facility
23. HCP: Health Care Provider
24. HDI: Human Development Index
25. HIV: Human Immunodeficiency Virus
26. ICDS: Integrated Child Development Scheme
27. ICMR: Indian Council of Medical Research
28. IEA: Indian Evidence Act, 1872
29. IEC materials: Information, Education and Communications materials
30. IPC: Indian Penal Code
31. IPV: Intimate Partner Violence
32. IRB: Institutional Review Board
33. JVC report: Justice Verma Committee report
34. KAP: Knowledge, Attitudes and Practices
35. LCoI: Law Commission of India
36. MH: Maharashtra
37. Ministry Guidelines: Guidelines for Medico-Legal Care for Survivors/Victims of Sexual Violence
38. MLC/s: Medico-legal case/s

39. MoH&FW: Ministry of Health and Family Welfare
40. MCH: Maternal and Child Hospital
41. MTP: Medical termination of Preganancy
42. MO: Medical Officer
43. MWCD: Ministry of Women & Child Development
44. NCRB: National Crime Records Bureau
45. NFHS: National Family Health Survey
46. NGOs: Non-government organisations
47. NHM: National Health Mission
48. NITI Aayog: National Institution for Transforming India
49. OSC: One Stop Centre
50. PCMC: Pimpri-Chinchawad Municipal Corporation
51. PHC: Primary Health Centre
52. PMC: Pune Municipal Corporation
53. PO: Protection Officer
54. POCSO Act: Prevention of Child Sexual Offences Act, 2012
55. PWDVA: Protection of Women from Domestic Violence Act, 2005
56. RH: Rural Hospital (Secondary level)
57. RTI: Reproductive Tract Infections
58. SAFE Kit: Sexual Assault Care and Forensic Evidence Kit
59. SC: Sub-centre
60. SDG: Sustainable Development Goal
61. SDH: Sub-District Hospital
62. SLL: Special & Local Laws
63. SOP/s: Standard Operating Procedure/s
64. STI: Sexually Transmitted Infection
65. SV: Sexual Violence
66. TA/DA: Travelling or Dearness Allowance
67. TFT- Two-Finger-Test
68. TG: Telangana
69. TISS: Tata Institute of Social Sciences
70. UCHC: Urban Community Health Centres
71. UT: Union Territory
72. UPHC: Urban Primary Health Centre
73. VAW: Violence Against Women
74. VAW&G: Violence Against Women & Girls
75. VDRL test: Venereal Disease Research Laboratory test
76. WHO: World Health Organisation

Executive Summary

Introduction: The rise in violence against women, girls and children has alerted the global communities to address it comprehensively. Global estimates suggest that one in every three women experience physical violence, sexual violence, or both; and the perpetrators include an intimate partner, or someone other than a partner in her lifetime. As per the National Crime Records Bureau (2019) data. A total of 4,05,861 cases of crime against women were registered during 2019, showing an increase of 7.3% over 2018 (3,78,236 cases). Violence against women and girls (VAWG) is a manifestation of gender inequality and hence referred to as gender based violence (GBV). All forms of sexual violence that women, girls and children face impacts on their physical, mental, social and economic lives. Sexual violence leaves deep and long-lasting trauma and distress among the survivors. Different forms of violence permeate the life course of women and girls which has detrimental affects on excercising their rights, freedom and life options. A spectrum of laws, policies and programmes exist to ensure gender equality, prevent violence and to deal with the effects of violence. Several institutions, formal and informal, are collectively responsible to address GBV. Among the formal institutions, judiciary, police and health systems have a particular role to play in providing comprehensive and convergent responses to deal with cases of VAWG and ensure that legal trials take place and justice is meted out.

Background: The Protection of Women from Domestic Violence Act (2005); Criminal Law Amendment (2013) and Protection of Children from Sexual Offences Act (2012), and the subsequent publication of guidelines and protocols by the Ministry of Health and Family Welfare (2014) for medico-legal care for survivors/victims of sexual violence, forms the context for this study.

Objectives of the study: *To undertake a comprehensive study of health care and medico-legal care for survivors of gender based violence with special focus on domestic and sexual violence and identification of gaps in infrastructure and human resources.*

Study Sites: This report is based on a study conducted in two districts in India. The study sites are located in Pune district, Maharashtra (West India) and Karimnagar district, Telangana (South India), India.

Methodology: With aid of a mixed methods approach the research studied:

1. The availability of requisite infrastructure
2. The practices and services surrounding healthcare provision to the survivors
3. The availability of psychosocial care and support provided to victims
4. The process of collection of forensic evidence and practice associated with the clinical exam
5. The reliability of applying protocols and guidelines and
6. The sensitivity by health care providers to contextual experiences affecting the 'victims'

A total of 61 health care facilities (HCFs)(primary, secondary & tertiary) **and 180 health care providers (HCPs)**(doctors, nurses, ANMs and ASHAs) were studied across both the study sites.

Key Findings across both the Study Sites:

Physical infrastructure in HCFs: Most of the HCFs were in designated government buildings and in good condition.
Health Facilities preparedness: Only 8% HCFs had separate room for medical examination. While 38% HCFs had the facility to lock the room only 34% HCFs had auditory and visual privacy. All the facilities had a toilet in the building, which was clean and had water.
Clinical Competence: 47.5% HCFs reported competency in conducting surgeries. Around 70.5% HCFs can test blood samples; only 49% had a system to safeguard the collected samples.
Medical Equipment and Supplies for evidence gathering:- Several requirements for forensic evidence gathering were unevenly available. Majority of the HCFs did not have Sexual Assault Forensic Evidence (SAFE) kits. These kits are pre-assembled kits for collection of forensic evidence.
Diagnostic tests, medicines and contraceptives: Provisions for HIV Rapid Test, Pregnancy Test and Tetanus Prophylaxis, medication for prevention of STI , emergency contraceptives for the survivors were not available in all the HCFs that handled Sexual Violence (SV) cases
Counselling: 50% of the facilities in Pune reported providing counseling for the survivors.
Doctors who examine SV cases: Most times the Medical Officer on duty performs the examination. There is inclination to seek for a female gynecologist.
Domestic violence: HCPs were not fully aware of their role to address domestic violence as per law.
Reporting to Police: HCPs were of the opinion that reporting to the police is not mandatory when women come to the hospitals directly. It is the woman and family's prerogative. They are more unclear in DV cases. However, they are alert about the law in the case of child survivors.
Availability of Standard Operating Procedures (SOPs) & Consent forms: Only 11.5% HCFs reported to have SOPs to handle survivors of SV. Barely any HCFs have consent forms.
Practice of Two-Finger-Test (TFT): Police requisition forms given for medico-legal documentation seek two finger test and are not in compliance with changed laws.
Presenting Evidence in the courts: Doctors who attended courts mention that courts continue to discount medico-legal evidence that does not report injuries or would want doctors to answer in 'yes' and 'no' choices in the court.
Change in Laws and existence of MoHFW guidelines: Majority of the HCPs were not aware of the change in the legislations, about several mandatory stipulations that are in the laws and the MoHFW protocols and guidelines for medico-legal care.
Referrals to Tertiary hospitals: Due to the sensitivity attached to sexual violence cases and concerns about court appearances, inadequate facilities and human power in the secondary HCFs, most cases are referred to designated district hospitals or to tertiary hospitals.
Training: Majority of the doctors, nurses, ANMs and ASHAs were keen to understand GBV, the laws, medical guidelines and strengthen their role as health care providers.

Recommendations

Mainstream the MoHFW 'Guidelines for medico-legal care for victims of sexual violence': Evolve a robust strategy to have the guidelines officially adopted and implemented by all the Indian states.
Enhance budgetary allocation for addressing GBV within National Health Mission and through funding from Nirbaya Funds.
Monitor VAW indicators in ranking states on health parameters set by NITI Aayog.
Enhance SV response strategies across primary, secondary and tertiary HCFs
Strengthen Inter-sectoral coordination between health, police and legal departments.
Recognise Domestic Violence as a public health issue and strengthen response of HCFs
Fund and support technology enabled support for training of HCPs in multiple languages
Prioritise primary prevention of GBV in collaboration with civil society groups to address Sustainable Development Goals 3 (Good health & well-being), 5 (Gender Equality) and 10 (Reduced inequalities).

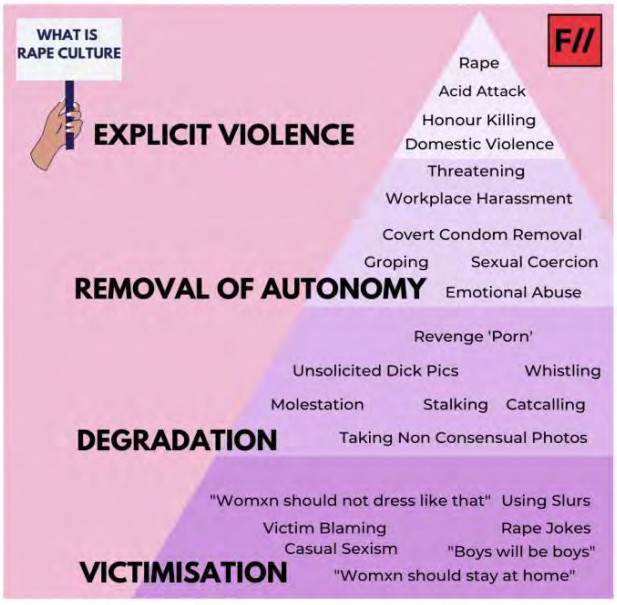
Note: Images are from Global Action of Action, popular version - https://apps.who.int/iris/bitstream/handle/10665/251664/WHO-RHR-16.13-eng.pdf?sequence=1

Chapter 1: Introduction

India is committed to ending all forms of marginalisation and discrimination against women in line with the Convention to End all forms of Discrimination against Women (CEDAW), 1979. India is also committed to achieving the Sustainable Development Goal 5, which targets Gender Equality with sub-goal 5.2 to "*eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation*" (UNECOSOC (2016). However, women in India continue to be disadvantaged with regard to core developmental parameters such as health, education, employment and political participation and also are subject to physical and sexual violence. Despite several institutional efforts, violence against women continues to be a daunting challenge.

The steady rise of Violence against Women (VAW) is a major issue hindering women's participation in development. Women face violence even before they are born and their vulnerability to violence continues through their lives changing forms across life stages: from sex selection to dowry deaths, from acid attacks to brutal sexual assaults, from verbal abuse to 'honour killing', the range is wide. While men are also vulnerable to a range of crimes, the violence faced by women stands out due to its gendered nature. According to the Convention on the Elimination of All forms of Violence Against Women (CEDAW), General Recommendation 19, "*violence that is directed against a woman because she is a woman or that affects women disproportionately"* is gender-based violence (GBV). GBV "*impairs or nullifies the enjoyment by women of human rights and fundamental freedoms*" (CEDAW, General Recommendation 19).

The rising numbers of rapes, domestic violence, crimes against girl children and crimes against Scheduled Caste (SC) and Scheduled Tribe (ST) women, highlight deep-seated issues like socialisation of children within a context of toxic masculinity, social norms that normalise everyday forms of violence; controlling women and their sexualities; victim-blaming, suspecting the women's narrative and normalising gender-based violence. In other words, this eco-system breeds what is now being called a 'rape culture'. According to a UN Women blog post (2019), "Rape culture is the social environment that allows sexual violence to be normalized and justified, fuelled by the persistent gender inequalities and attitudes about gender and sexuality"[1]. A visual from Feminism in India, depicts this.



Source: Feminism in India
https://feminisminindia.com/2020/05/04/infographic-rape-culture/

[1] 'Sixteen ways you can stand against rape culture' 18 November 2019 https://www.unwomen.org/en/news/stories/2019/11/compilation-ways-you-can-stand-against-rape-culture Accessed on 5 March 2020

Given the range of issues involved and that various scholars have worked on different aspects of the issue, this chapter covers the most significant aspects around gender based violence to provide a comprehensive overview of the issues at hand and the existing research engagement.

1.1 Physical and Sexual Violence: Key Data Points

Global estimates suggest that one in every three women experience physical violence, sexual violence, or both; and the perpetrators include intimate partner, or someone other than a partner in her lifetime (WHO, 2013a). Jewkes (2002), in the World Report on Violence and Health, defines sexual violence 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.".* (p. 149). Thus, understanding sexual violence emphasizes that while the form and the degree of violation might differ, a violation of a woman's sexual integrity is common across all sexual abuses such as forced sex or molestation.

A 13-state National Study by the Ministry of Women and Child Development, UNICEF and Save the Children, reported that about 21% of the participants were exposed to extreme forms of sexual abuse. Among the participants who reported being abused, 57.3% were boys and 42.7% were girls, about 40% were 5–12 years of age (Singh, M.M.2014; Choudhary, V, 2018).

According to the India's National Crime Records Bureau (NCRB), 2019 data released on 29 September, 2020[2]:

- A total of 4,05,861 cases of crime against women were registered during 2019, showing an increase of 7.3% over 2018 (3,78,236 cases) (Table – 3A.1)
- Majority of cases under crime against women under IPC were registered under 'Cruelty by Husband or His Relatives' (30.9%) followed by 'Assault on Women with Intent to Outrage her Modesty' (21.8%), 'Kidnapping & Abduction of Women' (17.9%) and 'Rape' (7.9%).
- The crime rate registered per lakh women population is 62.4 in 2019 in comparison with 58.8 in 2018 (Table – 3A.2)
- Average of 87 rape cases per day in 2019 (3.6 cases of rape for every one hour)[3]
- The number of rape cases went up from 32559 in 2017 to 33356 in 2018 and then to 32033 in 2019 (Table 1.2)
- The number of cases of assault on women with intent to outrage went up from 86001 in 2017 to 89097 in 2018 and then to 88367 in 2019 (Table 1.2)
- Crime head-wise cases revealed that simple hurt (1,675 cases) formed the highest number of cases of crimes/atrocities against Scheduled Tribes (STs) accounting for 20.3% during 2019, it was followed by rape with 13.4% (1,110 cases) and assault on women with intent to outrage her modesty with 10.7% (880 cases) (Table – 7C.3)

[2] https://ncrb.gov.in/sites/default/files/CII 2019 Volume 1.pdf
[3] https://thewire.in/women/average-87-rape-cases-daily-over-7-rise-in-crimes-against-women-in-2019-ncrb-data

- There were 3,486 cases of rape against SC women including girls. With reference to 2015, the increase is 37% for cases of rape against SC women alone[4].
- Uttar Pradesh also had the highest number of crimes against girl children under the POCSO Act with 7,444 cases, followed by Maharashtra (6,402) and Madhya Pradesh (6,053).

The National Family Health Survey, Round 5 (NFHS-5), India (2019-20) for 17 States and 5 Union territories presents data on violence against women in three categories – (1) Spousal violence (both physical and sexual violence), (2) Physical violence during pregnancy and (3) Young women aged between 18 and 29 years who experienced sexual violence by age 18 years[5].

Most states have recorded a downward trend in the cases of spousal violence. However, states like Telangana, Manipur, Bihar and Karnataka, recorded higher prevalence. Himachal Pradesh and Maharashtra also reported significant hike in prevalence of spousal violence in comparison to the earlier round of the NFHS (2015-16).

With reference to physical violence during pregnancy there is an overall decline. Telangana, one of the southern states in India reported the highest fall in such cases followed by Bihar, a northern state in India. The maximum rise in cases was led by three north-eastern states of Meghalaya, Sikkim and Assam followed by Maharashtra. Goa and Maharashtra witnessed the highest rise in cases of sexual violence against young women by the age of 18 years, of 3.3 per cent each.

1.2 Gender based Violence and Health Consequences

Acts of sexual violence give rise to myriad short and long-term consequences on the mental, physical, sexual and reproductive health of the victims/survivors. Consequences include Post-Traumatic Stress Disorder (PTSD), unwanted pregnancies, unsafe abortions, gynaecological complications, vulnerability to HIV/AIDS and other sexually transmitted diseases, injuries, suicidal behaviour, depression, stress and anxiety disorders (Jina & Thomas, 2013; WHO, 2002; McFarlane et al, 2005).

In addition, the stigma associated with sexual violence results in a series of social consequences to the women/girl survivors, such as rejection by families, pressures to relocate and change their identity (Bhate-Deosthali et al., 2018). 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. In some cases, the consequential social practice remains that women were coerced into a marriage with the perpetrator (WHO, 2002).

[4] Devyani Srivastava 'Rapes against Scheduled caste women rose 37% in the last 4 years', India Spend, 9 October, 2020.
https://www.indiaspend.com/in-hathras-backdrop-37-more-rapes-20-more-assaults-on-dalit-women-during-2015-2019/ (Accessed on 1st Feb 2021)

[5] Abhjit Kaur, Mahadev Bramhankar, Nand Lal Mishra – 'Gender violence drops, but prevalence remains high in bigger states: NFHS-5', Down to Earth, 15 December, 2020. Accessed on 20 December 2020.
https://www.downtoearth.org.in/blog/health/gender-violence-drops-but-prevalence-remains-high-in-bigger-states-nfhs-5-74652

Intimate partner violence and coercive sexual experiences within marriage 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 (Hill et al., 2016; Jejeebhoy & Bott, 2003).

An empirical research study (CEHAT, 2012) that documented consequences of sexual assault, observed that 64 out of 94 survivors reported at least one health complaint ranging from genital and physical injuries to pain in different parts of the body, pregnancy and infections. Some also reported problems such as bed wetting, sleep disorders and white discharge. The study noted that psychological health consequences in 13 to 18 years age group included survivors' anxiety and flashbacks while speaking about the assault. Further, at least a third of the survivors felt uncomfortable speaking with the interventionists. For instance, they did not make eye contact while speaking. In instances where the survivors knew the perpetrator, they expressed a sense of sadness, being cheated, and loss of trust.

1.3 Sexual Violence & Underreporting

Despite these rising numbers, many rape cases still go unreported due to the fear of social stigma, shame, lack of awareness and supportive systems, implying that the real picture of sexual violence in India could be much worse (Himabindu et al., 2014). Research across the world also shows that a large majority of women do not seek help or even report the crime (Fisher et al, 2003; Rennison, 2002). Women are reluctant to report the crime because of the social stigma and the fear of being disbelieved by authorities that have to record their complaints (Pitre & Pandey, 2009).

Jagori & UN Women's study in Delhi observed that over 90% of women experiencing sexual harassment do not report to the police assuming their ineffectiveness (Jagori & UN Women, 2011). Poor response from public institutions discourages reporting and decreases institutional credibility. This had been in evidence in many of the rape cases that came to light in recent years. While women may not report the crime, they are more likely to visit a health care facility (Shepherd et al, 1989; Kruger et al, 1998; Houry et al, 2000). International research shows that women facing violence utilize health facilities more often than others (Sansone et al, 1997; Koss et al, 1991; Koss 1994). It was observed that the incidence of re-assault on women reduced by 32% among those who received medical care (McFarlane et al, 2005). An empathetic response, with the provision of information and care, can build her confidence and morale (Pitre & Pandey, 2009). However, unfriendly and insensitive procedures if followed in a health facility will not only make women feel further victimized but jeopardizes their chances of securing justice. Thus, an apathetic response may exacerbate trauma, impact the woman's morale and deter further reporting (Pitre & Pandey, 2009). Further, conviction rates are strongly linked to gender-sensitivity, evidence gathering related infrastructure and capacities and compliance to protocols (Pitre, 2006; Himabindu et al., 2014).

1. 4 Sexual Violence and Legal Provisions

The Government of India set up Justice Verma Committee, in response to the protests after 2012 Delhi rape case, also known as Nirbhaya case. In its path-breaking report, significant directions to amend the antiquated Criminal Law regarding Rape[6] were given. The government did not accept all the recommendations of the Verma Committee. However, the amended criminal law is a vast improvement on the earlier version.

Among the recommendations, the definition of 'rape' was to be expanded to include a range of penetrative sexual offences; to amend the section on 'molestation' to 'sexual assault' including a wide range of offences other than penetration; to introduce the offences of disrobing, voyeurism, stalking, gang rape and gang rape causing death or persistent vegetative state; and to provide for enhanced punishments under each of these. Significantly, this definition had gone beyond the restricted understanding of rape as peno-vaginal penetration alone. The Criminal Amendment Law (CLA) passed in 2013 accepted these recommendations in the rape laws as codified under Indian Penal Code (IPC) Section 375 (which defines rape), Section 376 (which provides punishment for rape) and section 354 (which provides definitions and penal provisions for sexual harassment). The Protection of Children from Sexual Offences Act (POCSO), 2012, passed a year before provides for comprehensive measures against the inducement or coercion of a child into any unlawful sexual activity, the exploitative use of children in prostitution or other unlawful sexual practices and the exploitative use of children in pornographic performances and material. This legislation for the first time gave a comprehensive and graded definition of sexual assault against children (POCSO, 2012). Before this legislation was passed there was no separate law to take cognizance of child sexual abuse and the antiquated Rape Law was very inadequate to cover these abuses.

The Criminal Law Amendment (CLA) Act, 2013 that defines the Rape Law amendments, expanded the definition of Rape from an offence limited to peno-vaginal penetration to a range of penetrative sexual assaults, including penetration of the vagina, anus and urethra by the penis, objects or other body parts and penetration of the mouth with the penis. It also gave a comprehensive definition of Sexual Harassment under the amended IPC Section 354. Earlier this section was narrowly defined as *'outraging the modesty of a woman'*. Both the Criminal Amendment Law 2013 and POCSO 2012 put the age of consent for sexual activity at 18 years. This is another big change to the laws on sexual offences in India.

[6] *Justice J.S. Verma (retd), Justice Seth (retd), Gopal Subramanium (2013), Report on the Committee on Amendments to the Criminal Law, Government of India, New Delhi*

Box 1: Definition of Rape

Section 375 of the Indian Penal Code 1860 ('IPC'), amended in 2013, defines rape as follows:

"A man is said to commit "rape" if he –

a. penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or
b. inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or
c. manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any part of body of such woman or makes her to do so with him or any other person; or
d. applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions: –

First – Against her will.
Secondly – Without her consent.
Thirdly – With her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt.
Fourthly – With her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.
Fifthly – With her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent.
Sixthly – With or without her consent, when she is under eighteen years of age.
Seventhly – When she is unable to communicate consent.

Explanation 1. – For the purposes of this section, 'vagina' shall also include labia majora.
Explanation 2. – Consent means an unequivocal voluntary agreement when the woman by words, gestures or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act: Provided that a woman who does not physically resist to the act of penetration shall not by the reason only of that fact, be regarded as consenting to the sexual activity.
Exception 1. – A medical procedure or intervention shall not constitute rape.
Exception 2. – Sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape."

Source: https://www.iitk.ac.in/wc/data/TheCriminalLaw.pdf , pp. 5-6.

1.5 Institutional Mechanisms for Implementation of Legal Provisions

These legislative changes often referred to as post-Nirbhaya reforms have been lauded for their content as well as the pace at which government responded to people's disquiet and demands to bring these reforms (Bandewar, Pitre, & Lingam, 2018). To strengthen and assist these legal changes a series of guidelines and institutional mechanisms have been mooted and also implemented as follows:

- **MoHFW Guidelines:** The Ministry of Health and Family Welfare (MOHFW, 2014) had developed and released guidelines aimed at enhancing and strengthening the inter-sectoral response to survivors of sexual violence; streamline the medical evidence gathering and extend support health care to the survivor of sexual assault titled – *Guidelines & Protocols: Medico-legal care for survivors/victims of Sexual Violence (2014).*
- **Nirbhaya Fund:** A funded named Nirbhaya Fund was announced with a budgetary allocation of Rs 1000 crores per year for three years starting from the financial year 2013-14 was made by the Central Government to provide financial assistance and relief to survivors of sexual violence to help them withstand the financial strain that legal proceedings create. This sum of Rs 3,000 crore is a non-lapsable corpus fund to support initiatives by the government and NGOs working towards protecting the dignity of women in India and ensuring their safety (Bandewar, Pitre & Lingam, 2018).
- **One-Stop Crises Centres** (OSCC) were announced and established to provide immediate support and mitigate delays in evidence gathering and health support. As per the Press Information Bureau (February 2020) there are 680 Sakhi centres established across 35 states in India[7].

Notwithstanding all these changes and initiatives, the issue of violence on women and girls in general and sexual violence in particular, continues to remain a vexed issue in India. Serious lapses having been coming to light with reference to police and health sector responses. Taking cognizance of these lapses, perhaps, the National Human Rights Commission had issued a fresh set of guidelines on 9 December 2020 (in line with the MoHFW guidelines) to ensure medical evidence gathering and documentation of all-important observations of the medical examination titled - *Standard Operating Procedure (SOP) on Collection & Processing of Scientific/Forensic Evidences in Case of Sexual Assault on Women*[8].

Bandewar and colleagues (2018) had noted implementation gaps in relation to post-Nirbhaya reforms by presenting case analyses of select rape judgments and sexual assault and rape cases highlighting the fact that much needs to be done towards changing the perspectives of the key state apparatuses such as judiciary, police and forensic investigations, and response of hospitals. Deep-rooted prejudices, unscientific practices, and discrimination based on caste, gender, religion, disability, and sexual orientation manifest in the way sexual assault cases are dealt.

Two reports brought out by Human Rights Watch (2017, 2018) also demonstrate such colossal implementation gap in this regard. Human Rights Watch 2017 Report documents significant barriers that survivors confront in obtaining justice and critical support services. The report reasons that it is due to the lack of fuller realisation of legal and other post-Nirbhaya reforms coupled with prior biases based on the background of the survivors. The report discusses the continued irrational use of the two-finger test as part of an examination of survivors to assess the woman's past sexual history. Human Rights Watch 2018 Report observes, "they have yet to properly develop and implement support for survivors with disabilities in the form of trainings and reforms throughout the criminal justice system. It highlights gaps in enforcement and calls for concrete measures to address the needs of women and girls with disabilities

[7] https://pib.gov.in/newsite/PrintRelease.aspx?relid=199127
[8] https://nhrc.nic.in/acts-and-rules/standard-operating-procedure-sop-collection-processing-scientificforensic-evidences

seeking justice for abuse. These empirical realities underscore regressive attitudes and gendered bias of constituencies, critical to delivering justice to survivors of sexual assault.

Though the law pertaining to Rape has now changed to include a range of sexual assaults, it is important to remember that the medical jurisprudence around sexual assault has largely developed during the period of the limited definition of 'Rape', which continues looking for evidence around proving a 'rape' or 'sexual assault' as a peno-vaginal penetrative act. For example, 'potency'[9] tests continue to dominate the medical examination of the accused when the scientific validity of such a test has been challenged and the new rape law makes it more or less redundant. Before the crucial amendment to the IPC, a considerable amount of time and energy in the courts was spent on deciding whether the accused has the potency to engage in penetrative sex and whether the crime was rape or a lesser offence. In the infamous, Bihar Muzaffarpur shelter homes sex abuses of children that became public in 2018; the trial court convicted the key accused and accomplices. However, the key accused challenged the trial court's judgment of his conviction and jail term in the Delhi High court. One of the key points of contention from his side is that the trial court "Without establishing the potency of the accused specially one who is more than 50 years of age the accused cannot be convicted of the offence of rape." The High court has admitted the case and has sought the CBI's response on the accused's appeal as reported by a daily on 22nd July 2020.[10] The gang rape of a Dalit girl on 19th September 2020 and her death on 29th September 2020 after gang rape in a village in Hathras district, Uttar Pradesh, brought to light several irregularities in providing life-saving health care support to sexual violence survivor and serious lapses in medical evidence gathering (Bhate-Deosthali & Rege, 2020). On 19 January 2021, the Nagpur bench of the Bombay High court had acquitted a man of sexual assault observing that that the absence of skin to skin contact that happened with groping over the victim's clothes would not fall under the definition of 'sexual assault' as provided under POCSO Act, 2012. The Supreme Court had stayed the controversial verdict on 27th January 2021. These are the contradictions that are emerging with a gap in the legislation and their interpretation at all levels.

1.4 Public Health Approach to Sexual Violence

Responding to sexual violence is a complex phenomenon and involves the participation of police, health facilities, forensic laboratories and prosecution. Studies across the world illustrate that health facilities are often not women-centred in their approach and may not give equal importance to all aspects associated with sexual violence – such as providing gender-sensitive health care and carrying out evidence gathering for medico-legal purposes. Researchers and women's activists have documented several instances of delayed response, inadequate history taking, lack of sensitivity in providing health care and incomplete medico-legal evidence collection by health professionals in responding to sexual violence (Pitre & Pandey, 2009; Prakash, George, & Panalal, 1993; Gudalure M. J. Cherian vs Union of India, 1992; Kulkarni et al, 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 those specifically for

[9] Potency test is a test to find out if the penis can become erect and the person could perform the act of penile penetration.

[10] (2020, July 22). Bihar Shelter home case: HC asks CBO to reply on Brajesh Thakur's appeal against life term for sexual assault. *The New Indian Express.* Retrieved from: https://www.newindianexpress.com/nation/2020/jul/22/bihar-shelter-home-case-hc-asks-cbi-to-reply-on-brajesh-thakurs-appeal-against-life-term-for-sexua-2173265.html

sexual violence (Prasad, 1999). Studies also report that health care providers may be judgmental towards victims, may doubt whether a crime has been committed, may give low priority to the crime, make mistakes in documenting evidence and conduct inappropriate medical examinations (Prasad, 1999; Agnes, 2005; Baxi, 2005).

In dealing with a survivor of sexual violence, health care providers have multiple responsibilities:
1) Attend medically to the physical injuries sustained 2) Provide trauma counselling services 3) Provide emergency contraception and STI/HIV testing 4) Collect medical evidence to assist the investigation and prosecution of crime and 5) provide necessary referral to ensure the survivor's safety. However, 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, inadequate information and follow-up (Kilonzo et al, 2009; Amey & Bishai, 2002; Azikiwe et al, 2005; Suffla et al, 2001; Christofides et al, 2006). Health care personnel have also claimed that it is difficult to discuss the risk of HIV infections with a survivor (Christofides, Webster, Jewkes et al. (2003) as cited in Azikiwe et al, 2005).

The WHO report in 2013 documented detailed insights into the magnitude of the problem at hand. The purpose of the report was to offer global and regional estimates of violence against women and its health effects on survivors. In the same year, WHO (2013b) came out with clinical and policy guidelines by steering an international consultative process entitled 'Responding to intimate partner violence and sexual violence against women'. These guidelines are aimed at health-care providers given their unique position with regards to addressing health care and psychological needs of survivors of violence. It also includes guidance for those responsible for developing funding and implementing programmes to address VAW. It provides 38 recommendations across six areas – women-centred care; identification and care for survivors of intimate partner violence; clinical care for survivors of sexual assault; training of health-care providers on intimate partner violence and sexual assault; health care policy and provision; and mandatory reporting of violence.

1.5 Inter-agency coordination

Caring for survivors of sexual violence usually involves multiple stakeholders. In addition to the health facilities, police and law enforcement agencies are also involved because of the need for medical evidence and other investigations (Pitre, 2006). Within a health facility, several departments are involved including casualty, gynaecology, paediatrics, radiology and forensics. Survivors of violence are required to report in the Emergency Department, which is the same as the Casualty Department. This section deals with all emergencies, cases of trauma and patients with no prior scheduled appointments. Existing studies have indicated the lack of privacy and time to talk with the doctor, lack of continuity in care, and insensitivity in investigating and examining episodes of violence (Bacchus et al, 2003). Documentation of long waits in the emergency department and less priority given to sexually assaulted women over life-threatening emergencies by the nursing professionals in the United States helped formulation of dedicated Sexual Assault Nurse Examiner (SANE) Programs to care for survivors (Plichta, Clements & Houseman, 2007).

In South Africa, situational analysis of health services (is this Christofides et al, 2003? It needs to be here) demonstrated that the state hospitals had little relationship with NGOs working on violence and seldom referred patients to them for counselling. The same study illustrated that while most health providers had an average relationship with the police, up to a third of providers described their relationship as poor depending on the province. Nearly one in ten providers had no relationship with social workers (Christofides, Webster, Jewkes et al, 2003). It indicates that while the response to sexual violence includes multiple agencies, coordination between these is often poor. This has implications for the survivors who have to approach multiple agencies for services. Ariffin (1997) 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).

In India, while there are a few demonstration models that provide sensitive and one-stop care along with evidence collection models, such as the *Dilaasa* model which is being implemented at the Brihanmumbai Municipal Corporation's (BMC) peripheral hospitals in Mumbai in collaboration with an NGO, the Centre for Enquiry into Health and Allied Themes (CEHAT), the need to upscale such models cannot be overemphasied.

The public health approach in the fight against sexual violence advocates for prevention through multi-sectoral collaboration between the health system, the police, criminal justice, education, civil society and advocacy groups for a comprehensive response (World Health Organization/London School of Hygiene and Tropical Medicine, 2010).

Garcia-Moreno and colleagues (2015) presented a model (Figure 1) for a comprehensive health system response that is women-centred. This model gives an overview of the mandatory elements of the health system that are crucial for an effective woman-centred response to violence against women. It is divided into three different levels of factors: health providers, health systems (health care delivery), relevant multidisciplinary services and policy. The elements are grouped as "building blocks", notably: leadership and governance, information, health infrastructure, health workforce, service delivery, coordination and financing. These core-elements, when all present in the health system, ensure a woman-centred response to sexual violence, that is mindful of the life trajectories and specific needs of women survivors of sexual violence.

An exploratory study of health facilities in two districts in Maharashtra to study the response to sexual assault and rape by healthcare services, the medico-legal examination and the level of women-friendliness found that five of the six facilities examined did poorly on these counts, especially health care provision (Pitre & Pandey, 2009). A similar research was jointly undertaken by SAMA Women's Resource Group (SAMA) and CEHAT (2011) at a tertiary public health care facility in Delhi. It arrived at similar conclusions that there are several gaps in both medico-legal and therapeutic response of the hospital to sexual assault survivors.

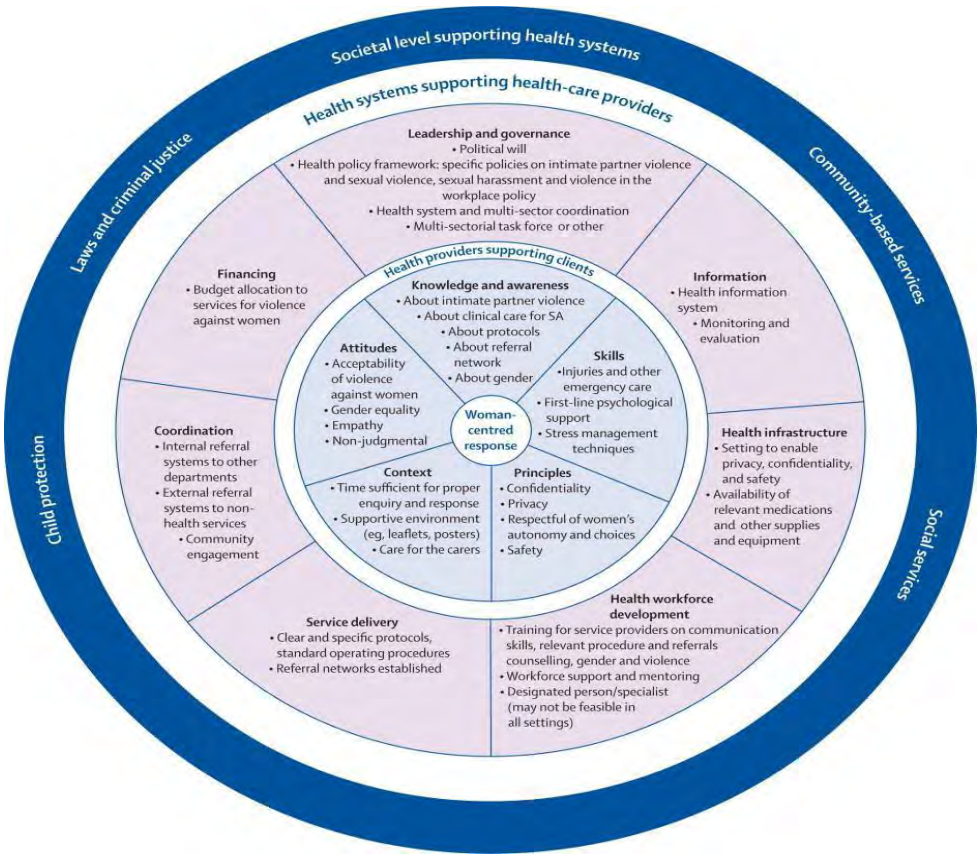


Figure 1- Elements of the Health system and health care response necessary to address VAW

Source: (Garcia-Moreno et al., 2015)

Research undertaken by CEHAT based on its intervention in three public health hospitals in Mumbai (CEHAT, 2012; Bhate-Deosthali et al., 2018) demonstrated the crucial role that the health care sector plays in responding to survivors of sexual assault. It also showed that engagement with and training of health care providers enable them to deliver their duties caring for survivors and also help them enhance confidence in playing the role of medico-legal service provider more effectively. More importantly, the findings demonstrated that training and perspective building of health care providers significantly contributes to better and reasoned medical opinion about sexual violence cases. It called for a re-assessment of how medical evidence is interpreted by the judicial system. Besides, rather than supporting the survivors of sexual violence, existing medical practices often impede reporting of sexual violence. Contrary to the experience narrated above, the most other health care facilities adhere to procedures and protocols that insist on finding bodily evidence to vouch for women's complaint of sexual assault. There are remarks made on the nature of the evidence such as her height, weight, past sexual history, presence of hymn and elasticity of the vagina. Bhate-Deosthali (2013) extolls the importance of extending care to survivors and carrying out a diligent and sensitive evidence gathering and documenting as imperative for better legal outcomes and doing justice to women and girls. Pitre and Lingam (2013) writing about post-sexual violence response refers to the 'two- finger test' often undertaken at health facilities. Such

practices often lead to a situation when the survivors feel blamed and they abstain from testifying leading to poor conviction rates.

1.6 Inadequate Medico-legal Services and Absence of Standard Protocols:

The World Report on Violence and Health (2002) specifically notes that standard and uniform protocols to guide medico-legal examination in cases of Sexual Assault add to the quality of care. Studies conducted in the United States compared the quality of services provided by Sexual Assault Nurse Examiners (SANEs) to non-SANE set-ups that have shown less than optimum medico-legal services (Sievers et al., 2003). Situational Analysis of the services 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 sexual assault were also not available uniformly to health care providers and there was often delay in examination while waiting for the provision of kits from the police. Kits were also found to be incomplete at times and sometimes health care providers were not trained in their usage.

A study conducted in one rural and one urban site in South Africa among both women who had used post-rape services and women from the community who are potential users, found that women preferred facilities which employed a sensitive, trained health care provider who could also provide counselling and centres 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 long distances to access such services and also return for follow-up visits if required especially for counselling (Christofides et al., 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).

Until the issuance of the MoHFW Guidelines (2014), no national guidelines or protocols regarding care or evidence collection were mandatory for use in India.

1.7 Extant Research on Implementation of Ministry Guidelines

The most prominent developments post Nirbhaya in India gave rise to the Ministry Guidelines issued in March 2014 and the Criminal Law Amendment (CLA) 2013, covered earlier in this chapter. The states took much longer to adopt the Ministry Guidelines and issue an order to that effect. These developments certainly are progressive; and are in tune with the global environment in promoting aspired systemic changes to enhance the quality of the system's response to women survivors of violence, especially sexual violence. These were also informed by intervention research in India similar to CEHAT in the past one and a half-decade.

To the best of our knowledge, there are no comments available on the Ministry's Guidelines in the peer-reviewed journals. As well, we did not come across any research assessing implementation of the Ministry Guidelines on ground. The reports and papers published since early 2013 assessed the quality of response of the public health care system based on the intervention implemented much earlier.

Simultaneously, the issue of violence against women was being pursued ardently. The fact that the issue of violence against women, especially domestic and sexual violence requires lot more attention and concerted efforts at various levels is underscored by the series of five papers on the theme of violence against women and girls (VAW&G) published by Lancet between 2014 and 2015. Garcia-Moreno, Zimmerman and colleagues (2015) put out a call to action to address violence against women. They highlighted the global nature of VAW&G affecting one in three women adversely impacting their well-being. It reiterates the need for violence-prevention interventions seeking to address norms, beliefs and attitudes linked to the notion of masculinity and the male authority over women which stems from it. Political leadership and government investments, they argued, are essential to reducing violence against women and girls. They have recommended the need for investments into research on VAW prevalence, and assessment of prevention and response strategies. Finally, they make a case for the crucial role health sector, other sectors and civil society play both in the prevention of and response to violence against women, girls and children.

1.8 Present Research

There is substantial evidence from across the world that health and medico-legal services for women facing sexual assault has been a neglected area until recently. However, there is a growing recognition of the issue, several innovative interventions emerging around the world and efforts to make interventions mainstream. Several issues exist including lack of standardized protocols, training and facilities in health systems for a sensitive and comprehensive response to sexual assault as well as a lack of laid out systems of coordination and cooperation between health and justice systems. These issues prevent women from getting much-needed health care and simultaneously, reduce their chances to make a strong case to seek justice. Unscientific and demeaning tests such as the 'two-finger test' demoralize the woman and further, actively work against her in the court-room. At the same time, there is evidence to show that the health system will be the first point of contact for assaulted women and a sensitive, prompt and non-judgmental response from the health system can boost her morale to recover from the trauma as well as seek justice. Quality documentation of injuries is significantly associated with convictions.

Most of the empirical work establishing comprehensive health care response to survivors of sexual violence in public health cares system and its assessment has been confined to Mumbai and Delhi. And to the best of our knowledge, there has been no empirical research undertaken post the issuance of the Ministry Guidelines and legal reforms, especially the CLA 2013. This makes the present study of immediate significance to inform the government, health care systems, child protection bodies and women's movement, the current situation and the way forward.

1.8.1 Study Objectives[11]

Objective 1: To undertake a comprehensive study of health care and medico-legal care for survivors of gender based violence with special focus on domestic and sexual violence and identification of gaps in infrastructure and human resources

- **Health Care provided:** The study would examine the practices followed and services provided with regard to psycho-social support and health care issues emergent on rape and sexual assault.
- **Medico-legal response**: The study would examine the practices to undertake medico-legal examinations and the forensic laboratory services to document adherence to recent legal reforms and Ministry Guidelines, quality of protocols/reports and suggest ways to address emerging concerns.
- **Understanding Intersections:** Given that gender, caste, class, and rural biases, age and 'special group' identities such as persons with alternate sexual orientation, transgender and intersex persons, sex workers, and persons with disabilities influence handling of cases, the study would capture sensitivity to these aspects.
- **Understanding negative attitudes and knowledge of recent legal reforms and guidance:** Given that sexual assault survivors face considerable negative response based on stereotypes, the project would capture the existing attitudes of healthcare providers. It will also explore the extent of knowledge amongst health care providers about the recent legal reforms and the guidance issues for them by the MOH&FW/GoI and orders issued by the state government in Aug 2015 seeking compliance with.
- **Women friendly services**: The study would examine the woman friendliness of the facilities - availability of women doctors and staff, privacy of settings, consents procedures etc. This would help to identify gaps in infrastructure and human resources and indicate capacity building needs.

Objective 2: ***Contribute through research to support health facilities to implement the Ministry Guidelines and enhance compliance with legal norms***

The findings of this study were expected to support health facilities to follow the Ministry Guidelines and other related legal norms by providing insights into the current state of implementation of privacy, securing consent, security, single location for convergent services and procedures. This second objective was envisaged as the second part of the total project as an advocacy and dissemination arm of the research study. However, due to inordinate delays in receiving the cooperation of the health departments and the lapsing of the project funding duration, this component was not taken up as envisaged, but the Principal Investigator and co-researchers have carried out academic engagement and advocacy on the subject matter of this research.

A pre-conference titled 'Enhancing quality of system's response to survivors of gender based violence: exploring challenges & perspectives' was organised at the Sixth National Bioethics Conference on Jan 12, 2017. The project collaborated with the conference organisers – Mahila Sarvangeen Utkarsh Mandal, Forum for Medical Ethics Society and Indian Journal of Medical Ethics. This served the purpose of

[11] Objectives were modified in response to the major changes introduced by the post-Nirbhaya legal reforms during the period between submission of the proposal to ICMR in the year 2012 and grant awarded by DHR in a communication dated Jan 5, 2015 (Communication ref no: No GIA/8/2014-DHR).

initiating engagement and advocacy with wide ranging constituencies of relevance to the topic of enquiry. The pre-conference concept note and day long program is available from: http://ijme.in/nbc-20140321/index.php/NBC-6/index/pages/view/pre-conf-workshop-gender-based-violence A brief draft report of the deliberations which took place at this pre-conference is available from http://ijme.in/nbc-20140321/index.php/NBC-6/index/pages/view/gbv-pre-conf-report

Published Paper/s: We published a paper with the following citation:

> Bandewar SVS, Pitre A, Lingam L. Five years post Nirbhaya: Critical insights into the status of response to sexual assault. *Indian Journal Medical Ethics*. Published online on March 28, 2018. DOI: 10.20529/IJME.2018.025

An in-congress workshop at the joint 14th World Congress of Bioethics and 7th National Bioethics Conference scheduled between Dec 5 and 7, 2018 in Bangalore at St John's Academy of Health Sciences titled – '**Gender based violence in India: Critical insights into the ground realities based on empirical and secondary research**'.

The Principal Investigator of this project had jointly published on the issue of age of consent, one of the changes in the POCSO Act. The citation of the paper is:

> Pitre, Amita and Lingam, Lakshmi. Age of Consent: Challenges and Contradictions of Sexual Violence Laws in India, *Sexual and Reproductive Health Matters,* 20 January, 2021 DOI: 10.1080/26410397.2021.1878656

The researchers of this project also engaged with intervening in urging for gender sensitive health system protocols, particularly with reference to the Government of Kerala's GO sending a different set of guidelines for POCSO cases. We ran a signature campaign and the published the joint statement in the Indian Journal of Medical Ethics with the following citation:

FATIMA, Adsa ; CHANDRASEKHAR, Aarthi ; PITRE, Amita (2018): Need for gender sensitive health system responses to violence against women and children. **Indian Journal of Medical Ethics**, V. 3, No. 3 (NS), p. 254, Jan. ISSN 0975-5691. Available at: <**https://ijme.in/articles/need-for-gender-sensitive-health-system-responses-to-violence-against-women-and-children/**>. Date accessed: 31 Mar. 2021.

Dr Sunita Bandewar had written on the death penalty and clamour for "instant justice" soon after the case of Priyanka Reddy's gang rape and the encounter deaths of the culprits. The citation of the paper is:

BANDEWAR , Sunita VS (2020) Public narrative on "instant justice": A slippery slope. **Indian Journal of Medical Ethics**, Vol. V, No. 1, p. 3-6, Feb. ISSN 0975-5691. Available at: <**https://ijme.in/articles/public-narrative-on-instant-justice-a-slippery-slope/**>. Date accessed: 31 Mar. 2021.

In this report the terms 'Sexual Violence' and 'Sexual Assault' are used interchangeably. Both terms include the spectrum of coercive sexual behavior towards a person. The term Sexual Violence is particularly useful to invoke the violation of a woman's bodily integrity whereas the term Sexual Assault

is useful to refer to particular incidents of violation or referring to persons who were assaulted. In the place of victim the term survivor is used through out the report.

1.9 Organisation of the report

Besides the Executive Summary, this introduction, which is the first chapter, the report has ten other chapters.

Chapter 2 covers the research design, methodology and research tools used for this study.

Chapter 3 provides a background to the select states, Maharashtra and Telangana and further the select districts, Pune (from Maharashtra) and Karimnagar (from Telangana). The health infrastructure of both the states and the violence statistics for both states has been covered in this chapter.

Chapters 4, 5 and 6 cover the Pune site. Chapter-4 covers the health infrastructure particularly in the health care facilities (HCF) sampled for the study and the availability of infrastructure and human resources, to assess the preparedness to handle sexual violence cases.

Chapter 5 covers the medical evidence gathering and health care provision practices at the Pune HCFs to understand the current practices and gaps in medical care to survivors and collection of forensic evidence from the survivor and the accused.

Chapter 6 covers the knowledge, attitude and perspectives of health care providers (HCPs) about the change in the rape laws, the existence of the ICMR guidelines, the mandatory requirement for medical and forensic evidence gathering, documentation and extension of support to survivors.

Chapter 7 covers the training needs of doctors, nurses, ANMs and ASHAs and their suggestions, willingness and concerns around training to deal with the changed legal systems.

Chapters 8, 9 and 10 cover Karimnagar of the Telangana study site. Chapter-8 covers the health care facilities (HCFs) and their preparedness to handle sexual violence cases.

Chapter 9 covers the compliance of the doctors and health personnel of Karimnagar to the changed requirements to deal with the medical and forensic aspects of handling sexual violence cases. The HCPs attitude and perspectives and the subject are also explored.

Chapter 10 covers the knowledge and attitudes of Nurses, ANMs and ASHAs. This chapter also looks into the training needs of this group.

Chapter 11 is the final concluding chapter that summarizes the report and comprehensively draws from the study the key learning regarding the study objectives and provides recommendations for strengthening the health systems response to sexual violence.

The references to all chapters and the annexures of all important and relevant information are given at the end.

Chapter 2: Areas of Enquiry and Research Tools

This study of public healthcare systems, practices, and responses was conducted in two states – Maharashtra and Telangana. This comprehensive study of the public health care system focused on response to survivors of sexual violence, identification of gaps in infrastructure and human resources; on insights into health care providers' knowledge of the Ministry Guidelines and the key aspects of the legal reforms in rape laws that took place in 2012 and 2013; their attitudes towards and perspectives about these reforms founded on principles respecting gender justice in the context of health care system responding to survivors/victims of gender-based violence in general and sexual violence in particular.

This chapter covers the areas and scope of the research enquiry, the research design and information on the research tools and the sampling strategy.

2.1 Study design and major components of the research

The study followed a mixed-methods approach, which employs both quantitative and qualitative research methods. The overarching criterion for site selection was the data on crimes against women from government sources. Data was collected primarily through one-on-one interviews with health care providers; and by administering an observation checklist to assess the health infrastructure. This study did not include interviews or engagement with survivors of sexual violence. Necessary permissions were sought from concerned offices such as the Directorate of Health Services and the Health Department of Municipal Corporations in both the states.

The study adhered to research ethics norms, such as, seeking informed consent, maintaining the anonymity of individual participants, and confidentiality of the data with utmost diligence. No major risks of participation were anticipated to the study participants and participating entities, that is, public health care facilities (HCFs). We expected potential informational/reputational risks to health care providers (HCPs) and/or HCFs arising from the possibility of less than adequately equipped health care facilities, and non-compliance with various aspects of legal reforms and medical ethics norms. Presenting this initiative as collaborative with the public health care system minimized this risk. For example, the project was conceptualized and implemented to complement the works done by the government and other entities such as non-government organisations (NGOs). It aims to contribute towards enhancing the compliance of the health care system with the legal framework, especially the legal reforms such as Criminal Amendment Act 2013 and the guidelines issued by the Ministry regarding the provision for medico-legal care for survivors of sexual violence in the year 2014. The benefits of the research would be both at a systemic and individual level towards enhancing the quality of the health system's response to survivors of sexual violence.

Four key components of research have been:

a. A survey of HCPs was undertaken to assess the availability of infrastructure facilities in adherence to the key principles of medical examination and evidence gathering in sexual violence cases.;

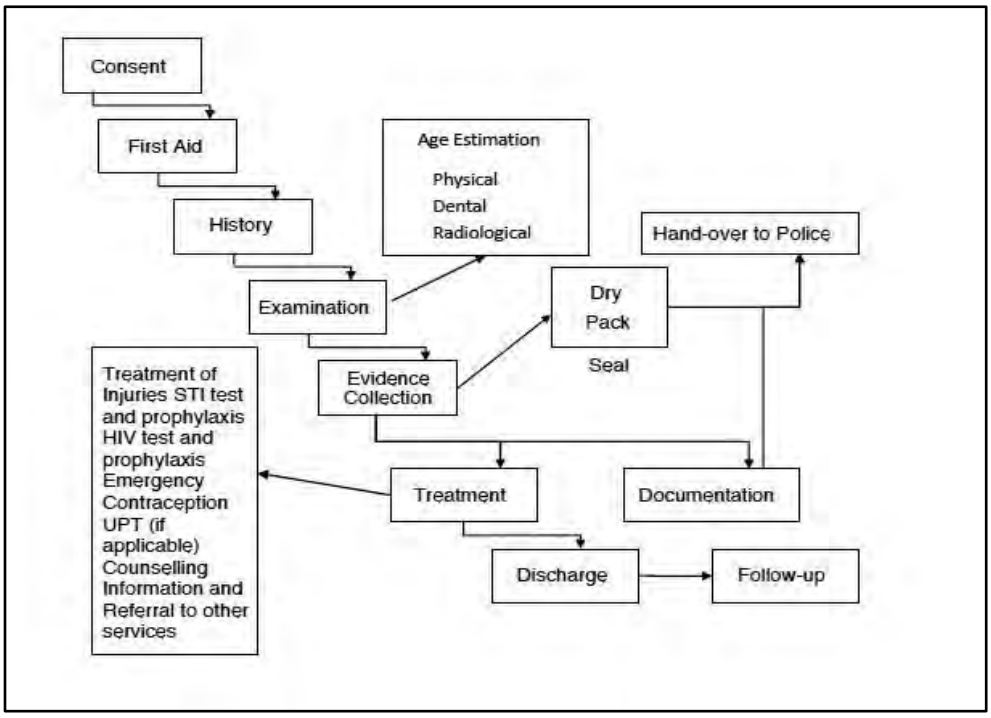
b. The study documents the knowledge, awareness, and attitudes of doctors with regard to legal instruments and the Ministry Guidelines concerning violence against women (VAW); the challenges they encounter in complying with these Guidelines; and any suggestions towards improving the situation.;
c. Grassroots health care workers such as Auxiliary Nurse Midwife (ANMs) and Accredited Social Health Activists (ASHAs) from PHCs and SCs were interviewed to get insights medico-legal care sought by survivors of violence.; and
d. An in-depth qualitative exploration of the sample HCFs proved useful in assessing the quality of medico-legal care available for survivors of violence, especially domestic and sexual violence.

Components 'a' and 'b' have been done at all the sampled health care facilities. It needed more than one visit depending upon the convenience of participating HCFs and individual HCPs.

2.2 Ministry of Health and Family Welfare Guidelines as Reference Point

The health systems' response to sexual assault recommended by best practices consists of a continuum of services providing medico-legal examination, clinical treatment, preventive therapy, empathetic listening, psychosocial support, information and referral networks to the survivors (García-Moreno et al., 2014). The medico-legal aspect should include a steady chain of collection, storage, analysis of forensic evidence in close collaboration with criminal justice to establish a legal case. A response of quality would fully integrate a gender perspective in comprehensive post-rape care to foster a woman-centred response (Germain, 2009). Figure 1, is a flow chart indicating all the aspects to be covered by a health system.

Figure 2 Flowchart showing the Pathway for Comprehensive Health Response



Source: Ministry of Health & Family Welfare (2014): Guidelines & Protocols: Medico-legal Care for Survivors/ Victims of Sexual Violence, Govt of India, New Delhi, p. 61.

According to the MoHFW guidelines a comprehensive response will cover:

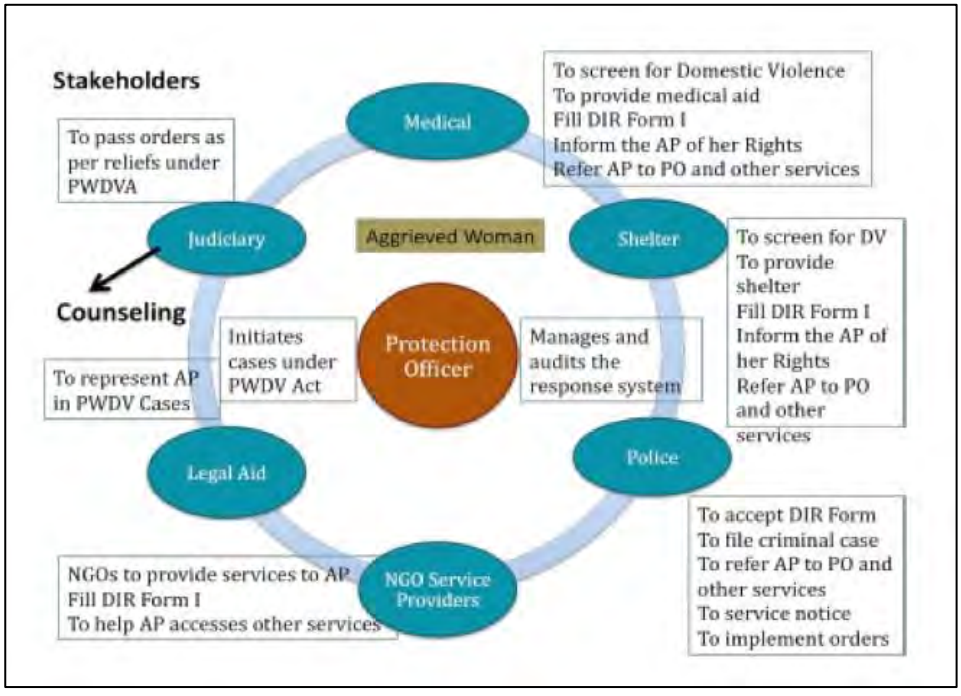
- *"Providing necessary medical support to the survivor of sexual violence.*
- *Establishing a uniform method of examination and evidence collection by following the protocols*
- *Informed consent for examination, evidence collection and informing the police.*
- *First contact psychological support and validation.*
- *Maintaining a clear and fool-proof chain of custody of medical evidence collected and*
- *Referring to appropriate agencies for further assistance (eg. Legal support services, shelter services, etc)."* (GoI, 2014: 9)

As per the guidelines, the components of health systems response have been presented in the Figure 1. The key areas of the study covered major parts of the comprehensive response. The tools shared in the Annexures covered all the aspects.

2.3. Key Legislations as Reference Point: PWDVA & POCSO

Ministry guidelines for medico-legal care cover survivors of sexual violence, whose cases are governed by various sexual violence-related legislations and stipulations where medical evidence gathering is mandatory. In the case of children, a medico-legal response is mandated in the Protection of Children Against Sexual Offences Act, 2012. In this study, we had also taken into consideration the Protection of Women from Domestic Violence Act, 2005 (PWDVA). This legislation covers different forms of intimate partner violence and has several components where health care providers have an active role to play.

Figure 3: Role of Medical Facilities as per PWDV Act



Source: MOHIM(undated). Proposed Guidelines and Reporting Formats to Medical Facilities for Implementation of PWDV Act in Maharashtra. p.3
https://arogya.maharashtra.gov.in/Site/Uploads/GR/Guidelines%20to%20Health%20Services.pdf

The roles of health professionals in responding to PWDVA are as follows:

- *"Identification of abuse*
- *Provision of comprehensive medical support*
- *Documentation of past and current episodes of abuse in a medico legal form.*
- *Emotional support and information about the available remedies under the act and make appropriate referrals*
- *Filling of a DIR (domestic incident report) and referral to the Protection Officer (PO)"* (Rege, 2016:11)

As part of this study, we have integrated relevant questions with reference to the PWDVA to ensure that the health systems and the health providers are carrying out their roles and also ensuring women's access to care and justice.

POCSO is the other reference point, which was considered in this study. One important change brought about by POCSO Act, as mentioned earlier in Chapter 1, was to redefine sexual assault against children (both male and female) to include all forms of penetrative and non-penetrative sexual assault, aggravated sexual assault, sexual assault for purposes of pornography, attempt to commit sexual assault and grading these as per severity. Sexual assault was no longer restricted to peno-vaginal contact, and the victim-survivor could be of any sex. The other important change was the definition of a child as a person below the age of 18 years who cannot consent for consensual sexual activity. This means that any sexual activity below the age of 18 years is statutory rape, notwithstanding whether there was consent or not, as per the law. The act also makes reporting of child sexual abuse mandatory by law for any person in any institution dealing with or providing any service to a child.

Health care services and medical personnel come into the picture in

- Identification of injury and abuse
- Providing comprehensive care
- Ensuring privacy and informed consent procedures
- Documenting the abuse
- Providing necessary referral for counselling
- Mandatory reporting to police
- Opine on forensic reports and a later date
- Depose in a court of law on the case

This study covered the knowledge of the medico-legal stipulations and the adherence to the same with reference to POCSO Act 2012 among health care providers.

2.4 Methods of data collection

Crucial to the assessment of health care facilities preparedness to respond to cases of sexual assault is therefore:

i. The availability of requisite infrastructure
ii. The practices and services surrounding healthcare provision to the survivors
iii. The availability of psychosocial care and support provided to victims
iv. The process of collection of forensic evidence and practice associated with the clinical exam
v. The reliability of applying protocols and guidelines and
vi. The sensitivity by health care providers to contextual experiences affecting the 'victims'

In order to capture the availability of the above facilities and to assess the preparedness of health care providers, the following three sets of tools were used:

(a) **Health Facility Checklist:** a structured tool combined with an observation checklist for studying the health facilities;
(b) **Interviews with Health Care Providers:** closed and open-ended questions for the health care providers, i.e., Doctors and Nurses;
(c) **Collection of SOPs, etc.:** Attempt was made to collect standard operating procedures (SOPs), informed consent forms, and a sample of MLC records (wherever possible).

Each of the data collection tools are discussed in the following sections.

2.4.1 Observation of Facilites using observation checklist

Actual observation of the facility (ies) where examination and care provision takes place was undertaken to assess how well equipped they have been as per the standard quality of care framework guided by the Guidelines. The facility tool covered the following areas **(Annexure-1 – Tool 1).**

i. Availability of doctors, their specialisations, qualifications, gender, and their department
ii. Premises, its physical status, amenities, and facilities
iii. Equipment and supplies for medical evidence gathering
iv. Xray equipment and blood testing facilities and
v. Counselling service

2.4.2 Structured Interview Schedules

Structured interview schedules were developed with closed and open-ended questions for covering HCPs of all three categories, that is, doctors, nurses, and outreach health care providers, ANMs and ASHAs. Different tools of data collection for these three types of HCPs. **(Annexure 2, Annexure 3 & 4).**

In these tools, we covered the following broader themes in alignment with study objectives:

a. Health Care provided (with reference to checklists)
b. Medico-legal evidence gathering (with reference to guidelines)
c. Informed consent (as per medical ethics and guidelines)
d. Knowledge & attitudes (with reference to medico-legal guidelines)
e. Knowledge about the recent legal reforms (with reference to stipulations in the legislations)
f. Issues about capacity building and training requirements

2.4.3 Knowledge Attitudes and Practices (KAP) strategy for the HCPs:

KAP as a methodological approach is popular in social sciences, policy and implementation research. The origin of KAP surveys can be traced to studies in family planning in the 1950s and 1960s. Such surveys were intended to capture the extent to which overt hostility to the idea and organisation of family planning services existed during those initial times (Cleland, 1973). It continues to be a popular approach although not without a critique. In the context of family planning programme uptake, these were mostly administered to clients or users of family planning services as opposed to health care providers. In many other contexts, too KAP surveys were used with users of particular services. For example, Higuera-Mendieta and colleagues (2016) attempted to determine the socio-demographic factors related to different levels of KAP regarding dengue in two hyper-endemic cities of Colombia. Goswami and colleagues (2013) evaluated knowledge, attitude and practice, regarding the use of fixed-dose combinations (FDCs) by resident doctors at tertiary care teaching hospital to conclude that there was a need to improve knowledge about rationality, essential medicine list (EML), usage and banned FDCs in postgraduate medical students to promote the rational use of drugs. Van de Ameele and colleagues (2013) employed KAP survey methods in the context of sub-Saharan transmigrants in Morocco who are extremely vulnerable to sexual violence. It was to identify the role of and position of the Moroccan healthcare sector in the prevention of sexual violence against sub-Saharan trans-migrants given the globally acknowledged perspective that the health care system is a key partner in the prevention of sexual violence.

In this research, we carried out Knowledge, Attitude, Practice (KAP) assessment with all the participating HCPs. Earlier, we noted that one of the areas in policy implementation gap is the key stakeholders' awareness of the issue, and the content of policy; their attitude towards the issue and the content of the concerned policy; and whether they practice in compliance with the overall policy on the issue at hand, in this case, health care system's response to survivors of gender-based violence. For the outcome of the KAP survey to be favourable, it is logical to assume that policy measures have to be in place. For example, in the context of current research, for HCPs to know about the post Nirbhaya legal reforms relating to the health care system's role in responding to survivors of violence, there must be a mechanism in place for HCPs to have an opportunity to access this knowledge systematically and as part of the health care system's functioning.

2.4.4 Collection of Standard Operating Procedures, template of consent forms, and others

At HCFs, the system of documentation, availability of standard operating procedures for providing care, and treatment to survivors of sexual violence helps to maintain the standards of care across departments/specialities and HCPs. The consent forms from patients in general and survivors of sexual violence, MLC registers, and case examination forms stand to be important tools to operationalise the Guidelines. These have been central to the Guidelines, too.

For example, the ICMR Guidelines require that consent is sought from survivors for three aspects of care: examination and offering treatment; for collecting forensic evidence; and for intimating the police about the case. We, therefore, aimed at collecting these various templates enabling us to analyse standards of documentation that, to some extent, reflect actual practices. We have treated these as proxy indicators of

actual practice at a particular HCF since we considered the possibility of a breach of both medical and research ethics norms in observing actual service provided to survivors.

All the above tools have fetched us three types of data: quantitative data; descriptive data in the form of responses to open-ended questions or narratives offered by study participants during interviews, and descriptive data documenting observations and; the documents/templates collected from HCFs.

Below, the approach to analyse these three types of data have been explained.

2.5 Quantitative & Qualitative sets of data

Broadly speaking, all the quantitative data across two sites – Maharashtra and Telangana – have been analysed using SPSS version 16.

As mentioned earlier, the sources of the narrative/descriptive data which, we shall refer to as qualitative data, comprise the open-ended questions in the interview guides/data collection tools for various types of health care providers; field notes, transcripts, and observational notes.

Interviews often were conducted both in English and the local language (Marathi and Telugu) depending upon the preference and comfort of study participants. Interviews, if audio-recorded, were transcribed and translated into English. We also included analytical notes and observations to the transcribed and translated interviews. These comprise the narrative/qualitative data.

2.6 Research ethics obligations

The research study received research ethics approval by the Institutional Review Board, TISS, the host institute of the study. (Approval letter dated March 6, 2017, IRB meeting no 2, 2016-17 **(Annexure - 5)**. All the necessary research ethics obligations, such as, seeking informed consent, and maintaining privacy and confidentiality have been met with utmost diligence.

2.7 Conduct of study

As a norm, we first met the head of the HCF to share more details about the research, to hand them over the letter of authorisation from the concerned authorities (for example, for all rural HCFs, it was the authorisation from the Directorate of Health Services; for all HCFs run by Municipal Corporations, it was the authorisation by the Health Officers of the said Municipal Corporation) along with the DHR-ICMR grant award letter, TISS IRB approval letter for the study. At sites in Pune, we also gave each one of them a copy of the Guidelines and a copy of the most recent Government order on Domestic Violence, which mentioned the role of HCPs and HCFs if they were to manage cases of domestic violence. As part of this conversation with heads of the HCFs, we offered them an overview of post-Nirbhaya reforms in relation to the roles and responsibilities of the public health care system. It was important for us to highlight during these opening conversations that the project goal was not to criticize individual HCFs and HCPs. Instead, it was to get insights into the systemic issues and that it is a collaborative effort to do so with their participation in the research. By and large, these conversations helped us establish rapport and trust-

based relationship with heads of the institution. It also allowed space for them to ask us questions and clarifications regarding the project.

In the case of large HCFs, the authorities signed letters indicating to their colleagues in the HCF that s/he has no objection to their participation in the study if they wished to do so. In certain cases, they invited heads of the relevant departments or medical officers (MOs) for the purpose of mutual introduction. In certain other cases, they suggested names from within the set up whom we could meet and explore their interest to participate in the study. The same was the case with the nursing staff. These processes helped us to begin at an HCF.

We included HCPs from specialties relevant to care provided to survivors of sexual violence. We often approached the ones present on the days of our visit. However, if needed, we made extra visit/s if more than one sitting might be warranted with any HCPs and if a key HCP/s could not be contacted during the days the visit to a particular HCF was planned. With each HCP, during the opening conversation, we covered most of the areas that we mentioned above with reference to our meeting with heads of HCFs. We then initiated the consent seeking process by giving them the study information sheet and sought informed consent.

We generally made up to three visits to each HCF to ensure that we included HCPs relevant to the study. Sometimes we made more than three visits if HCPs indicated their interest in participating in the study and that they were busy on days when we were there. We always visited HCFs as a team of at least two researchers or more. On average, it took about 2 – 4 days to complete data collection at one HCF.

The tool to document infrastructure and human resources at an HCF was filled with the help of more than one person from the HCF. Often these include the senior nursing staff. The Observation checklist was filled by carefully touring HCFs.

2.8 Potential risks and mitigations

We did not expect major risks in studying participant or participating entities, that is, public health facilities. However, we were cognizant of potential informational/reputational risks to health care providers and/or health care facilities. These could arise from possibly inadequate health care facilities, lack of appropriate human resources, and non-compliance with various legal obligations in relation to service provision to survivors of sexual violence. We have minimized this risk by maintaining the anonymity of individual study participants. The names of the districts and the type of health facility in each of the state are indicated in the report but not the actual names of these HCFs.

The other imminent risk that we had anticipated was reluctance or refusal of both the selected HCFs and individual HCPs from selected HCFs to participating in the study given the sensitive nature of the research. The sensitivity of this research can be attributed to both the topic at hand and the inherent risk of it being perceived as being an ‘assessment’ of participating HCFs and HCPs. We did face challenges in getting the time and attention of practicing doctors given their busy schedules at public health care facilities, which are always overcrowded with patient load. The response to the research has been uneven.

2.9 Challenges

Research involving the public health system could not be without challenges of its own in addition to those, which would arise due to the sensitive nature of the topic of enquiry. Below we list some of the key challenges encountered, approaches or strategies we adopted to respond to them, and a brief discussion on research governance systems that require strengthening in the Indian context.

2.9.1 Delays in approvals, IRB clearance and Health administrations clearance

The project funding was approved and communicated by the ICMR (vide letter dated 5th January 2015) and the money was released on 20th January 2015. However, the Project Director, felt the salary structure of Rs 20,000 per month for the Project Coordinator is inadequate to hire well-educated senior persons that the project requires. A request for a revised budget was sent on 4th March 2015 and a formal approval for the same came on 7th March 2016. The project staff and the Project Coordinators for both the states were hired and work affectively commenced from June 2016. The team carried out an updated review of literature, took cognizance of changed laws, and the new Ministry guidelines that were released. Study tools and the sampling framework with up-to-date data from the health departments of the respective states were prepared between June – August 2016.

Table 2.1 Timelines for Permissions

Activity	**Date**
Submission to the TISS IRB for ethical clearance	27th August 2016
Received final IRB clearance	6 March 2017
Submissions for clearance were made to Department of Health Services, Directorate of Medical Education in both the states and followed up for permission letters	March – May 2017
Pune Urban CHC & Rural and Karimnagar PHC & CHCs were surveyed	May – December 2017
Fresh IRB submissions were made to Sassoon Hospital, Pune for carrying out the study jointly to cover the Tertiary hospital	8th October 2017 – No approvals received

We had to seek authorisation from various offices at the state level, district level, and at the level of each sampled HCF. At the Maharashtra site, the additional strand of authorisation involved seeking and securing authorisation from health departments of the municipal corporations.

Overall, we had to seek authorisation from three strands of authorities that corresponded with three categories of HCFs selected to comprise the study sample across two sites.

1. For Pune (Urban) and Karimnagar (Urban), we included select HCFs run by municipal corporations. This required us to seek authorisation from health departments of the respective municipal corporations.

These included the Pimpri-Chinchwad Municipal Corporation (PCMC), Pune Municipal Corporation (PMC) and Karimnagar Municipal Corporation.

2. Given our focus on the public health system, from rural areas, we included rural hospitals (RHs), PHCs and SC, that is, ANMs and ASHAs. Also, civil hospitals at the district level fall under the purview of the Directorate of Health Services (DHS). These facilities administratively fall under the purview of the state-level of the DHS and district level District Health Officers (DHOs). We, therefore, sought authorisation from respective Directors of DHSs, which were further approved by the respective DHOs.

3. Because we included tertiary level teaching hospitals in Maharashtra since a large number of referrals from HCFs from around the district and even outside of the district are made to this tertiary level teaching hospital, it required us to seek authorisation from the Director, the Directorate of Health Education and Research and further the Dean, Sassoon Hospital. This approval, we never received.

It is pertinent to note that nearly a year had gone into seeking permissions from the key Health Administrators across both states. Although an uphill task, in Maharashtra, we did receive the aforesaid authorisations over a period of time except one meant for the teaching hospital in Pune, which was the main hospital that dealt with sexual assault cases. In Telangana, during the period of the project, we could not get the time and cooperation of the doctors at the District hospital that essentially handles all the sexual assault cases.

2.10 Data archiving

For the Pune site, all the data collected so far have been appropriately digitized and archived both physically and electronically. For the Telangana site, the archiving of data collected is in process. These include the consent form, filled tools, field notes, audios, transcripts, the sample templates/SoPs, and any photographs relevant to the data. These are available only to the core team and to no one else outside of the team.

Other documents such as DHR-ICMR award letter, progress reports sent to DHR-ICMR, extensions letters, authorizations secured from various authorities from both the sites, and IRB TISS research ethics approval are digitized and archived.

This report is based on the in-depth qualitative and quantitative research done at both districts. The report would have been enormously enriched if he received cooperation from the tertiary level District hospitals.

Chapter -3 Study Sites: Description of the States and Districts

The selection of two states in India—Maharashtra (from Western India) and the state of Telangana (from South India) was guided by two criteria: incidence rates of crimes against women as per the NCRB updated data of 2014; and the pragmatics, which had a bearing on quality and efficiency of any research initiative.

We also factored in pragmatic considerations in choosing these two states to complement the substantive criteria of the 'very high' incidence of crimes against women in selecting the states. The location of TISS in both Hyderabad (Telangana) and Mumbai (Maharashtra) contributed to the management and conduct of the study in these two locations. It constituted and hosted the project and the teams by equipping them with knowledge about local context and language.

This chapter describes the states under study in terms of various key health and demographic information, health infrastructure, crime rates, choice of districts within the selected states, and the public health care facilities from the selected districts.

3.1 Public Health Facilities

The public healthcare infrastructure in both the states is structured as a pyramid along rural healthcare infrastructure suggested by the Bhore Committee Report in 1946. At the primary level, Primary Health Centres (PHC) are established in areas covering a population of either 30,000 people (in plain areas) or 20,000 people (in hilly or tribal areas). Each PHC has from 2 to 6 beds based on the population it serves and whether it functions 24/7 or is only open during the day. PHCs are typically staffed with doctors who are general practitioners, nurses, community health workers, and auxiliary nurse-midwives (ANM).

PHCs have sub-centres that are meant for a population of 5000 (in plain areas) or 3000 (in hilly or tribal areas). Sub-centres are typically staffed with one or two ANMs. They provide services related to maternal and child health, family welfare, nutrition, immunisation, diarrhoea, and communicable diseases programmes. They also provide basic drugs for minor ailments. Sub-centres are envisioned as the first point of contact between the community and the rural public healthcare system. While the sub-centres and PHCs are in the rural areas, the urban areas have Urban Community Health Centres (Maharashtra) and also Bashti Dhawakhanas (in Hyderabad) to cater to the poor in urban neighbourhoods.

Community Health Centres (CHCs) are meant to reach a population of 1,20,000 people (in plain areas) and 80,000 people (in hilly or tribal areas). They function as 30-bedded hospitals or referral units and are supposed to be staffed with a minimum of four medical specialists—a surgeon, a physician, a gynaecologist/obstetrician, a paediatrician—supported by 21 paramedical and other staff. It ought to have facilities such as an operating theatre, X-Ray, ultrasound, labour room, and laboratory facilities. At the tertiary level, the health system includes sub-district or area hospitals, district hospitals, and medical colleges.

At the district level, there are District Hospitals (DHs) that provide services with a bed strength that ranges from 200 to 350; Area Hospitals that provide services with 100 beds; and Community health

centres (CHC) with 30-50 beds with various clinical specialities and health personnel. Apart from these, Maternal and Child Hospitals (MCH) with 50 beds and Urban Community Health Centres (UCHCs) with 30 beds are also available. Health infrastructure covering Ayurveda, Unani, and Naturopathy are also provided by the state. Besides the state-run infrastructure to cover the health needs of the population, there are health care facilities also run by the EGS, Municipal Corporations, Railways and the Armed forces. Along with the Primary Health Centres and Teaching hospitals (Tertiary Hospitals) these hospitals act as a platform for the implementation of various National Health Programmes like Malaria, Tuberculosis, Family Welfare, AIDS, etc.

3.2 Comparative Information of the two States

The state of Maharashtra was formed in 1960 as opposed to Telangana, which became a state in 2014. Maharashtra has 36 districts in all, while Telangana at the time of formation in 2014 had ten districts, and these have been further sub-divided to form 33 districts. However, the health infrastructure and all related services are steadily being organised.

On the major population and demographic indicators, there are differences. Maharashtra has a higher urban population, higher levels of literacy and female literacy compared to Telangana. Few statistics are presented below:

Table 3.1: Key Indicators

	Maharashtra	**Telangana**
Population	116 million	35.04 million
Sex Ratio	929	925
Urban population	45.22%	39%
Rural population	54.78%	61%
Literacy Rate	82.34%	66.54%
Male literacy	88.38%	75.04%
Female literacy	75.87%	57.99%

Source: States Websites, 2011 Census and State estimates

In terms of the comparative health infrastructure that are available in both the states—Maharashtra as an older state and Telangana as a younger state with continuous attempts to augment infrastructure—present the following picture.

Table 3.2: Public Health Facilities across Maharashtra & Telangana, 2018

	Primary Health Centres	Community Health Centres	Sub-District/Divisional Hospitals	District Hospitals	Total	No. of beds available in public facilities
All India	29,899	5,568	1,255	1,003	37,725	7,39,024
Maharashtra	2,638	430	101	70	3,239	68,998
Telangana	788	82	47	15	932	17,358

Source: Data as uploaded by States-UTs on HMIS portal, status as on 20 July 2018.
https://pib.gov.in/PressReleasePage.aspx?PRID=1539877

3.2.1 Maharashtra: Health Infrastructure

Maharashtra is considered to be one of the progressive states in terms of performance on health indicators and access to health services. As per the Niti Aayog's second Health Index ranking of states on performance based on 23 indicators grouped into the domains of Health Outcomes, Governance and Information, and Key Inputs/Processes, Maharashtra is ranked among the top-performing states along with Kerala and Andhra Pradesh both in terms of overall rankings on the index and improvements from the base year scores (Niti Aayog, 2019). The indicators include Neonatal Mortality Rate (NMR), Under-five Mortality Rate (U5MR), Proportion Low Birth Weight among New-borns, Proportion of districts with functional Cardiac Care Units (CCUs), Proportion of ANCs registered within the first trimester, Proportion of CHCs/PHCs with Quality Accreditation Certificates, full immunization coverage, institutional deliveries, Proportion of Specialist positions vacant at District Hospitals and Proportion.

Maharashtra has a three-tier health infrastructure to provide comprehensive health services. The primary tier comprises of Sub-centres, Primary Health Centres (PHC) and Community Health Centres (CHC). The sub-district hospitals and district hospitals constitute the secondary tier, whereas well-equipped hospitals attached to medical colleges and super-specialty hospitals are at the tertiary level. Apart from Government-run hospitals, funded and managed by the State Government and Municipal Corporations, the state has a huge presence of private health sector with a higher presence in the urban areas compared to rural areas.

There is a wide rural-urban gap in health infrastructure and facilities, both quantitatively and qualitatively. Urban areas have a concentration of public and private hospitals, nursing homes as well as qualified doctors. Apart from rural-urban differences in access to health care services, there are differences in availability across the districts. The state capital Mumbai and districts like Pune, Wardha and Nagpur have a better population to facility ratios. While Maharashtra is making rapid strides in improving several SDG indicators, there are significant inequalities with region, caste, gender, ethnicity, and occupation (SATHI, 2008). The issue of preparedness of the health system to respond to sexual assault cases has been studied within this context.

Table 3.3: Health infrastructure of Maharashtra **(As on 31st December, 2019)**	
Sub-centres	10,668
Primary Health Centres	1828
Community Health Centres	364
Primary Health Units	193
Mobile Medical Units	40
Sub-district Hospitals	91
District Hospitals	23
Hospitals	1402
Hospitals having Medical Colleges	18
Dispensaries	3087
General Hospitals	8
Women Hospitals	13
Mental Hospitals	4
Leprosy Hospitals	4
TB Hospitals & clinics	5337
Other Hospitals (Orthopedic)	1
Regional Referral Hospitals	2
Beds in institutions**	127,943
Beds per lakh population*	103
Regional Referral Hospitals	2

** Includes beds in Public, Local Bodies and Trust Hospitals only.
Beds in Private hospitals not included.
* Based on mid-year projected population of the respective year.
Source: 'Economic Survey of Maharashtra, 2019-20', p 192
Directorate of Economics and Statistics, Govt of Maharashtra, March, 2020.

3.2.2 Telangana Health Infrastructure

The Telangana Government's public health care facilities are provided by two sub-departments of the Department of Health and Family Welfare (DoHFW) – the Telangana Vaidya Vidhana Parishad (TVVP) and the Department of Medical Education (DME). The TVVP runs primary and secondary healthcare facilities in urban and rural tertiary, whereas the DME is responsible for state-run teaching hospitals.

The Telangana Social Development Report 2017 shows sharp differences in the distribution of medical facilities across districts in the state. Further, it reports that many sub-centres are still running out of rented buildings, but primary and secondary facilities are all based in government buildings. With regard to human resources in PHCs and CHCs in Telangana, the report finds that several specialist and medical

officer positions remain vacant across the state. High vacancy in female health worker and ANM positions at sub-centres and PHCs have also been reported (Kannabiran, Jeyaranjan & Swaminathan, 2017). As per the Niti Aayog's health assessment, Telangana is classified within the 21 large states, which seems to be making incremental improvements.

Table 3.4 : Hospitals in Telangana, 2015-16

Health Sub-Centres	4797
Primary Health Centres	683
Community Health Centres	98
Area Hospitals	31
District Hospitals	6
Teaching Hospitals	18
Ayurveda Hospitals (incl. Dispensaries)	272
Homeopathic Hospitals (incl. Dispensaries)	130
Unani Hospitals (incl. Dispensaries)	141
Naturopathy Hospitals (incl. Dispensaries)	24
Doctors in all Hospitals	2595
Beds in all Hospitals	20389

Source: Government of Telangana website. https://data.telangana.gov.in/dataset/overview-government-hospitals accessed on 1st March 2021

3.3 Crime Statistics: Locating Maharashtra and Telangana in the larger context of India

The NCRB records for the year 2014 were the latest data available at the time when the proposal was made to the ICMR and at the time when the this proposal was submitted to Institutional Review Board (IRB) in 2016 for review and approval.

As per the 2014 NCRB data:

- Maharashtra was in the second highest category labelled as 'high incidence' (20001-30,000 actual cases) in the new scheme of classification of states as per the absolute number of CAW incidence cases. However, it fell under the third highest category of CAW incidence rates (incidence rate between 40.1 and 50.0 per 100,000 population) **(Annexure-6)**

- Telangana was in the category of 'medium high incidence' of Crimes Against Women (CAW range = 10001- 20000 actual cases) Telangana was in the second highest category of CAW incidence rates (incidence rate between 70.1 and 90.0 per 100,000 population) **(Annexure-6).**

As per the **NCRB 2019** data, at the national level, there is a 7.3% increase in registered cases of crimes against women compared to 2018. Of the total number of crimes against women cases, a large proportion is under Section 498 A, which covers cruelty by husband or his relatives. At the all-India level, this is 30.9% of the total cases of crimes against women. This is followed by cases - 'assault on women with

intent to outrage her modesty' (21.8%), 'kidnapping & abduction of women' (17.9%) and 'rape' (7.9%). The crime rate registered per lakh women population is 62.4 in 2019 compared to 58.8 in 2018, highlighting the increase in the incidence of violence against women.

UP reported the highest number of crimes against women (59,853), accounting for 14.7 per cent of such cases across the country. This was followed by Rajasthan (41,550 cases; 10.2 per cent) and Maharashtra (37,144 cases; 9.2 per cent). Telangana stands nineth in this ranking. Telangana reported 18,394 cases of crime against women. The number of cases has risen by 14.76% compared to 2018 data. For Telangana, there were 17,521 cases reported in 2017, 16,027 in 2018 and 18,394 in 2019. Cases under Section 498A for Telangana is 46.3% compared to the national figure of 30.9%. These figures are the highest in Telangana compared to all other Southern states. The state capital, Hyderabad also recorded the second highest number of domestic violence cases after Delhi.

A close examination of the latest **National Family Health Survey** Round 5 too reveals the information on intimate partner violence and sexual violence. According to NFHS-5 2019-20, where data was collected from 22 states pre-pandemic, 15 states and union territories, spousal violence recorded a decline. (Table 3.5). According to data, the states and UTs that have seen a rise in the percentage of cases of spousal violence (by women aged 18-49 years) over the last five years include Karnataka, Maharashtra, Assam, Ladakh, Sikkim, and Himachal Pradesh. More than a quarter of the women surveyed have reported facing physical and sexual violence from a spouse in seven of the 22 states. Such violence had more than doubled in Karnataka, from 20.6% in 2016-16 to 44.4% in 2019-20. In Bihar, as many as 40% of women continue to be victims of spousal violence even though the figure has come down from 43.7% in 2015-16. Data shows that about 39% women in Manipur, 36.9% in Telangana, 32% in Assam, and 30% in Andhra Pradesh suffered spousal—physical and sexual—violence. Further, at least nine out of the 22 states surveyed reported an increase in the percentage of women aged 18-29 years who have faced sexual violence as a child, or before turning 18. These figures are staggering.

These macro statistics give an insight into the percentage of women who visit hospitals to seek medical attention for a variety of injuries, for violence induced health problems. Women who face intimate partner violence or spousal violence are more likely to have unwanted pregnancies, delay in getting admitted to hospitals for deliveries, experience miscarriages, have low birth weight babies and experience physical and mental health problems (Jejeebhoy et al., 2013; Raj & McDougal, 2015). Health initiatives within hospital settings like the Dilaasa, a hospital-based women's support centre, had found much higher rates of detection of domestic violence by the hospital functionaries and a better response to provide clinical and medico-legal support to women (Bhate-Deosthali et al., 2012).

The next stage of selection of sites for the study was selecting specific districts with a clear sampling strategy to focus on studying the health services across both the states.

3.4 Selection of the districts

Within Maharashtra and Telangana, the primary study was conducted in one district each. In Maharashtra the selection covered, Pune (both rural and urban). In Telangana, the original plan was to include Hyderabad as the urban site and Karimnagar district as the rural site for this study. However, due to operational difficulties we had to restrict data collection only to Karimnagar. Further, in the year 2014, Andhra Pradesh state had been bifurcated and Telangana was formed as a separate state. The state was

formed as the 29th state of India and had only 10 districts at the time of formation. The period of seeking permissions for the data collection coincided with a lot of administrative flux with senior administrative heads and medical staff movement across the states. In the year 2016, the Telangana Government had subdivided the State into 31 districts and had added another 2 districts during 2019. Karimnagar district had also been sub-divided. Originally, the district specific crimes data was used as the basis for choosing Karimnagar for the study as a sample district. That selection was retained without any further rethinking on the validity of data with a change in the population figures. Pune district in Maharashtra and Karimnagar in Telangana were selected on the basis of district specific crime incidence information **(Annexure 7a & 7b).**

Table 3.5: NFHS 4 – 5 Rounds data on violence against women

State/Union Territory	**NFHS-4 2015-16**		**NFHS-5 2019-20**		**NFHS-5 2019-20**		**NFHS-5 2019-20**	
	Ever-married women age 18-49 years who have ever experienced spousal violence (%)		Ever-married women age 18-49 years who have ever experienced spousal violence (%)		Ever-married women age 18-49 years who have experienced physical violence during any pregnancy (%)		Young women age 18-29 years who experienced sexual violence by age 18 (%)	
	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
Andaman & Nicobar Islands	19.4	17.4	23.2	13.2	0	0.5	1.4	2.2
Andhra Pradesh	42.4	43.6	28.8	30.5	3.5	3.9	3.8	3.7
Assam	15.9	26.2	26.6	32.9	2.2	2.3	7.4	8.1
Bihar	40.2	43.7	40.6	39.9	1.9	3	7.1	8.5
Dadra & Nagar Haveli and Daman & Diu	22.1	58.2	21.8	10.8	1.3	7.8	4.4	4.1
Goa	15.3	8.7	6	11.4	0.9	2.7	1.6	8.8
Gujarat	14.1	24.8	10	16.8	2.2	1.2	3	4
Himachal Pradesh	10.6	5.2	6	8.7	0	0.7	0	2.8
Jamma & kashmir	6.7	10.6	5.9	11	0.3	1.6	1.4	5
Karnataka	20.6	20.4	44.5	44.4	4.9	6.4	10.9	11.2
Kerala	13.7	14.8	9.9	9.9	0.5	0.5	1.8	1.3
Maharashtra	16.4	26.2	21	28.6	2.5	4	4.5	7.6
Meghalaya	22	30.4	23.2	14.2	2.5	1.4	7.9	6.4
Manipur	48.1	56.1	35	42.8	1.6	3.8	1	8.4
Mizoram	16.7	17.5	11.3	10.3	0.9	0.4	1.4	2.7
Nagaland	11.3	14.2	5.2	7	0	0.6	2.4	1.3
Sikkim	0.4	4.2	-13.1	11.7	-0.4	2.4	-3.2	3.1
Telangana	37.1	47.6	27.3	42.3	2.1	5.1	3.1	6
Tripura	16.7	32.4	14	23.4	0.1	2.9	3.5	8.4
West Bengal	23.7	36.9	22.9	28.7	2.3	4	6.7	10.9
Average all India	18.79	24.50	16.82	19.93	1.33	2.51	3.19	5.20

Source: NFHS-4 (2015-16) and NFHS-5 (2019-20) Fact sheets, IIPS, Mumbai.

3.5 Selection of secondary and tertiary public health care facilities

Only public health care facilities were included in the study. As discussed earlier in this chapter, the public health care system is layered in India. In terms of facilities there are different kinds, varying in terms of population outreach, specialised on and who administers them: Sub-Centres (SCs), Primary Health Centres (PHCs), Rural Hospital (RH)/Community Health Centres (CHCs), Sub District Hospitals (SDHs), District Hospitals, Civil Hospitals (all are supported administratively by the State Govt); ward level health posts, family welfare centres, mother and child care centres, Integrated Child Development Scheme (ICDS) units, dispensaries, nursing homes, and general hospitals (all are supported by respective Municipal Corporations in cities). Besides these, there are several private health establishments, which run as clinics, dispensaries, nursing homes, specialized limited-bedded hospitals, large private hospitals with attached medical colleges and super-specialty hospitals.

This study was limited to public health care facilities. The inclusion criterion was drawn up based on the MoHF&W Guidelines (henceforth Guidelines). According to the Guidelines it is mandatory for all the secondary and tertiary public HCFs to be equipped to care for survivors/victims of sexual violence. In addition to the tertiary and secondary HCFs we had included PHCs and sub-centres to understand access to immediate care and referrals for medico-legal evidence and advance care.

3.5.1 Pune District facilities

In this study, for the Maharashtra site, all the secondary and tertiary public health care facilities—supported by the state and the respective Municipal Corporations—of the two urban centres, Pune, and Pimpri-Chinchwad were selected (Table 3.6). The decision to include the entire universe of secondary and tertiary public HCFs was guided by two factors. One, as mentioned earlier, to the best of our knowledge this is the first of its kind study since the MoHF&W Guidelines have been published and compliance with it was made mandatory for public HCFs on March 19, 2014. Two, the study covers only one district each from the two selected states. In this context, we felt that including the entire set of facilities would help shed light on various other dimensions of the issue at hand, such as, awareness of the legislative reforms, and challenges faced by the public health system in complying with the Guidelines in the selected districts across tehsils, which would vary based on context defined by caste, class, socio-economics, political environment, and other factors such as transportation facilities, presence of civil society based entities and their work.

In Pune (Rural), PHCs and SCs from four different tehsils were selected. The selection was guided by the CAW incidence rates or reported cases of crimes against women at the tehsil level. From selected tehsils, one or more PHC/s guided by pragmatic considerations were selected. PHCs and sub-centres from tribal pockets of the selected districts were also selected. There are 14 tehsils in Pune with 20 Rural hospitals (RH). Some tehsils have more than one RH.

Table 3.6 Sampling framework of health care facilities, Pune District

Rural										Urban			Total [General Hospitals]
Sub Centre *			Primary Health Centre*			Rural Hospital/Community health Centres*	Sub District Hospital*		Women Special Hospital**	Pune Municipal Corporation & Pimpari Chinchawad Municipal Corporation run Hospitals***	Cantonment & Defence run Hospitals****	State run Hospital(Civil Or District Hospital)	
Tribal	Non Tribal	Total	Tribal	Non Tribal	Total		50 Bed	100 Bed					
HEALTH CARE FACLITIES													
61	478	539	8	88	96	19	3	2	1	3+6	3 (3)	2	39
SAMPLED HEALTH CARE FACILITIES													
3-5	5-7	8-12	1 - 2	8 to 9	9-11	19	3	2	1	9	None	2	36

* Source: https://arogya.maharashtra.gov.in/1114/Secondary-Services. Bhor, Indapur, Daund and Baramati are the tehsil headquarters where the sub-district hospitals are

** Located in Baramati

*** The initial search indicated 16 civic hospitals in Pune – Pune Municipal Corporation - of which three are General Hospitals (Naidu/Gadikhana General Hospital, Kamla Neharu Hosptial and a somewhat newly established hospital in Yerwada (180 bedded). There are six General Hospitals in the Pimpri-Chinchwad Municipal Corporation (PCMC) area. All general hospitals were included in the sample.

**** Defence health care facilities are of two types- cantonment hospitals and defence hospitals. The former serves to the non-defence/civilian population in and around cantonment area whereas the latter serves exclusively to defence personnel.

3.5.2 Karimnagar district facilities

The secondary and primary facilities in one of the districts of Telangana were studied. The sampled district being newly-formed Karimnagar. It has only 1 District Hospital (DH), no Area Hospitals or Rural Hospitals (AH or RH), 3 CHCs (including one that had only been upgraded a few months prior to data collection, so the staffing had not been fully done, nor the infrastructure fully upgraded), and 16 Primary Health Centres (PHCs).

The district has 16 primary facilities, of which six sub-centres were chosen for the study. The criterion for choosing 7 PHCs was based on the number of rape cases reported in the respective blocks. Such PHCs were identified by the District Medical and Health Officer (DM&HO) as low, moderate, and high blocks. The DM&HO's information was corroborated by the data

supplied by the District Crime Records Bureau, which provided a police-station wise breakdown of the crimes against women in the years 2014, 2015, 2016, and 2017. The names of the relevant villages of the PHCs have been anonymised in the report.

Table 3.7 – Type of Health Facility Covered, Pune & Karimnagar district

Urban/Rural	Category of Hospitals					Total
	Sub-Centre	Primary hospital	Secondary Hospital	Tertiary Hospital	MC-Hosp	
Urban		**0**	1(8.3)	2(16.7)	9(75)	**12 (100)**
Rural	0	8(24.2)	25(75.8)	**0**	**0**	**33(100)**
Pune - Total	**0**	**8 (17.8)**	**26 (57.8)**	**2(4.4)**	**9 (20)**	**45 (100)**
Karimnagar-Total	**6 (37.5)**	**7(43.75)**	**3 (18.75)**	**0**	**0**	**16 (100)**

3.6 Selection of Health care providers considered for inclusion

Health care providers at the tertiary, secondary, and primary levels were selected for the study. At the tertiary and secondary hospitals, Casualty Medical Officers (CMOs), Gynaecologists, Paediatricians, Forensic specialists, Radiologists, Psychiatrists, Nurses and Psychologists were covered, as available. In PHCs, there is the nursing staff and Medical Officers with no specific specialty. Health facilities consist of a cadre of grassroots-level health care workers, Auxiliary Nurse Midwives (ANMs), Accredited Social Health Activists (ASHAs) and within each of the sampled facilities, HCPs who provide services to survivors of sexual assault and other types of VAW have been enlisted. As mentioned earlier, outreach health care workers such as ANMs and ASHAs affiliated with selected HCFs—PHCs and SCs—were also included. The details of the health care facilities and the health care providers across both states are given below:

Table 3.8: Types of Health Facilities and Providers covered Pune & Karimnagar

Category of Health Facilities	Type of Health Providers			Total
	Doctors	Nurses	ANM & ASHA	
Primary	8 [10.53]	9 [19.15]	12 [46.15]	29 [19.5]
Secondary	49 [64.47]	27 [57.50]	1 [3.84]	77 [51.7]
MC-Hospitals	14 [18.42]	9 [19.15]	13 [50]	36 [24.2]
Tertiary	5 [6.58]	2 [4.26]	0 [0]	7 [4.7]
Pune -Total	**76 [100]**	**47 [100]**	**26 [100]**	**149[100.0]**
Primary	6 [40]	6 [60]	6 [100]	18 [58]
Secondary	9 [60]	4 [40]	0	13 [42]
Tertiary	0 [42.8]	0 [48]	0	0
Karimnagar-Total	**15 [100]**	**10[100]**	**6 [100]**	**31 [100]**

Table 3.9: Types of Health Care Providers by Location of the Health Care Facility, Pune & Karimnagar districts

Location & State	Types of personnel			Total
	Doctors	Nurses	ANM/ASHA	
Urban	19[25]	13[27.66]	14[53.50]	46[30.9]
Rural	57[75]	34[44.73]	12[46.15]	103[69.1]
Pune-Total	**76[100]**	**47[100]**	**26[100]**	**149[100]**
Urban	9[60]	4[40]	0	13[42]
Rural	6[40]	6[60]	6[100]	18[58]
Karimnagar-Total	**15[100]**	**10[100]**	**6[100]**	**31[100]**

Conclusion

This chapter introduced both the states' health infrastructure, crimes against women statistics, selection of the sample districts, and the facilities further within them. The detailed preparedness of the health care facilities will be taken up in Chapter 4 for Maharashtra and in Chapter 8 for Telangana.

Chapter 4: Quality of care provision: Assessment of Infrastructure & human resources (Pune)

The Ministry of Health and Family Welfare's (MoHFW) Guidelines for Medico-Legal Care of survivors of sexual violence delineate protocols for health care facilities' comprehensive response to survivors, with a focus on both forensic evidence and healthcare. According to MoHFW Guidelines, all Healthcare Facilities (HCFs), whether private, public, primary, secondary or tertiary must be prepared to respond to survivors of sexual violence. To ensure a comprehensive response for survivors, all Public HCFs are required (by the Guidelines) to include the following:

a. **Health Infrastructure:** Adequate physical infrastructure in good condition, including a government-owned building, essential facilities such as continuous water and electricity supply, working telephone lines, and a vehicle for transport.
b. **Infrastructure for examination**: Diagnosis, treatment, and counselling for the survivor including reliable method of collecting, and storing medical evidence, as well as a fool-proof chain of custody for medical evidence;
c. **Clear protocols:** Forms and documentation formats for examination and evidence collection, protocols for a referral to appropriate agencies for further assistance. Standard Operating Protocols for providing immediate medical care, consent-taking, medical examination, informing the police, prescribing treatment, and follow-up.
d. **Levels of knowledge of guidelines and gender sensitivity:** Well-trained and gender-sensitive medical professionals including doctors, nurses, counsellors, social workers, and outreach workers who are aware of relevant laws and best practices; Awareness and outreach to foster a safe environment for survivors to seek and receive help (covered in Chapter 5).

All the secondary and tertiary public health care facilities, supported by the state and the respective Municipal Corporation of the two urban centres - Pune, and Pimpri-Chinchwad - were selected as mentioned in Chapter 3 for studying the availability of infrastructure, preparedness for handling sexual violence cases, and availability of resources to follow the protocols in handling sexual violence cases. This chapter shares the findings based on the field study of the above-mentioned points a to b which cover the comprehensive response guidelines of the ICMR.

The assessment of the preparedness of the health care establishments that have been covered in this study was based on a checklist of tools, as indicated in Chapter 2 and given in **Annexures- 1 & 2 .** These tools, in turn, were developed based on the requirements for health infrastructure, necessary equipment and protocols for medical evidence gathering, and health care practices supporting survivors of sexual violence. The normative frameworks used in the present study were developed and presented by Pitre and Pandey (2008) in their exploratory study of six health care facilities in two districts of Maharashtra. These frameworks in turn were drawn from 'Guidelines for medico-legal care for victims of sexual violence', (WHO, 2003); 'Sexual Assault Care and Forensic Evidence Kit' (CEHAT, 1998 and 2005); and 'How to conduct a Situational Analysis of Health Services for Survivors of Sexual Assault, Sexual Violence Research Initiative' (Christofides et al., 2006). The ICMR Guidelines and the protocols provide a complete road map for all the procedures to be followed and steps to be taken to respond to sexual assault survivors.

4.1 Physical Infrastructure & Facilities

The first requirement is a physical infrastructure that allows interaction with the survivor, provision for privacy, medical evidence gathering with necessary sensitivity and thoroughness. (Table 4.1A). The physical infrastructure should also permit the survivor to take a bath and change into a fresh set of clothes after the medical evidence collection while depositing the clothes she is wearing for forensic examination.

Table 4.1A: Physical Environment of the Examination Room: Expected Standard

Physical Environment of the Examination Room	
1	Separate room with attached or adjacent toilet and bath with lockable door. Separate waiting area.
2	Adequate light and ventilation
3	Continuous water supply in room, bath and toilet
4	Services should be accessible, secure, clean and private

	Facilities in examination room	**Purpose**
5.	Presence of examination table with Lithotomic position	Aids examination of the genital area
6.	Clean bed linen	For good hygiene
7.	Lockable door, Partition and Curtains	To maintain privacy in room
8.	Adjustable lamp for examination	For better lighting during examination
9.	Lockable cupboard for storing of samples till transported.	To maintain chain of custody.
10.	Hospital gown to wear during examination	To facilitate examination
11.	Set of clothes to change into	Women's clothes need to be submitted for forensic analysis
12.	Soap to wash hands	For good hygiene
13.	Chairs and table for documentation need to be on-going	Examination and immediate documentation
14.	Labels, sticking plaster and wax	For sealing
15.	Carbon papers, plain papers, pens and pencils copies need to be made.	To aid documentation. At least two carbon
16.	A telephone	For communication
17.	Refrigerator and cupboard, preferably lockable for preservation of samples	To store samples in a cool place.

With reference to the expected requirements, the facilities and amenities that we had observed in the study sites of Pune district are given in Table 4.1B.

Table 4.1B: Status of premises and infrastructure within the HCFs		
Building	**Categories**	**Counts**
Designated govt Building	Yes	44[97.8]
	No	[2.2]
Present observed state of the building	Building in good condition	27[60]
	Adequate space/rooms/ facilities	8[17.8]
Present observed state of the premises	Quite clean	30[66.7]
	Somewhat dirty	13[28.9]
	Very dirty	2[4.4]
Bed capacity	5-10 beds	12[26.7]
	30-50 beds	26[57.8]
	100 or more beds	7[15.5]
Number of wards	0-2 wards	12[26.7]
	2-5 wards	9[20]
	5-10 wards	17[15.6]
	10 or more wards	7[15.6]
Separate wards for women	Yes	36[80]
	No	9[20]
Waiting room with seating arrangement	Yes	42[93.3]
	No	3[6.7]
Sheltered waiting area	Yes	41[91.1]
	No	4[8.9]
Health Facilities where Sexual Violence Cases are handled (N = 22)		
Separate room for SV examination	Yes	3
	No	19
Auditory and Visual Privacy in the room where SV examination room takes place	Yes	21
	No	1
Availability of room for 24 hrs	Yes	12
	No	10
Facility to lock the room	Yes	21
	No	1
Adequate light	Yes	22
	No	0
Working angle lamp in the room	Yes	19
	No	3
One or more toilets in the facility	Yes	22
	No	0

Cleanliness of the toilets	Yes	22
Availability of water in the toilets	Yes	22
Cleanliness of the bed linen	Very Clean	4
	Moderately Clean	18
Changing the linen after each SV examination	Yes	13
	No	9

In terms of the requisite competencies for several medical interventions in general and to address any sexual violence victims, the healthcare facilities were surveyed. (Table 4.2).

Table 4.2: Health care facilities Clinical Competence

Clinical Competence	**Frequency**	**N (%) (N= 45)**
Surgeries carried out	Always	27[60]
	Sometimes	5[11.1]
	Never	13[28.9]
Minor Surgeries	Always	29[64.4]
	Sometimes	5[11.1]
	Never	11[24.4]
Major Surgeries	Always	11[24.4]
	Sometimes	6[13.3]
	Never	28[62.2]
X-ray Facility	Always	20[44.4]
	Sometimes	3[6.7]
	Never	22[48.9]
Blood tests	Always	40[88.9]
	Sometimes	4[8.9]
	Never	1[2.2]
System to safeguard the collected samples	Yes	30[66.7]
	No	15[33.3]

From the above data it is evident that the competencies for surgical interventions and ability to support such interventions is linked to the size of the hospital and its level in the health system, that is, sub-centre, PHC, secondary or tertiary. Almost all the secondary level hospitals have the necessary competencies to handle sexual violence cases.

4.2 Medical Equipment and Supplies

Table 4.3A, below lists tools essential for providing a minimum level of service to survivors of sexual violence. Depending on the circumstances and time lag after the assault, the doctor would have to decide which equipment has to be used. Nevertheless, all the equipment will have to be in place to provide prompt response to deal with sexual violence cases.

Table 4.3A: General Medical Items and Equipment

	General Medical Items and Equipment	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 of needles and sharp objects
12.	Proctoscope/ anoscope	For anorectal examination

Forensic Supplies and Equipment

	Forensic Supplies and Equipment	**Purpose**
1.	Standard proforma / checklist Pre-packaged rape examination kit	
2.	Sterile cotton swabs and containers for transporting swabs	For collecting various samples
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 & envelopes	For collection of clothes/specimens
7.	Scissors	To cut control samples of head and pubic hair
8.	Combs	To comb pubic and head hair
9.	Nail cutter	To take nail clippings
10.	Sanitary napkins	

Source: Pitre and Pandey (2008)

The assessment of the health care facilities in Pune based on the study tool and information gathered provides us with the picture presented in Table 4.3B. The health institution checklist was administered only in 31 institutions that reported handling sexual violence cases.

Table 4.3B: Requirements for Medical Equipment for Forensic Evidence Gathering and their availability in the health care institutions (N=31)	
Equipment	**No of establishments**
EDTA Tubes	30
Syringes and needles for drawing blood	31
Distilled water	31
Disposable gloves	31
Woods lamp/Good torch	29
Vaginal Speculums	30
Urine Pregnancy test kit	28
Surgilube	11
Medications	26
Double oxalate bulb for drug/alcohol assessment	16
Containers (to dispose needles and sharp objects)	31
Forensic Supplies & Equipment	
SAFE kit	2
Forms for Documentation	10
Large sheet of paper to undress over	14
Paper bags for clothing collection	10
Catchment paper	2
Cotton swabs and swab guards	29
Comb	17
Nail cutter	24
Wooden stick for finger nail scrapings	9
Small scissors	31
Urine sample container	31
Glass slides	31
Envelopes or boxes for evidence samples	25
Labels	27
Lac (sealing wax) Stick for sealing	27
Clean clothing	15
Drying rack for wet swabs/clothing	14
Patient gown, coversheet, blanket, pillow	27
Post-It notes to collect trace evidences	7
Camera (35mm Digital)	2
Microscope	28
Colposcope/Magnifying glass	19
Toluidine blue dye	5
1% Acetic Acid diluted spray	10

It may be observed that most of the health care institutions did not have all the medical and forensic equipment necessary for evidence gathering. The most relevant and important are available. However, there are gaps, especially the absence of SAFE Kits. These kits provide all the guidelines step-wise to enable collection of important evidences. Further, only 50% of the institutions had a set of clothes that a woman could wear after depositing her clothes that she had worn at the time of the rape incident. Not keeping a change of clothes for women not only acts as a disincentive but also may actually hamper the investigation and thereby collection of crucial forensic proofs.

4.3 Treatment Items & Medicines

One of the important aspects of comprehensive care is the provision of health care that enables the survivor to stabilize and also receive necessary contraception and preventive measures. As per the normative requirement, hospitals are expected to have the following medicines and treatment kits.

Table 4.4A: 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 a woman comes within first five days of assault • is at risk of pregnancy • provided after counselling
3.	Suture Materials 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

Source: Pitre and Pandey (2008)

The assessment of the health care institutions in Pune provided us information as given in Table 4.4B. This information was gathered for all the 45 institutions that have been studied irrespective of whether they receive sexual assault survivors or not. It may be observed that large majority of the institutions (above 90%) were prepared to conduct HIV Rapid Test, Pregnancy Test, provide Tetanus prophylaxis and treat injuries. Tests for STI/RTI, emergency contraception, HIV prophylaxis, counselling, Hepatitis B were available in 50 to 75% of the institutions. With additional augmentation and support, most of the establishments at the secondary level can handle sexual violence cases.

Table 4.4B: Availability of Diagnostic Tests, Equipment for Treatment

Diagnostic test and treatment	Availability	Nos (%) (N=45)
Tests for STI/RTI	**Available**	**33[73.3]**
	Provided elsewhere	7[15.6]
	Not Provided	5[11.1]
HIV Rapid Test	**Available**	**44[97.8]**
	Not provided	1[2.2]
Pregnancy test	**Available**	**44[97.8]**
	Provided elsewhere	1[2.2]
Ultrasound for pregnancy/ internal injury	**Available**	**11[24.4]**
	Provided elsewhere	24[53.3]
	Not Provided	10[22.2]
X-ray for injury	**Available**	**23[51.1]**
	Provided elsewhere	22[48.9]
STI Prevention treatment	**Available**	**28[62.2]**
	Provided elsewhere	10[22.2]
	Not Provided	7[15.6]
Emergency Contraception	**Available**	**38[84.4]**
	Not provided	7[15.6]
Wound treatment	**Available**	**44[97.8]**
	Not provided	1[2.2]
Tetanus Prophylaxis	**Available**	**44[97.8]**
	Not Provided	1[2.2]
Hepatitis B Vaccination	**Available**	**23[51.1]**
	Provided elsewhere	11[24.4]
	Not Provided	11[24.4]
Post exposure Prophylaxis for HIV	**Available**	**15[33.3]**
	Provided elsewhere	20[44.4]
	Not Provided	10[22.2]
Counselling	**Available**	**26[57.8]**
	Provided elsewhere	4[8.9]
	Not Provided	15[33.3]

Conclusion

This chapter presented the assessment of the health care provision preparedness of 45 health care institutions in Pune based on the availability of infrastructure, medical equipment, medical and forensic supplies in responding to sexual violence cases of women and children. For each section in this chapter, information was provided on the standard expectation for each parameter based on WHO standards. The health institutions seem to be maintained as per the expectation in matters like infrastructure, equipment, amenities, and medical tests. However, several of the key requirements like standard guidelines/protocols, change of clothing, dedicated space for medical examination, and counselling services were lacking.

Chapter 5: Medical Evidence Gathering and Health Care Service Provision Practices (Pune)

This chapter presents data on the various aspects of medical evidence gathering and care given to survivors of both sexual and domestic violence in the HCFs included in this study. We locate the data in the current status of included HCFs and whether these facilities provide care to survivors of sexual violence and the reported extent of cases of sexual violence(SV) are presented in these facilities.

We conversed with the participating doctors to explore the availability of necessary infrastructure and the procedures followed at the HCFs to gather medical evidence in sexual violence cases. These include: whether HCFs accept the cases of survivors of sexual violence; whether filing first information report (FIR) compulsory; what would be the qualification of the examining HCP—will it be a specialized doctor?; where are referrals made; whether there is free transportation service to the referred hospital/HCF for the survivor; whether police is stationed at the HCFs; and availability of necessary relevant facilities and examination kits, such as, sexual assault forensic examination (SAFE) kit and age estimations facilities.

5.1 Limited HCFs accept sexual violence cases

In the study, 76 doctors participated from Pune city and sub-district level hospitals. The data pertaining to the infrastructure availability and procedures followed are presented as reported by these doctors. Only 31of 76 participating HCPs reported that their HCFs receive cases of sexual violence.

> *"We don't take the cases of sexual violence in this hospital. When I was appointed here, I was given a document, which stated that cases of sexual violence are not admitted and attended in this hospital. This is a not a critique of anyone here but I don't know as to why we don't serve these cases in this hospital. It is a big hospital and offers range of specialty health care.".* (Participant No 2: Male doctor, Casualty Medical Officer, PCMC run HCF)

Out of the 31, 27 mentioned **that they do accept these cases.** Some claimed that they provide only primary care, which is required immediately until the survivor travels to the tertiary care facility where she is referred.

> *"We provide care, such as, examination of injuries and providing cleaning and dressing etc., but we don't do collection of samples for such cases. ... We cannot undertake examinations of survivors here since there are no facilities to do so; there is no gynaecologist, either. During the court hearings, they need expert opinions. We, therefore, don't collect samples for such cases. ... We refer cases to Sassoon Hospital.".* (Participant no 122: Male doctor, Medical Officer, Rural)

Thirty one participating doctors, whose facilities receive sexual violence cases, reported that referral of SV survivors to their respective HCFs (where they were currently posted) was largely done by the police;

nine HCPs said that their HCFs receive referrals from other public health care facilities such as PHCs, and RHs; three said that referrals come from private health care facilities; ten doctors reported that HCFs are referred by relatives of the survivors; five of HCPs said survivors themselves come to HCFs. Majority of the cases are brought by the police.

A few participating HCPs explained as to why cases are referred to their respective HCFs from other HCFs. These factors primarily involved inability of HCFs from where they receive these referrals; and also, because these cases are considered as 'medico-legal' matters.

> *"We receive these referrals from other HCFs, because these are medico-legal cases (which they can't manage).".*(Woman doctor, Casualty Medical Officer, State run HCF, Urban).

Table 5.1: Reported sources of referrals of SV survivors received at the HCFs as reported by participating doctors, Pune district

Cases Referred from									
Self	**Relatives**	**Friends/ Neighbours**	**Police**	**Private Clinic**	**Private Hospital**	**PHC/ Sub-centres**	**RH/SDH/WH**	**NA**	**N**
5 (6.6)	10 (13.2)	1 (1.3)	31 (40.8)	2 (2.6)	1 (1.3)	5 (6.6)	4 (5.3)	43 (56.6)	**76 (100)**

5.2 Procedures Followed

Seventeen HCPs mentioned that **filing FIR is compulsory** at the HCF they are posted.

> *"Yes, it (FIR) must be done.".* (Participant no 180: Woman doctor, Gynaecologist, State run HCF, Urban)

> *"Yes, it (FIR) must be done. There is a specific reason why I say so. Our focus is on providing treatment to survivors. However, at later point in time, she (survivor) wishes to file a case, and may question us as to why did we not inform them about this (filing a FIR). We therefore tell them to at least inform the police so that later there should not be legal issues.".* (Participant no 178: Woman doctor, Casualty Medical Officer, State run HCF, Urban)

The doctors who reported that their HCF receives SV survivors noted that the **medical officer (MO) on duty undertakes the examination of survivors**. Only two HCPs reported that a female doctor examines survivors while two said it might be a gynaecologist, if available. Twelve HCPs reported that male doctors accompanied either by a female nurse or female attendant examine survivors. Whether a female doctor and/or gynaecologist could examine a survivor is contingent upon their availability at HCFs.

"We don't undertake examination of (survivor). We invite gynaecologist on duty to examine. The cases first are presented to casualty department. But when police bring accused to us, we (HCPs at casualty department) do examine them. I have mostly examined the accused (brought by police).". (Participant no 179: Woman doctor, Casualty Medical Officer, State run HCF, Urban)

We had further explored the HCPs response to situations when survivors decide against reporting/informing to police. Responses varied in that some expressed a view that they would honour survivor's wishes on this front and a few others felt that it is safer for the survivors to at least inform police even if they don't intend to register a formal FIR.

"It (our response to a scenario when survivor decides against informing to police about the incident) depends. If a survivor is a minor (less than 18 years), we compulsorily inform the police (regardless of). However, if a survivor is not a minor, we inform police only if she is willing to do so. If she is not willing, we don't report.".
(Participant no 180: Woman doctor, Gynaecologist, State run HCF, Urban)

"If the person (survivor) decides to not report to the police, we make sure that she signs on the case paper saying she did not have any complaint to register against anyone. That is it. Matter ends. Mostly, such cases are referred to us by police only.". (Participant no 149: Male doctor, Head, HCF, Rural)

"Such situation (survivor deciding against registering a police complaint) has not confronted me to date. In such cases, generally women would not resist to report because further threats (of assault) are involved in such cases. They (survivors), therefore, seek police protection. I have never come across such situation. But if it does, that is, if the person (survivor) decides to not report, we can't thrust upon them to do so. If they don't wish to make it public, we don't force them to do so. Instead, we get it in writing (from survivors) that they don't have any complaints to register with police, get one of the staffers to be a witness to sign the same paper, and archive it for our records.".
(Participant no 122: Male doctor, Medical Officer, HCF, Rural)

Overall, the general sentiment amongst the participating doctors was to safeguard themselves and the concerned HCF when questioned whether they would honour the decision of the survivor to not report the case to the police. However, there was also a sentiment that if survivors decide against registering a police complaint, it would be honoured, and they would not exert force or coerce the survivors to register police complaints against their wishes.

"If (the survivor) declines to report to police (the incident), we don't examine (her). It happened in one case. She wanted to get examined but did not want to report to police. She was pregnant of 6-7 months. Unmarried pregnancy of 6-7 months (!) I told them that police case needs to be done. You go and register your case with police and come back then we shall give you treatment. They said 'yes' and left, but did not come back. … We don't seek consent from the survivor when we inform to police.". (Participant no 148: Male doctor, Medical Officer, State run HCF, Rural)

The above narrative by a practicing doctor who heads an HCF is disturbing for two reasons: (a) it was assumed that it was a case of sexual violence because the survivor was an unmarried woman/girl; (b) if so, then providing care to her was contingent upon her decision to report to the police. This completely violates the current legal framework. More importantly, there is a denial of medical care in this case which violates the MoHFW guidelines and Maharashtra government circular on care to survivors of sexual violence **(Annexure – 8).**

All the 31 participating HCPs, who mentioned that their HCFs receive, accept and provide care for cases of sexual violence, claimed that there is **no police personnel stationed at their HCFs**. However, during our field visits for data collection, we observed that at one urban-based HCF run by the PCMC, police staff is stationed at the hospital entrance close to casualty department. It almost appeared like a small sized police *chowki* as there was always more than two-three police staff sitting around. We did not observe police stationed at any other HCF that has been included in this study.

5.3 Responses to why cases are referred to a Tertiary Hospital

Of the HCPs who said that their HCFs accept cases of SV, 28 HCPs reported that the cases are **referred** and sent to the Sassoon Hospital – a tertiary hospital attached to a teaching medical college in Pune city, run by the State. Most of the qualifying responses reasoned that referrals are made since their HCFs were not equipped with something or the other to provide the necessary care and to undertake the examination. Referral to the Sassoon Hospital was also due to its proximity to the HCFs, or for untreatable injuries, as some participating HCPs mentioned. Some mentioned that because these are medico-legal cases, we have referred the cases to Sassoon hospital as other neighbouring HCFs do not entertain or respond to such cases.

> *"Since expert opinion of forensic specialist and gynaecologist is required, we refer cases to the Sassoon Hospital."*. (Participant no 148: Woman doctor, Medical Officer, Sub-District HCF, Rural)

> *"We refer cases to Sassoon for age estimation, DNA testing, and psychiatric opinion (when these are required as part of examination of a survivor)."*. (Participant no 172 (joint interview with two): Women doctors, Women's HCF, State run, Rural).

> *"We refer these cases to the Sassoon Hospital since it is a big hospital, it has all facilities. We don't have facilities (to respond to survivors of SV) here, don't have sufficient doctors, and they are not trained (in responding to and management of SV cases)."*. (Participant no 19: Male doctor, General Physician, District Hospital, State run HCF, Urban)

Table 5.2: HCFs in relation to evidence gathering to SV survivors when they are received and accepted to care for as reported by participating HCPs, Pune district (N= 31)		
Aspects of Care Provision to survivors	**Categories**	**Count**
Acceptance of cases	Yes	27
	No	4
If filing of FIR compulsory	Yes	17
	No	14
Have you ever done two-finger-test/ PV	Yes	20
	No	11
Who examines the survivor? (Multiple responses)	Female Doctor	2
	Male Doctor with Female Nurse	10
	Male Doctor with Female attendant	2
	General Physician	1
	Gynaecologist	2
	Other (On Duty MO)	23
Policeman stationed at the hospital	Not Present	31
Referrals made to	Sassoon Govt. Hosp	28
	Women's Hosp	1
	No/DNK & NA	2

"If there a is requirement for MTP (Medical Termination of Pregnancy), it is referred to Sassoon.". (Participant no 160: Male doctor, Medical Officer, Sub-District HCF, State run, Rural).

"The prevalent understanding is that only gynaecologist should examine SV cases, expert opinion is required. As a result, we refer our cases to Women's Hospital.". (Participant no 130: Male doctor, Medical Superintendent, State run HCF, Rural).

Yet another doctor mentioned *"we have to refer to the cases to elsewhere because we don't have specialist – gynaecologist – here. As a result, outcome of our examinations are not considered valid in the court of law. Therefore, we don't collect samples."*. (Participant no 122: Male doctor, Medical Officer, State run HCF, Rural)

One doctor (Participant no 120: Woman doctor, Medical Officer, State run HCF, Rural) reported that referrals are made directly by police, too. She described a case in which the police had brought to her HCF the 'accused' but not the survivor. Upon her enquiry, she was told that they (police) directly took the survivor to the Sassoon Hospital since she was minor and that they had anticipated that the case required age estimation.

5.4 Availability of specific equipment and kits required for examination of SV survivors

Only six out of 76 participating HCPs reported that their HCFs did have **SAFE kits.** However, 14 HCPs mentioned that even though their HCFs do not have SAFE kits as such, it has all the constituents of the SAFE kit. The rest 9 HCPs, of the total 31, who reported that their HCFs accept survivors of SV mentioned that they do not have all the constituents of SAFE kit. Some HCPs mentioned that they were not aware of SAFE kit but that their HCFs have the things required for examining survivors.

Table 5.3: Reported availability of age estimation facility at included HCFs

Age Estimation Methods	Without Probe					
	Yes Count (%)	No Response Count (%)	No Age Estimation Facility Count (%)	Not Administered Count (%)	NA Count (%)	Total Count (%)
Physical Age	2 (2.6)	7 (9.2)	21 (27.6)	2 (2.6)	44 (57.9)	**76 (100)**
Dental Age	3 (3.9)	6 (7.9)	21 (27.6)	2 (2.6)	44 (57.9)	**76 (100)**
Radiological Age	7 (9.2)	2 (2.6)	21 (27.6)	2 (2.6)	44 (57.9)	**76 (100)**

Only 9 HCPs of the 31 reported that their HCFs had age estimation facilities available. Most (26 of 31) HCPs reported that their HCFs had transportation available free of cost for survivors, if needed. Some HCPs mentioned that since police department brings such cases, their vans are used for survivors' transportation to the HCF where the survivor is referred for further investigation.

5.5 Practice of seeking consent from survivors and availability of standard templates

We explored whether participating doctors were aware of documentation-related procedures and whether standard templates are available for the purpose of health care services provided at their HCFs for survivors of SV.

Table 5.4: Reported availability of standard consent forms and other Standard Operating Procedures for examination of survivors of sexual violence

Aspects of documentation	Categories	Count
Form for obtaining consent	Yes, Copy Collected	11
	No	20
Standard Operating Procedures for conducting examination for SSV	Yes	7
	No	21
	Don't Know	3

As per the Guidelines, it is expected that consent from survivors must be sought for three aspects of the care provision and examination of survivors. **These include medical examination for treatment; sample collection as part of evidence collection; and informing police about the incident.** Data show that only 20 HCPs reported that they seek consent for a medical examination for treatment of survivors; only 16 HCPs said that their HCFs seek consent for collecting samples; only one doctor reported that they seek consent from the survivor for informing the police about the incident.

> *"If woman is complaining of rape then it is not necessary to take her consent for doing her examination."*. (Participant no 157: Male doctor, Medical Superintendent, State run HCF, Rural)

> *"There is no separate need to seek consent for medical examination. We don't seek consent for informing the police about the incident, we (just) inform them (survivors) that we are informing police (about the incident)."*. (Participant no 102: Male doctor, Gynecologist, State run HCF, Rural).

> *"Consent of the victim is taken for medical examination; for treatment consent is not required, and consent is also taken for informing police. ... consent form is included in the examination format itself."*. (Participant no 115: Male doctor, Acting Medical Superintendent, State run HCF, Rural)

> *One doctor mentioned, "We need to inform police. But if she (survivor) is saying no and not willing, it should not be done. (if we do against her will), it is like making it all public (chavatyawar aanlyasarakhe hote)."*. (Participant no 148: Male doctor, Acting Medical Superintendent, State run HCF, Rural).

This is an interesting perspective where the doctors also subscribe to the idea of 'family dishonour' if the episode becomes public. There were a few other doctors who shared a different view. They stressed that it must be reported to the police, and later it would be up to the survivor as to what statement to give to the police, and she may then say that she doesn't want to report the case formally to the police. One doctor stressed the importance of informing survivors, as part of consent seeking, adequate details as to what the examination involves, and if necessary, provide her counselling support, as well as honour her decision if she requires some time to think about the same before she decides on whether to agree for the proposed examination. Further, he explained the challenges involved in this approach.

With regard to the availability of standard templates, as mentioned earlier, only 31 HCPs provided that their HCFs accept survivors of SV. Of these, two-third (20 of 31 HCPs) reported that as per their knowledge, their respective HCFs did not have any standard template for seeking consent from survivors of SV for providing care to them. The rest 10 HCPs reported that they do not know any such standard templates for seeking and documenting consent. It is not clear whether the hospitals did not have these templates or these doctors were not aware of their existence.

Two-third HCPs (21 out of 31) reported that their respective HCFs do not have any standard operating procedures (SOPs) available for use with regard to providing care and undertake an examination of

survivors of SV. Only seven of 31 HCPs reported that their HCFs have SOPs, and three reported that they did not know whether they are available or not.

At one HCF, we interacted with a psychiatrist. He reported:

> *"We don't have any SOP (relating to providing psychiatric care to survivors or even others). We provide care drawing upon our trainings and our own experiences. If mental (manasik) issues are not addressed in timely manner, later the adverse consequences could be extremely serious.".*
> (Male doctor, Psychiatric, State run HCF, Urban)

5.6 Administration of two-finger test as part of medical examination of survivors

The Guidelines are now explicit and stringent about doctors employing two-finger-test (TFT) or per vagina (PV) test which almost often, conventionally speaking, is practiced to know if a survivor has been sexually active in the past and generally referred to as 'sexually habituated'. This restraint imposed in the Guidelines on undertaking TFT has been informed by the Justice Verma Committee which was convinced that previous sexual history of a survivor has nothing to with an incident of rape. A woman with past sexual history should not be understood as though she is available to anyone for coercing her into sexual interactions and raping her or subjecting her to any kind of sexual assault and violence. We, therefore, explored if participating doctors had used TFT as part of a medical examination of survivors and their viewpoint on the same.

We explored TFT practices among the participants with the help of three questions:

- Have you ever done the two-finger test or PV exam for a survivor of sexual violence?
- What is generally the purpose of such examination using two-finger test?
- Do you think two-finger test is needed or useful in cases of sexual survivors? In what way?

These questions helped in understanding the relevance of TFT for survivors of SV and locate it in the context of how the participating doctors view TFT in general. About 20 participating HCPs reported that they have done TFT for survivors of SV and 10 of them reported that they did not.

> *"Yes, I have done the two-finger-test (as part of examination of survivors of sexual violence). (I did it) to know (her) virginity, whether she is sexually habituated. (I believe that) it should be done after seeking her consent (for this test). … At times, girls tend to blackmail … (for example), they may have (engaged) in sexual activities (with a man/boy) by consent, but later if there is any problem (in the relationship), girls may blackmail (saying they have been raped). Therefore, it is needed to check if the girl is sexually habituated.".*
> (Participant no 102: Male doctor, Gynaecologist, State run HCF, Rural)

Some articulated the importance and essentiality of TFT to the extent that if TFT cannot be done or administered, then it eliminates any possibility of an incident of sexual assault. This particular narrative not only underscores the lack of any understanding of what 'sexual violence' means to at least some health care professionals but also sole reliance on TFT as evidence of sexual assault has taken place or

not. The quote below also reflects a common assumption among doctors that the survivors deliberately lie about being raped. Sexual violence, to such doctors, is linked exclusively to penetrative sexual interaction and the needle of suspicion is on the woman and her narrative.

> *"Two finger test (if it can be done, that is, if two fingers can be inserted) itself indicates that sexual intercourse has taken place. If two-finger-test is not possible (can't be done), that rules out any sexual assault…. If only finger is possible to insert in the vagina then the possibility of rape is almost not there. … And it is absolutely essential to do it (TFT) else how can one know if rape has happened … if sexual intercourse has happened. … It is very much important to know.".* (Participant no 149: Male doctor, Medical Superintendent, State run HCF, Rural)

> *"I haven't ever done (TFT). It is generally done to see the condition of genital track, especially during ante natal care and infections. … It is necessary to do (TFT) in case of sexual violence examination because it adds to examination… .".* (Participant no 179: Woman doctor, Casualty Medical Officer, District HCF, Urban)

> *"Yes, PV needs to be done. It tells us the nature of sexual violence – forceful (or not). … One needs to know if it was with her consent or not. …, therefore, is necessary. From that one can know if violence has occurred.".* (Participant no 134: Woman doctor, Medical Officer, State run HCF, Rural)

> *"(If the survivor) is virgin, then it is helpful to support other findings in the court. Also to diagnosis pregnancy, loosening of vagina, and if she is sexually habituated – PV is helpful.".* (Participant no 149: Male doctor, Medical Officer, State run HCF, Rural)

> *"It depends whether to do PV (or not). If hymen is not ruptured of the person (survivor) then PV is not necessary. But if hymen is ruptured then PV is necessary to know if she is sexually habituated, to know if there any internal injury, and if there is any infection.".* (Participant no 175: Male doctor, Medical officer, State run HCF, Rural)

A couple of doctors mentioned that they have to undertake TFT as police ask them to do so. Such articulation indicates that doctors feel the pressure exerted by police machinery in such cases. It is uncertain whether in such a situation doctors are aware of the appropriateness of using TFT; and if so, do they feel confident enough to let the police know that these are unwarranted demands from police and that doctors should be using their discretion on deciding which tests are required for medical evidence gathering.

> *"(We have) to do PV because police ask us if there is a sexual assault, if (she is) sexually habituated, and if there are any injuries.".* (Participant no 115: Male doctor, Acting Medical Superintendent, State run HCF, Rural).

Box 2- Impact of orientation and training in reforms and the Guidelines

"In the new Guidelines, PV has no role! I have seen the Guidelines as I have received those. I got to know all about (how to do) male and female examination in cases of SV. It is mentioned in these Guidelines that insertion of penis has no role in SV. I have been seeing SV cases since 1999, since I got into the job. I am now a senior officer. So, I don't have to see or do these cases, now. During those times, I used to see the cases as a gynaecologist. But there is world of difference between old (methods) and new ones. I used to present medical evidence in the court. Once we presented that two-finger-test could be done, it meant the survivor was sexually habituated. Cases used to get resolved (and perpetrators went scot free!). But now, two-finger-test doesn't have any role (in the court proceedings).

In the past, whether the girl (survivor) was 16 or 17 years old used to be discussed meticulously in the court hearing. If in case the girl was 16-year- old, she was considered 'minor', and 17 year old were considered 'major'. If she was 17 years old and (sexually) habituated (determined based on the TFT outcome), the incident of sexual activity (rape) was considered consensual by the courts then. Because of the age factor, age determination and its outcome was used as major part of the discussion in the court hearing.

Participant no 121: Male doctor, Gynaecologist, Medical Superintendent, State run HCF, Rural

Some other opined that whether TFT is needed or not can be assessed only on case-to-case basis.

> *"(TFT) is undertaken to examine internal injuries, and in case of gynecological complaint or obstetric issue. ... (in case of examination of survivors of SV) it varies from case to case. In certain cases, it is essential, say (for example), injury is visible and foreign object/body is seen there. PV then has to be done to take out the foreign object."*. (Participant no 178: Woman doctor, Casualty Medical Officer, District HCF, Urban)

> *"Generally, it (TFT) is needed to examine if there is any infection; to confirm pregnancy and to check uterus size. ... It (TFT) is not compulsory (to do in case of examining survivors of SV). If it is 13/14-year girl, PV can be very painful for her, and already it would be hurting her at that place. ... Instead, per vagina speculum (PS) examination and external examination of genital part is more important. (Generally speaking) PS needs to be done before PV to see if there are any injuries."*.
> (Participant no 180: Woman doctor, Gynaecologist, District HCF, Urban)

> *"It is not necessary. (Generally) if there is injury on both sides, one comes to know about it (sexual violence). ... I never used to do PV, unless indicated. PS is sufficient. We were also told in a workshop that PV is not necessary."*. (Participant no 157: Male doctor, Medical Superintendent, State run HCF, Rural).

"PV should not be done. Because, if rape has not really happened, PV will cause hymen rupture. (We could) do (PV) amongst married (survivors). However, it is useful only to do a swab and of nothing else.". (Participant no 151: Woman doctor, Medical Officer, State run HCF, Rural).

Some doctors had stressed the point that TFT amongst minors who have not been sexually active can cause immense trauma to them, which can be worse than an experience of forced sexual activity. They argued that the medical practitioners should resort to TFT in cases of survivors who are married women.

One doctor (Participant no 174: Male doctor, Medical Officer, Women's Hospital, Rural) brought forth an important constraint of TFT which is, as the aforesaid expressions of participating HCPs confirm, that while it identifies hymen rupture, it is not the cause behind it; and there are many reasons for hymen rupture.

5.7 Experiences of presenting evidence in the courts during case hearings

With CLA 2013 and the Guidelines in place, examining doctors' opinions hold much significance in cases of SV court hearing. It is critical that the examining-doctors participating in the legal procedure have positive experiences in their engagement with the courts. We, therefore, explored this aspect briefly.

Ten of 31 HCPs reported that they have attended the court calls and presented themselves in the court of law during the hearing of cases of SV that they handled.

"I had gone to the court when I was completing a course at the Sassoon Hospital. ... No challenges. Just tried answering questions asked.". (Participant no 145: Woman doctor, Medical Officer, State run HCF, Rural)

"Opposition advocate say that you are not a specialist and so you can't comment on it and can't give your opinion. So, we have to explain to them that there are some limitations. In case of male accused they ask us whether he is able to perform sex or not; and if we have done potency test. They ask for specialist opinion.".
(Participant no 115: Male doctor, acting Superintendent, State run HCF, Rural).

Another doctor (Male doctor, Medical Superintendent, State run HCF, Rural) also mentioned that it is a time-consuming process to be present oneself in the courtroom. It almost takes away an entire day. Often, the opposition lawyer (defending lawyer) insists for expert opinion, and they never appreciate the evidence presented by the HCPs from the facilities. At times, court raises questions about incomplete papers, such as, missing signatures.

Box 3 Court Experiences

"At times, we have to wait (in the court) for quite some time. (This implies), they don't appreciate that how important the time is for us (doctors). …. Their (the court's) first question is then as to why you checked the case when you are not a gynaecologist. I then have to tell them that I am MBBS and Lady Medical Officer (LMO) and that day I was on duty and therefore I had seen the case. They (the court) prefer opinions by the examining gynaecologist.

If we claim (based on the evidence) that incident of sexual violence has occurred. And they would ask us as how we have arrived at the decision. Just from hymen (status), they ask us, how you say it was forceful. In one case, we were asked to remove the word 'forceful' word from the report. Because there were no injuries and PV and ruptured hymen also does not carry that much value. We have patient's (survivor's) history (survivor's narrative of what happened). (But the court says), No history, did you find anything? If not, then you (examining doctor present in the court) can't say it was forceful (the court said).

The survivor has told me that she bled after the sexual intercourse (rape). But she had approached us 15 days after the incident took place. Evidence was lost. But she (survivor) has told me about the bleeding. But (the court) did not care for this history and was only focused on presence of injury at the place. [Note: Actual case managed by the reporting doctor]

Woman doctor, Medical Superintendent, State run HCF, Rural

The above narrative indicates that it is not only the medical fraternity that is far behind with regard to understanding the concept of sexual violence, the police, and the judiciary continue with the old ways of proceeding with these cases, and in their understanding sexual violence and medical evidence.
Old ways, as indicated here, are demonstrative of the different ways in which sexual assault is understood by the police and deliberated in the court of law: (1) Man's potency test to prove that he can undertake a penetrative sexual activity; (2) the two-finger vaginal test to prove that the woman is habituated to sex; (3) undermining the reports that have been given by a Medical doctor by seeking reports from a Gynaecologist; (4) the police asking the doctor to document whether rape has occurred or not.

Furthermore, the narrative presented in Box 2 suggests complexities involved for medical professionals to engage with the judiciary during SV case hearings. There are issues both of practical challenges and substantive issues relating to conception of what constitutes sexual violence and what, therefore, should be considered as an appropriate evidence on which the fate of the court decision hangs.

5.8 Challenges faced and responses while caring for survivors

Participating HCPs described challenges faced by them while responding to survivors of SV and shared with us their response to those challenges, which are often shaped by the system o which they belong. As mentioned earlier, almost all referrals are made to the Sassoon Hospital, Pune for reasons, majorly, (a) lack of infrastructural facilities such as diagnostics, age estimation facilities, and if needed, surgical interventions and MTP services; (b) trained and adequate human resources in general, and specialists such

as gynaecologists and counsellors. Over and above this, HCPs face challenges even at the level of providing basic care to survivors before referrals are made.

> *"Yes, there are obstacles. There is no privacy maintained. Confidentiality must be maintained. In fact, there should be different (separate) room for examining survivors with counsellor so that patient (survivor) won't get scared. ... It is important that patient (survivor) feels comfortable and safe, too. ... We refer them to Maitrayee Clinic (a space run by a local NGO to engage with survivors, provide counselling, and other supporting services), and then refer them…".*
> (Woman doctor, Casualty Medical Officer, District Hospital, State run, Urban)

> *"… it is a crowded (case load) place. We have to prioritize which patients to be cared first. ... We have to first attend the patients faced with life threatening situations ... it is tragedy (that we have to prioritize in this manner leaving survivors unattended). We at times can manage physically (case load wise) but we can't manage mentally (to take it one's stride all that goes on with patients).".* (Woman doctor, Casualty Medical Officer, District Hospital, State run, Urban)

> *"… We do something here, and then the perpetrator might go scot free. He had surely committed the crime. And if investigation (here) is faltered and makes even a small mistake which leads to his acquittal… so we refer the cases.".* (Male doctor, Medical Superintendent, State run HCF, Rural).

5.9 Reported Sexual violence cases presented to the HCFs

We explored the number of SV survivors that approached HCFs over the preceding three months in the last 12 months to help us understand the caseload at included HCFs and at which HCPs reported that they do get survivors of SV seeking care. About 24 percent (18 out of 76) HCPs reported that their HCFs received less than five such cases during the preceding three months; and about 16 percent (12 out of 76) HCPs reported that less than five cases at their HCFs over the past 12 months. Also, 18 doctors said that their HCFs received more than five such cases over the past 12 months. One of the HCPs from rural area based HCFs reported that about 45 such cases were received by the HCFs he was posted at the time of our interaction with him.

We listened to HCPs posted at primary health care centres articulating reasons as to why they do not receive SV cases. These included the local cultural context such as tribal culture; and the absence of police *chowkis*/police posts in the village. The former tends to assume that certain culture are inherently less prone to indulging into sexual violence; and the latter suggests that SV cases first either approach police *chowkis*/posts or in other words, police machinery is the first one to know about such cases. The explanations for why survivors do not present themselves to their respective HCFs included one factor that repeatedly featured in responses from HCPs. They reported that this might be due to the fact that there is no police station in this place. Therefore, survivors might not be coming to us. These responses highlight the relationship between the absence of a police station at a place and survivors not presenting themselves to HCFs at these places.

A few mentioned that what we receive at our HCFs is only "a tip of iceberg". A number of them mentioned that sexual violence is perpetrated by family members and is not a rare occurrence. In such situations, there is a tendency to not report cases.

5.10 Experience and Observations of Doctors who handled SV cases

Twenty two of 76 (29%) HCPs reported that they were involved in handling cases of sexual violence at the HCFs where they were posted at the time of our study. The experience of the doctors is linked to their respective hospital and the overall caseload of SV cases that come to those hospitals. The tables below provide insights into the typical pattern of cases, in terms of age group, sex of the survivor, duration between the occurrence of the episode and reporting to the hospital, who brings the survivor to the hospital, whether the accused is known to the survivor, and so on.

The responses that have a higher frequency and also indicate the pattern of SV cases have been highlighted in Tables 5.5 and 5.6. The Police refer the majority of the SV cases for medical examination. There is a usually time-lapse with reporting the incident to the hospital or the police station happening within 96 hours and the absence of any other support like a Counsellor or Social Work etc., missing in the HCFs.

Table 5.5 is the collected data involving various crucial aspects of SV cases that required medico-legal procedures. While 3 responses claimed that they handled survivors who were brought to them directly after the assault, 19 doctors noted that it was not the case. Further, complimenting the statement were the responses to the question-who referred the survivor to the facility? In majority of the cases, police brought in the survivors to the HCFs, however, only 3 participating doctors, out of 22, mentioned that it was another individual which could have been a relative as discussed in the earlier sections in this chapter. Only one of the doctors had handled a case with a minimum or no time-lapse. These responses are supplemented by the facts explained in Table 5.6 which is based on the conversations between the doctors and the survivors. 20 out of the 22 doctors claimed that at most times the survivors knew the accused.

The relationship between the survivor and the accused impacts the survivor's actions, after the event of sexual assault. In most cases, doctors accounted for the accused to be a friend (9 responses) or relative (6 responses) or neighbour (2 responses) of the survivor.

Table 5.6 accounts for the time-lapse in reporting the case where 10 doctors mentioned that SV were reported within 96 hours while 8 doctors mentioned 5 to 30 days and 4 doctors noted a gap of 1 to 6 months. Here, age of the survivors was noted by 12 doctors to be in the age group of 12 to 18 years and moreover, 7 doctors held that survivors were of the age between 19 to 40 years. Although, it is discouraging to see that only two doctors had affirmed that the survivors were facilitated by counsellors or social workers during examination, 18 doctors have claimed to inform the survivors about the risk involved.

Table 5.5: Data regarding Specific Survivors across all the health care facilities (N=22)		
Doctor's responses to various details crucial to the case of specific survior	**Categories**	**Count**
When was the last time you examined a survivor (Year)	2013-2016	6
	2017	16
Was survivor brought to this facility directly	Yes	3
	No	19
Who referred survivor and where was s/he referred from	Individual	3
	Police	19
Time lapse between the episode and visit to the hospital	Yes	21
	No	1
If yes, how much was the time lapse	Less than 96 hours	10
	5 to 30 days	8
	1 to 6 months	4
Were you the only doctor examining?	Yes	9
	No	13
Was there a social worker or councellor to facilitate conversation with the survivor during the examination	Yes	2
	No	20
Informing the survivor about the potential risk of pregnancy, infections, STDs & HIV	Yes	18
	No	3
	Don't know	1
Time taken for the examination	Less than 1 hour	18
	1 to 5 hours	4

Table 5.6 : Survivors across all the health care facilities as per doctors		
History of specific survivor as narrated by the doctor	**Categories**	**Doctors Count**
Age of the survivor	Between 12 to 18yrs	12
	Between 19 to 40yrs	7
	Upto 11yrs	2
	More than 40	1
Sex of the survivor	Male	1
	Female	21
Marital Status of the survivor	Unmarried	15
	Married	5
	Live-In	1
	Widowed	1
Was the accused known to the survivor	Yes	20
	No	1
	Don't Remember	1
Relationship between the accused and the survivor	Friend	9
	Relative	6
	Neighbour	2
	Other (Fiancé, Driver, living in the same village)	5

With the increasing time-lapse, medical evidence collection becomes complex. For instance, Table 5.7 lays data as per the doctor's experience, the latest case that he/she examined, the survivors reached the hospital with minimum time-lapse but most of the evidence is erased away because the survivor had bathed, brushed, eaten, passed stools, washed clothes, etc.

Table 5.7: Status of the specific survivor examined by the Doctor when she arrived at the Hospital

Had the Survivor…	Yes	No	Do Not Know
Bathed or Washed	19	1	2
Brushed or washed mouth	18	2	2
Eaten	18	2	2
Drunk Fluids	20	0	2
Changed clothes/washed clothes	19	1	2
Passed stools and urine	19	1	2
Cut the nails	7	7	8

In Table 5.8, we have the to-do-list of the sample collecting process and also what the doctors say they had done or never done. High numbers in the procedures the doctors claim to have not done (Table 5.8) highlights a compromise in the gathering crucial evidence. The history of the patients are noted by the examining doctors with a count of 21 'yes' even the doctors who do not collect any samples have taken information specific to the survivors. While 17 doctors had provided counselling to the survivors, and 17 doctors had noted that they ensure the privacy of the survivors, only 14 doctors had sought consent from the survivors for the medico-legal procedures and only 12 doctors had provided initial comforting for the survivors. Only 3 doctors had collected scalp hair during examination while 8 doctors have collected swabs from the stains on the body and 8 doctors had collected nail clippings and nails scrapings each separately. From the above, we see a list of priorities that develop among the examining doctors regarding evidence gathering. No doctor had collected blood for alcohol test but twelve doctors had checked for HIV, VDRL, HbsAG and 4 doctors had collected blood for DNA analysis. Further, 12 doctors had collected urine for pregnancy test or to check internal injury but only 2 doctors collected urine sample for a drug testing. None of the doctors had collected any other objects from the survivors and their possessions such as condoms, tampons or sanitary napkins.

A count of eight doctors has not collected any samples for most items in the list. Moreover, we see variations in internal examination of vagina, urethra, or mouth. While 12 doctors had collected vaginal swabs and 9 had collected vulva swabs, only 2 doctors had collected urethral swabs. In comparison, 11 doctors have never collected urethral swabs and 11 other doctors have claimed to have never collected swabs from glans of penis/clitoropenis. In this context, we have also noted in the earlier sections, the high number of cases that are referred to other healthcare facilities. Another reason for not gathering particular evidence could also be the time-lapse in reporting SV. We could link it to Table 5.2 where the data provides that in all the included facilities of Pune, there were only 2 female doctors and only 2 gynaecologists as examining doctors for sexual violence cases.

Table 5.8: Information about the to-do-list while doing sample collection of specific survivors (N=22)			
List of things to do for sample collection	**Yes**	**No**	**No Sample Collected**
Swabs from stains on the body	8	6	8
Scalp hair (10-15 strands)	3	11	8
Head hair combing	2	12	8
Nail scrapings (both hands separately)	8	6	8
Nail clippings (both hands separately)	8	6	8
Oral swab	3	11	8
Blood for identifying group(etc)	10	5	8
Blood for alcohol levels	0	14	8
Blood for DNA analysis	4	10	8
Urine (drug testing)	2	12	8
Any other (tampon/sanitary napkin/condom/object)	0	14	8
Matted pubic hair	4	10	8
Pubic hair combing	8	6	8
Cutting of pubic hair	7	7	8
Two Vulval swabs	9	5	8
Two Vaginal swabs	12	2	8
Two Anal swabs	2	12	8
Vaginal smear (air-dried) for semen examination	9	5	8
Vaginal washing	1	13	8
Urethral swab	3	11	8
Swab from glans of penis/ clitoropenis	3	11	8
Initial comfort provided	12	7	8
Privacy Ensured	17	2	8
Inform Consent Taken	14	0	8
History taken in patients own words	21	1	0
Counselling Done	17	5	0
Blood for HIV, VDRL, HbsAg	12	3	7
Urine for pregnancy/internal injury	10	5	7
X-ray done for Injury	1	13	8
Was Debris collection paper done	2	12	8
Was Clothes collected	2	12	8
Physical injuries recorded	13	9	0

Doctors were asked about all the evidence that they gather from a survivor. It is observed that several important shreds of evidence are not gathered. This is linked to the use of SAFE kit, the knowledge of what is required from a forensic enquiry point of view and the new Ministry guidelines. The figures for 'No' and 'No sample collected' in Table 5.8 tells us about the importance of training health care providers and also make the ICMR guidelines, SAFE kit and other checklists available along with augmenting the infrastructure in health care facilities.

5.11 Care provision to child survivors of sexual violence

Cases of sexual violence of children are brought to the HCFs. Only 25% of the facilities under this study indicated that they accept cases of child survivors of sexual violence. Only 24% of participating doctors indicated that they had handled cases of children. The majority of them mentioned that they had handled cases of children between the ages of 12 - 18 years. About 24% of the doctors indicated that they had referred the cases to Sassoon hospital in Pune.

Table 5.9: Care provision to child survivors of SV as reported by participating HCPs

Aspects of care provision to child survivors of SV	Categories	Count
If participating doctor ever examined a child survivor of SV	Yes	18
	No	4
Age distribution of the cases	Up to 11yrs	7
	Between 12 to 18yrs	14
	All the above	1
Referrals made to	Sassoon Govt Hosp	18
	No	3

5.11.1 Consent seeking from children

With regard to seeking consent from children, the majority of the doctors who handle these cases mentioned that they take consent of the children. The Medical Officer on duty handles these cases, and procedures like taking consent of the child and the signature of the adult accompanying the child on important papers.

Table 5.10: Participating doctors reporting on practice of consent seeking at their respective HCFs regarding examination of child survivors

	Yes	No	No Response
Medical Examination for Treatment	18	2	2
Sample Collection	17	0	5

Table 5.11: Practices followed while examining child survivor of SV as reported by participating HCPs at their respective HCFs (N=22)		
Aspects of care provision to child survivors of SV	**Categories**	**Count**
Who examines the survivor	Male Doctor with Female Nurse	2
	Gynaecologist	2
	Paediatrician	1
	On Duty MO	17
Use of any specific tools/techniques while taking history	Yes	6
	No	16
Insist guardian signature if the survivor's age falls in the range from 12 to 18	Yes	18
	No	4
Ensure the survivor's consent for examination if he/she is in between 12 to 18 years old	Yes	10
	No	9
	I Don't Know	2
	I Don't find it relevant	1

In response to questions that doctors pose to assess the possibility of sexual abuse among children who present with a variety of physical and psychological problems. Table 5.12 notes the symptoms that were read out to see if these are considered by the Doctors. It is observed that the Doctors are more likely to probe the physical changes and symptoms rather than the psychological and the social consequences of the abuse in ascertaining the possibility of sexual abuse of children.

Table 5.12: Information about symptoms or indicators for routine enquiry in cases of child survivors (N=18)		
Aspects of routine enquiry	Yes	No
Pain on urination and /or defection	16	2
Abdominal pain/ generalized body ache	18	0
Inability to sleep	11	7
Sudden withdrawal from peers/ adults	6	12
Feelings of anxiety, nervousness, helplessness	9	9
Weight loss	6	12
Feelings of ending one's life	5	12

In response to questions on cases under the POCSO Act 2013, covering children across all age groups below the age of 18 years, one doctor said:

> *"…these are various cases that come. Just few days back I went to the court in case of sexual assault of a 11-month-old baby done by a 40-year-old man. I went for this to the court. Just some days back there was a 16-year-old female who was 11 - 12 weeks pregnant. But she did not lodge a complaint. This becomes a rape only. But she did not do the FIR. If she is not reporting then how can we say that this was the case? This makes us to underreport such cases. So those we see on the record are jut tip of iceberg.".* (Male Chief Medical Officer, Rural hospital)

5.12 Care provision to survivors of domestic violence

As part of this study, the original focus was only to study health system's response to sexual assault cases. However, as the project was being operationalized, our understanding of the high prevalence of domestic violence, women approaching health systems for medical care, and the possibility of responding to domestic violence formed the background where the tool also had questions on domestic violence and intimate partner violence. Through the study, we had observed that doctors do come across several cases but there is a reluctance to reach out to address the issue and provide the necessary support to women. Doctors acknowledge that the:

> *"Mismatch between nature of injuries and women's narration about how they got those injuries is what helps to identify these cases. i.e., inconsistencies in the injuries and narratives. We treat such cases as DV cases and we record them in MLC and inform the police accordingly. Often women are reluctant to tell us that it is DV…. Sexual violence within DV is not brought here by the police.".* (Male doctor, Medical Officer, Urban Govt run tertiary hospital)

> *"The woman said that she had a fall but there were no injury marks anywhere on the body except the face and scratch marks on the hands so I felt suspicious and asked her, then she said that her husband had hit her.".* (Woman doctor, Urban Govt maternity home)

Table 5.13: Domestic Violence cases & Hospital response

	Categories	Count [%]
Do you maintain MLC register	Yes	38 [50]
	No	8 [10.5]
	NA	30 [39.5]
Women ready to register MLC	None/rarely	10 [13.2]
	Less than 5%	9 [11.8]
	Between 5 to 10 %	7 [9.2]
	Between 10 to 20%	4 [5.3]
	Between 20 to 90%	13[17.1]
	100%	3 [3.9]
	NA	30 [39.5]
SOPs to examine DV Cases	No	45 [59.2]
	Don't know	1[1.3]
	NA	30 [39.5]
Referrals made to	Sassoon Govt Hosp	26 [34.2]
	Other	5 [6.5]
	No	15 [19.7]
	NA	30 [39.5]
Occurrence of sexual violence in cases of domestic violence	No such thing	1 [1.3]
	Can not tell	2 [2.6]
	Between 1% to 100%	8 [10.4]
	Women do not tell	19 [25]
	Haven't come across such cases	14 [18.4]
	NA	32 [42.1]

Levels of sensitivity of the doctors can be seen through this interview:

> *"If you come to me with backache, I will ask you if you did more household work yesterday, or if you had a fall, or if anybody has hit you. These are our daily investigations, but she does not wish to tell, she won't. If you have faced violence your tone will be different while saying that you have a backache, your body language will be different, so from all that we can make out that she has faced violence, that this is not normal, so that time we ask if she has faced violence, even if she tells or does not tell, I have a doubt so I will do the investigations, do the sonography. Now all this depends on that person and the doctor, that how much they can make out. We have that type of vision, we can make out by seeing a woman walking if she has faced violence, now if anyone has really hit you with a rod, your gait will change. Mentality of doctor is also very important, now if the doctor is just looking down and writing then he/she will never be able to make out."*. (Woman gynaecologist, Govt Rural hospital)

With regards to awareness on the DV Act and the medico legal issues:

> *"Till now we have not even a received any such kind of a letter. The protection officer does not do anything. PO should have contact numbers of doctor, gynaecologist, social worker, counsellor and nurse. They should provide information about the meetings. A senior doctor from the hospital should be appointed to attend these meetings. If the concerned doctor is not present an alternative doctor or nurse should attend the meeting."*. (Woman doctor, Urban Govt tertiary hospital)

Table 5.14: Information about the number of DV Cases and the examinations done by the doctors (N=76)

Number of cases	DV Cases in last 3 months Count [%]	No. of Examinations Done at the Facility Count [%]
No Cases In Last 3 months	6 [7.9]	4 [5.3]
Less than 10	22 [28.9]	15 [19.7]
Between 10 to 20	13 [17.1]	7 [9.20
More than 20	5 [6.6]	20 [26.3]
NA (I do not know)	9 [11.8]	9 [11.8]
NA (We do not handle here)	14[18.4]	14[18.4]
NA (I haven't handled yet)	3 [3.9]	3 [3.9]
NA (PG Student)	2 [2.6]	2 [2.6]
NA	2 [2.6]	2 [2.6]
Total	**76 [100]**	**76 [100]**

Challenges in dealing with Domestic Violence:

> *"The woman is usually very scared; the relatives tell something else and she herself speaks something different so we cannot make out from it. Women do not speak openly about it, they keep on changing the statement we cannot make out the reality."*. (Woman doctor, Urban Govt tertiary hospital)

> *"There are no SV cases among DV cases. We saw such cases during our internship days. Means such cases might be happening here also, but they don't speak about it. They are dependent on their husbands; they don't have their own identity. A woman should endure is the common belief, that is their normal. They don't have the awareness. They don't have any other option, they can't go back to their parents' place, the surroundings in the village are all*

the same. There is a woman medical officer here, so women speak up.". (Woman Doctor, PHC)

Table No 5.15: Care provided to DV cases by the Doctors					
Health care services offered	**Yes**	**No**	**Do Not Know**	**NA**	**Total**
Test	38 (50)	6 (7.9)	2 (2.6)	30 (39.5)	**76 (100)**
Treatment	46 (60.5)	0	0	30 (39.5)	**76 (100)**
Information about law and rights	25 (32.9)	17 (22.4)	4 (5.3)	30 (39.5)	**76 (100)**
Counselling	34 (44.7)	11 (14.5)	1 (1.3)	30 (39.5)	**76 (100)**
Referral made to shelter	3 (3.9)	19 (25)	24 (31.6)	30 (39.5)	**76 (100)**
Referral made to protection officer	0	14 (18.40	32 (42.1)	30 (39.5)	**76 (100)**
Give her filled DIR form	0	13 (17.10	33 (43.4)	30 (39.5)	**76 (100)**
Record MLC	39 (51.3)	6 (7.9)	1 (1.3)	30 (39.5)	**76 (100)**

5.12.1 Varied understanding of counselling

"We do the counselling, if the husband is constantly hitting her we talk to her that don't argue with him, if the husband is present we tell him 'women are like poor cows don't trouble them, this is not masculinity, there is no masculinity in troubling your own wife. You work and earn money that is masculinity'. We also talk to the relatives.". (Participant No 6:Male doctor, Rural hospital)

"90% times the violence is repeated. Many a times what I do, I call the husband and interrogate him in front of the woman. So, if I feel anything is wrong, I immediately call the husband, they also know that if the doctor has called then they need to come, then I talk with them, try to give them counselling and they (husbands) they are quite receptive to what I tell. Mostly nobody back answers me here even the general public and I also take the follow up of such cases. The women share that they observe changes in the husband. Alcoholism is basic in DV, so firstly it is alcoholism, secondly it is the suspicious nature of husband.". (Male doctor, PHC)

Frustrated that change in laws do not get communicated to doctors.

"Till what level we can manage such cases in casualty …our responsibilities as CMO need to be made clear, we need to be given information about DV, SV law, how can we provide maximum and timely help to the victims, if comprehensive information is not given to us. Information on shelter homes is also needed.".

Conclusion

In this chapter, attention has been drawn to two keys aspects pertaining to sexual assault related response – **one, the evidence gathering procedures** followed in the case of sexual assault cases of

adult women and children; adult women who reach hospitals with intimate partner violence and domestic violence and **two, health care provisions** and necessary support to the survivors.

This chapter is based on the conversations and interviews with the participating doctors of healthcare facilities in Pune. Only half of the participants had claimed that their HCFs receives, accepts, and handles cases of sexual violence. Most of the examinations of the survivors are done by the Medical Officer on duty as there is always inadequate number of specialists like gynaecologists in the facilities. Survivors of sexual violence are brought either by the police or by the relatives. Some HCFs are able to only provide immediate and primary care and then the survivors are referred to tertiary facilities or other HCFs.

Only six HCFs had SAFE kits although fourteen HCPs claimed that their hospitals had all its constituents. When a case of sexual violence received at a healthcare facility, as per MoHFW Guidelines, consent must be sought from the survivors for medical treatment, evidence collection and reporting it to the police. This study notes that while most doctors seek consent for medical treatment and examination, only half of the HCPs sought consent for collection of medical evidence.

Some of the doctors and their facilities hold that filing a FIR is compulsory to accept and treat a case of sexual violence. While a few participants affirmed that they honoured the women's decision to not report to the police. In certain areas, the first-to-know about an occurrence of sexual assault is the police and sometimes, with lack of police stations, the cases go unreported and therefore, they are not referred to HCFs by the police. Often, the doctors administer Two-Finger-Test (TFT) even if they do not believe in relying on that particular test to confirm sexual violence because the police asks for it. Often, in cases of sexual violence, the doctors feel the pressure from the law enforcement department.

A few participant-doctors noted when called for hearing about a case they had handled, a whole day is spent in the court. At times, the defence lawyer will not accept the evidence provided by the doctor from the HCFs and they appeal for an expert. This practise discourages the HCPs to accept sexual violence cases. Broadly, we understand from this chapter that medical personnel and the judiciary have a skewed understanding of the concept of sexual violence and medical evidence in such cases. Like in the case of sexual assault cases which are generally referred to the large Pune based tertiary hospital, domestic violence cases are handled by the hospitals at all levels, however, when it has medico-legal implications they often refer the case to tertiary hospital. It is also evident from the study that knowledge of the Domestic Violence Act and the provisions within which doctors have to respond and also file a detailed information report (DIR) and hand it over to the Protection Officer responsible for the DV Act is not known to most of the doctors. However, HCFs often face challenges in providing even primary care to survivors of sexual violence and the cases are referred to other facilities.

With reference to medical procedures involved in sexual violence such as medical treatment and evidence gathering, the study produces the doctors' accounts regarding the procedures followed. Almost all the doctors noted the physical injuries, history specific to the individual examined, and ensured privacy of the survivor. However, only two doctors had mentioned a presence of social worker/counsellor during medical examination. We also made a note of the high number of 'no' and 'no sample collected' against the list of items presented in the table in section 5.10. Although the blood and urine are collected for HIV/VDRL/HbsAG and Drug test/pregnancy test respectively, there is a lower number of internal examinations such as the mouth, vagina, or urethra. In cases of sexual

violence of children, more emphasis is given to physical examination rather than the symptoms of psychological consequences of an assault.

Medical evidence collection becomes difficult when there is huge time-lapse between the occurrence of the assault and the reporting of the violence. Most of the services provided in HCFs are designed to help forensic enquiry alone. The chapter underscores the need to train the HCPs and create awareness regarding the SAFE kits, the Guidelines apart from upgrading the healthcare infrastructure.

Chapter 6: Knowledge, Attitudes and perspectives of Health care providers (Pune)

One of the objectives of this research initiative was to understand the extent of knowledge amongst health care providers about the recent legal reforms, the guidance issued by the MoH&FW/GoI, and orders issued by the state government in August 2015 seeking compliance. Also, given that sexual assault survivors face considerable negative response based on stereotypes, the project attempted to capture the existing attitudes of healthcare providers.

Besides, we also explored whether research participants—doctors, nurses, and administrators of the health care facilities—have been trained on post-Nirbhaya legislative changes and Guidelines to be better equipped in delivering their obligations. Furrrrther, if they would be interested in getting trained to strengthen their knowledge and skills, if they had no such opportunities in the past.

Against the backdrop of the slow progress on the implementation of post-Nirbhaya legal reforms (Bandewar et al., 2018; HRW, 2017; Inoue, 2020; Lapsia, 2015; Starrs et al., 2018), we considered it essential to integrate a KAP approach in this empirical research to examine the status of the healthcare systems on the grounds of preparedness, and if the HCPs are sufficiently ready to deliver on their responsibilities. This, in turn, is envisaged to develop and enable robust action plans to respond to implementation gaps. We have briefly presented under each of the sections below – knowledge, attitude and practice – the details regarding the various dimensions included for KAP assessment and rationale behind the same.

As mentioned earlier in the report, legal reforms in the form of CLA 13 and the Guidelines are the two major facets of the post-Nirbhaya reforms. We explored the awareness about these reforms among the participating HCPs. We also included the PWDV 2005 since women subjected to domestic violence has been recognized globally as a public health issue and the health care system and health care providers have a key role to play in responding to those affected by domestic violence. A set of questions to estimate the awareness about these facets of legal reforms constituted a dedicated part of the closing sections in the respective interview guides designed for doctors, nurses, and outreach health workers ANMs and AHSAs. The overall motivation behind exploring the knowledge of HCPs has been to appreciate the current knowledge deficit as a systemic issue and work towards addressing it.

We had included five questions each for the constituency of doctors and nurses and four questions to the constituency of ANMs-ASHAs to understand if they were aware of key legal reforms and related matters. (Table 6.1). The tool included health related questions (1) CLA 2013;(2) PWDV Act of 2005; (3) the Health Ministry guidelines; (4) The Maharashtra state guidelines issued for health care facilities regarding their roles and responsibilities towards those subjected to domestic violence who present themselves in health care facilities, and SAFE kit used for survivors of sexual violence. Except the question about SAFE kit, the rest of the four questions were asked to ASHAs and ANMs, too. To restate, because we employed purposive sampling in this study, the data provides, at the most, some indications and is heuristic in nature. The detailed legal provisions and a few case laws corresponding to the 21 statements are given in **Annexure – 9.**

This chapter covers the Knowledge, Attitude and Perspectives of Doctors, Nurses, ANMs and ASHAs on the procedural matters, forensic collection understanding, medical care, and support.

6.1 Knowledge of the post Nirbhaya legal reforms

Of the total 76 doctors we interacted with, 9 said that they were aware of the CLA 2013 and four said that they had heard of it but did not know the details. The rest of 63 doctors (82.9%) reported that they were not aware of post-Nirbhaya reforms – CLA 2013. Those who were aware of CLA 2013 or the Guidelines have had some opportunities to participate in training on the topic of sexual violence. However, they could not tell us more details to the extent that most of them could not recollect who had organized them and what might have been the content of the training. Data show that amongst the three types of HCPs, none of the outreach health workers—ANMs and ASHAs—in the sample knew about the post-Nirbhaya reforms – CLA 2013 and the Guidelines. They also did not know about the PWDV 2005 and the Circulars issued by the Maharashtra Government **(Annexure 10).**

Table 6.1: Health care providers' awareness of CLA 2013

Knowledge related questions administered with survey participants	**Yes/No**	**Doctors**	**Nurses**	**ANMs & ASHAs**
Are you aware of the Criminal Law Amendment Act 2013?	Yes	9 (11.8)*	2 (4.25)	0 (0)
	No	63 (82.9)	45(95.74)	26 (100)
	Yes, but not in details	4 (5.3)	0	0
	Total	**76 (100.0)**	**47 (100)**	**26(100)**

6.2 Ministry Guidelines on Medico legal care

With reference to the Ministry guidelines on medico-legal care for survivors of sexual violence, 78%, 96%, and 100% of doctors, nurses and ANMs/ASHAs, respectively, were not aware.

Table 6.2: Health care providers' awareness of Ministry Guidelines for Medico-legal care

Knowledge related questions administered with survey participants	**Yes/No**	**Doctors**	**Nurses**	**ANMs & ASHAs**
Are you aware of the 'Guidelines & Protocols for Medico-legal care for survivors/victims of Sexual Violence' brought out in 2014 by Ministry of Health & Family Welfare Government of India?	Yes	14 (18.4)	2 (4.3)	0 (0)
	No	59 (77.6)	45 (95.7)	26 (100)
	Yes, but not in details	3 (3.9)	0	0
	Total	**76 (100.0)**	**47 (100)**	**26(100)**

6.3 Awareness of Protection of Women against Domestic Violence Act, 2005 & Maharashtra Guidelines for Medical Facilities

The health care system has an important role to play when survivors of domestic violence present themselves at health care facilities with injuries. Often women reach out to HCFs in order to deal with injuries and negative health outcomes. Women confronted with domestic violence might not be in a

position to report that their injuries are because of the same. Hence, there is an additional responsibility on the health care system and health care providers in recognizing such situations, respond to women's health care needs and facilitate legal steps. Lack of awareness and a time-lapse of more than 12 years, in the backdrop of the enactment of the PWDV Act 2005, demonstrates an implementation gap.

The percentage of doctors who did not know about the Guidelines to Medical Facilities for Implementation of PWDV Act 2005 in Maharashtra was a high 92%. They also did not know about the PWDV 2005 and the Circular issued by the Maharashtra Govt (mentioned earlier). Only 18% of doctors knew about the PWDV Act of 2005 and only 6% knew about the state Government's guidelines to medical facilities as to how domestic violence cases have to be handled.

Table 6.3: Health care providers' awareness of PWDV Act and Maharashtra State Guidelines

Knowledge related questions administered with survey participants	**Yes/No**	**Doctors**	**Nurses**	**ANMs & ASHAs**
Are you aware of PWDV Act 2005?	Yes	14 (18.4)	9 (19.1)	0 (0)
	No	60 (78.9)	38 (80.9)	26 (100)
	Yes, but not in details	2 (2.6)		
	Total	**76 (100.0)**	**47 (100)**	**26 (100)**
Are you aware of 'Guidelines to Medical Facilities for Implementation of PWDV Act 2005 in Maharashtra'?	Yes	6 (7.9)	1 (2.1)	0 (0)
	No	70 (92.1)	46 (97.9)	26 (100)
	Total	**76 (100.0)**	**47 (100)**	**26 (100)**

Overall, across the three types of HCPs, only a small number of them knew about the change in laws and its direct relevance to health care delivery. Doctors as a constituency are better placed compared to nurses; however, the deficiencies are glaring. Outreach health workers seem to be lacking opportunities to learn about these reforms. They were unaware of their role in prevention and providing support to specific cases of violence.

Nurses, though a small percentage, fared better than the outreach health workers in their familiarity with the legal reforms, the existence of the PWDV Act of 2005, Guidelines or the SAFE Kit. As part of the National Rural Health Mission, the Ministry of Health & Family Welfare (MoHFW) prepared a handbook educating ASHAs about different forms of violence, how the experience of violence changes throughout a woman's lifecycle, and how to recognize the signs and symptoms in women experiencing violence. These frontline workers are expected to contribute to creating awareness among communities on issues of violence against women, and address cases of violence by providing support, providing referrals and information on legal recourse. However, it is clear from this data that there is hardly any awareness or any attempt to address the issue within the community setting.

6.4 Attitudes and perspectives

The Guidelines from the MoHFW and the Maharashtra Health department are specifically meant for the health care institutions providing detailed guidance for HCPs to enable them to provide a quality

response to survivors of domestic and sexual violence. Health care system's central role in collecting quality forensic evidence is underscored both in the Guidelines and CLA 2013. Furthermore, via these reforms, the two-finger test to check the elasticity of the vagina and any enquiry into the past sexual history of survivors during investigations at any stage has been proscribed. Many other key features of the CLA 2013, the Guidelines and the PWDA Act of 2005 reflect foundational shifts from the earlier legal frameworks and instruments, which often obstructed timely justice delivery to women facing gender-based violence. These reforms also centre-stage the critical mandatory role of the health care system not only in collecting quality forensic evidence for the judicial process but also in providing quality care to survivors and respecting their rights to privacy and informed consent.

Mazur (2015) notes the changing attitudes of key players to be one of the indicators of policy implementation and part of the evaluation of policy implementation. The post-Nirbhaya reforms reflect a radical shift in the conception of concepts relating to sexual violence, legal processes, and nature of forensic evidence. We considered that an assessment of HCPs views to be a proxy for the perspectives and attitudes they hold concerning GBV and justice delivery which involves a key role of the health care system.

For HCFs and HCPs to appreciate their ethical and legal responsibilities and deliver the same, it is necessary that they also are well-aware of the various aspects of CLA 2013 and the Guidelines. Against this backdrop, we explored with HCPs to know how they, as part of the healthcare system, are placed on this count as part of knowing if the system is prepared to respond to survivors. The intention was to know if the system is equipped to comply with the Guidelines and CLA 2013 and appreciate the gaps, which could be systematically addressed by the Ministry and the health department of the State government.

6.5 Awareness or Attitudes on the Benchmark Laws and Guidelines

We therefore identified various aspects of CLA 2013, the Guidelines and the PWDV Act 2005 and developed a set of statements to capture HCPs perspectives on them. 22 statements were administered on doctors which included both correct and incorrect statements (Table 5.3a and Table 5.3b). We chose only five of these 22 aspects to administer to nurses since their supportive role in providing care for survivors is limited (Table 5.4). We administered this tool in two ways. If participating doctors responded to questions posed earlier, claiming that they were aware of all the Guidelines, CLA 2013 and PWDA Act 2015, they were asked to respond if the statements were true or false. If they had said that they were not aware of these matters – a knowledge component, they were asked to tell us if such law or guidelines were to be designed, would they agree to include a particular aspect in the forthcoming law – an attitude component. Further, we presented these data in a manner to know the percentage distribution of those whose responses which complied with reforms.

The awareness and attitudes of doctors on issues of medical evidence gathering and caregiving to survivors of sexual violence are provided in the following sections. The first set of statements pertains to the provisions in the law and guidelines from the Ministry to health service providers. In the following section, statements in line with the provisions and guidelines have been made, and the responses from Doctors have been elicited. These statements and the response to these statements provide the normative framework and alignment at an attitudinal level by health care providers. The qualitative responses received at the time of administering these statements are shared to give insights into their views on the subject.

6.5.1 Is police requisition required for medical examination of the survivor of sexual violence?

Access to medical examination will help in early medical evidence gathering and remove the obstruction and/or delay in survivor getting medical attention. The health providers must attend to women survivors, who reach a hospital, report sexual violence and seek medical examination, even if there is no police requisition. However, there are often delays when the hospital sends the survivor to the police; police delays in filing a FIR and taking the woman to the hospital for a medical examination; and hospitals tend to delay examination since there is no female gynaecologist. All these lead to loss of vital evidence and also, lead to delay in providing medical care to the woman.

Statements based on various provisions in CLA 2013 and Ministry Guidelines	Sources of Legal provision
Medical examination of the survivor of sexual violence does not require police requisition. It is up to the survivor if she would like to move forward with reporting to police towards initiating police investigation.	• Supreme court case verdict (yr 2000: State of Karnataka Vs Manjanna) • Sec 357 C CrPC 2013

The response to this statement had a 63% of the doctors agreeing to this provision while 37% of the doctors would carry out medical examination only if there is a police requisition. If confronted with the situation to respond to a survivor seeking care from her/him, the HCP would wait for a police requisition before attending the survivor.

> *"If a survivor has come on her own then police permission is not required." (Woman doctor, HCF, Rural)*

> *"If the case of sexual violence has happened on a smaller level and is not very severe, then no need to inform police because the case procedures are very long and the girl gets harassed in this procedure. But if the victim wants to file the case, then the hospital should inform the police." (Male doctor, State run HCF, Rural)*

> *"Permission need not be sought. But we need to inform police because if FIR is not registered, we can't issue injury certificate to the survivor. She has been presented to us as a medico-legal case." (Woman doctor, Gynaecologist, State run HCF, Rural).*

6.5.2 Is it mandatory to provide free healthcare for survivors and inform the police about the case?

Statements based on various provisions in CLA 2013 and Ministry Guidelines	Sources of Legal provision
It is mandatory for health care facilities both private and public to provide treatment to survivors free of cost and not deny care for want of police requisition or FIR.	• Sec 357C into the Code of Criminal Procedure, 1973 as per Sec 23 of the CLA 2013 • Rule 5 POCSO 2012 Act
Not providing comprehensive free care to survivors and not respecting voluntary reporting to the hospital can attract imprisonment of one year and/or fine	• Sec 166 B of IPC

It is reassuring to note that 91% of the doctors agree to this legal provision, which lays emphasis on a quick response from any of the health system, and provide supportive care, irrespective of the payment capacity of the survivor. However, with reference to information to police on a case that a doctor had examined, only 84% thought that it is a must. This response contradicts the response to Statement one, where doctors indeed spoke about the right of the survivor to decide to complain to the police. This seems to be a grey area in the minds of doctors.

One doctor said -

> *"to register a complaint or not is an individual choice. If it is done forcefully by anyone then it is like the doctors or the hospital is blackmailing the survivor about it. Even police can harass them. Also, if the hospitals report the case against the wish of the survivor then it implies that the hospital is exposing the patient forcefully.". (Male doctor, State run HCF, Rural)*

Another doctor said:

> *"If we don't inform, who will be doing further procedures? So, it must be mandatory to do so. Else, justice can't be delivered.". (Male doctor, State run HCF, Rural).*

One doctor who was serving at a HCF located in rural Pune agreed with the idea of making reporting about a case mandatory for an examining doctor and the HCF. However, he qualified his view as below:

> *"Such reporting ought to be mandatory but if the survivor doesn't want to register a police complaint, it needs to be respected. However, we would make her understand the pros and cons of her decision. We would tell her that in the future, if in case you decide to seek legal redressal, you will face challenges if you don't register the complaint now; and all evidence will be lost.".*
> *(Male doctor, State run HCF, Rural)*

The following narratives are doctors' opinions with regard to free health care:

> *"In private (HCFs), they incur expenses (of undertaking examinations), it (examining survivors) takes time. They (HCPs from private HCFs) should be offered remuneration for their services if they provide these (of examining survivors). Medical education to become a doctor requires crores of rupees. If so, why would they provide free services (to survivors)? Do teachers and advocates/lawyers provide their services free of cost?". (Male doctor, HCF, Rural).*

> *"It should be made compulsory to private health care sector to attend medico-legal cases.". (Male doctor, State run HCF, Rural).*

> *"It can't be made compulsory to them. But they should provide first aid as a courtesy.". (Woman doctor, State run HCF, Rural)*

One doctor expressed concerns about the heavy fees that might be charged to survivor if they are seen at or cared for at private HCFs.

> *"Who will pay the high bills of the hospital, they will not provide quality service and hence, they should save the life and then refer the case to the govt hospital.".*
> *(Male doctor, Anaesthetist-Medical Officer, State run HCF, Rural).*

"It should not be mandatory for private sector. Uncertain if they will be ready to do so. Generally, private health care practitioners have a tendency (to think) that if it (providing such services) doesn't pay them, why would I do this work. (As a result) it is likely to hamper the treatment (to survivor).". (Male doctor, State run HCF, Rural).

"If free of cost might not be possible, at least at subsidized cost services should be provided by private HCPs.". (Male doctor, Sub-district HCF, Rural).

6.5.3 Is it mandatory to have a woman doctor/female gynaecologist for examining adult women in sexual assault cases?

The 2005 amendment of Criminal Law Amendment Act in Section 164 A CrPC, removed the insistence for a female doctor to attend to survivors of sexual violence. This was done because all health care facilities are not equipped with a woman gynaecologist. An insistence for a woman gynaecologist may therefore cause denial or delay in examining survivor in case of unavailability or absence. Needless to mention that survivor's consent is needed to proceed with such examination with or without a woman gynaecologist. As such, a survivor needs to be informed about these procedural matters in detail with necessary sensitivity without either coercing her or using a pretext of her refusal, which might be possible, if health care facility does not have well-equipped doctors and/or social workers and/or Counsellors or other such service providers who can facilitate supporting conversation with survivors. As per the data from our study, about 65 percent (49 out of 76) doctors, however, reported that it is essential to have a woman gynaecologist examining a survivor. This response, in fact, reflects the sensitivity amongst doctors as survivors certainly would be more comfortable with a woman gynaecologist. Nevertheless, such views amongst doctors likely mean that survivors would miss the opportunity to get examined on time and receive the necessary health care.

"A gynaecologist is a must for examination. Else, later in the court (during the hearing of the case) prosecutors harass us like anything and question us as to why was the examination undertaken if there was no gynaecologist.". (Woman doctor, HCF, Rural)

Yet another doctor mentioned *"not only specialist but other doctors can also handle these examinations if they are imparted special training in the same.".* (Male doctor, Paediatrician, State run HCF, Rural)

Section 27 of the POCSO Act 2012 stipulates for the presence of a woman doctor for medical examination of child survivors. This clause is critique as there is a possibility when a woman doctor might not be available and there is a necessity to undertake a child survivor's examination.

6.5.4 Is presence of injuries on the survivor necessary to arrive at an opinion that a woman has been sexually violated/raped?

About 89.5 percent of the participating doctors disagreed that presence of injuries is necessary to arrive at an opinion that a woman has been SV/raped. Some HCPs shared with us their understanding of this aspect of sexual violence.

"To be able to arrive at a decision that the person has been raped, it is not necessary that person has bodily injuries. It is secondary (to the investigation) that survivor has injuries on

her body. If the patient (survivor) was handicapped, she will not have sufficient ability (takat) to resist (the assault); or if the person is mentally challenged (matimand), she will not be able to resist (pratikar) or oppose the assault. Even in normal conditions, if she is weak and the perpetrator is hefty (dhaddhakat) and in case her hands are tied or held with force, she will not be able to do anything.". (Woman doctor, State run HCF, Rural)

In the above presented view pertaining to a lack of injuries on the survivor's body, the doctor provides an understanding of various types of sexual assault survivors who either were not in a position to consent or understood to be physically incapable of resisting the assault. While the doctor's observations are important to note, the underlying assumption is – women who are capable of resisting will have injuries or must have injuries. Very often when women survivors do not fall in the above categories of survivors, then there is a tendency for bias to set in and the women's narrative to be suspected.

Another doctor opined: *"Yes, it (evidence of bodily injuries) is necessary. Because she would certainly resist (pratikar) and therefore, will have injuries on her body. However, if she was threatened and adversely pressured, she wouldn't be able to resist."* (Male doctor, Rural).

"… it is very much needed that we trust in what survivor tells us. It will be the judge who will decide whether is true or a lie. We should not become a judge. I have this clear opinion on this. … The wounds of her mind will not show just like that…". (Male doctor, Sub-district HCF, Rural)

These views support the existence of multiple possibilities of how survivors present themselves to the health care setting and the need for doctors to have high levels of sensitivity and knowledge of the legal reforms and medical and forensic guidelines.

6.5.5 Is documentation of sexual activities prior to Sexual Violence required as part of medico-legal evidence?

This aspect will be dealt with partially in the section on provisional report of the doctor on medical examination. There is long history of about two decades between 1979 and 2000 during which the irrelevance of documenting sexual activities prior to an incidence of sexual violence was debated before it was acknowledged in the legal frameworks. To mention briefly, the 172nd Law Commission of India (LCoI)-2000 report recommended an amendment to the Indian Evidence Act (IEA) of 1872 by adding Section 53A to affirm irrelevance of past sexual history. The 185th LCoI -2003 upheld it. The Justice Verma Committee (JVC) Report notes that the parliament took 25 years to enact this amendment regarding medical examination in Criminal Procedure Code which passed in the year2005 (CrPC Amendment 2005, Section 164A). JVC report (2013) mentions, "…Thus, we note that Parliament has acted in alignment with modern understanding that previous sexual intercourse of woman would be irrelevant.". (pp: 278). Sec 146 of the IEA 1872 prohibits debate on previous sexual experience or past sexual practice in the witness box. This is one of the foundational reforms which acknowledge that even if a girl might have been sexually active before an incidence of sexual violence against her, it is not acceptable to violate her and her body. The obvious difference between two scenarios is about consensual sexual activity and non-consensual forced imposition.

The data show, disappointingly, that more than half – about 54 percent, i.e., 41 doctors out of 76 doctors, whom we interviewed, believe that such documentation is required as part of evidence collection. This included even those participating doctors, who had showed their deeper understanding of complexities of rapes and overall sexual violence in their responses to other questions.

> *"Yes, it (documenting sexual history prior to sexual violence) is important. If it (sexual activity) is for the first time, then that place of hers would not be as widened (fatleli, literally speaking, it means 'torn') because of repeated (sexual activity) thing has happened. It will not be easy to know if this (rape) has happened to her."* (Woman doctor, State run HCF, Rural).

> *"Sexual history is helpful to document which is not to say about whether the survivor is sexually habituated or otherwise. But it is to know if she might have HIV or sexually transmitted diseases."*
> (Male doctor, Sub-district HCF, Rural)

The above responses provide an insight where one doctor believes that previous sexual activity will be helpful in understanding the status of the vagina and the other doctor opines evidence of sexually transmitted diseases.

6.5.6 Should examining doctors provide an opinion about the case only after the reports from Forensic Science Laboratory arrive?

When posed this statement, doctors choose to wait for the Forensic Science Laboratory (FSL) report before offering their provisional opinion based on examination they undertake of survivors. This could be attributed to the doctors' general tendency of adopting a defensive practice. In today's context, they are encouraged to provide their opinions without having to wait for the FSL report.

About 58 percent doctors, or out of 76 doctors, 44 had reported that examining doctors should wait for FSL report before they express their medical opinion on the sexual violence case.

6.5.7 Is Medical opinion in the current context of various legal reforms the only evidence?

Circumstantial evidence and survivor's testimony play an important role in arriving at a judgement in the court of law. With the significant shifts taken place in the notion of rape and sexual violence and the understanding of what comprises evidence, a medical opinion is not considered as the only evidence.

About 32 percent of the doctors, which is 24 out of 76 doctors, reported that they believe that medical opinion is the sole evidence in cases of sexual assault in the current context of various legal reforms. Once again, this is a not a small proportion whose opinions on this aspect doesn't align with the current understanding of what comprises evidence in rape cases. However, we came across HCPs who not only had clarity about sexual violence but also about the significance of other circumstantial evidence. Few doctor's opinions are as follows:

"Even if she (survivor) is telling us (that she has been sexually assaulted) she can be telling us lies. Also, her family may also be lying with us. But what the body reveals can't be untrue ever. (Therefore) it is the primary evidence but not the only one." (Woman doctor, State run HCF, Rural)

"History (documenting) has a lot of value. And survivors' words have immense importance." (Male doctor, State run HCF, Rural).

"No. If she (survivor) visits us much later, there will not be any (medical) evidence available at all. It is not necessary that sexual violence has to be a penetration. And even if it was penetration, there will not be any evidence available when survivors come to us later. Besides, even if it is not penetration, it is still a sexual violence." (Woman doctor, State run HCF, Rural).

"It can only be contributory evidence and not the sole evidence." (Male doctor, State run HCF, Rural).

"Only medical evidence is not considered in court (of law). Circumstantial evidence is also taken into account." (Male doctor, Casualty Medical Officer, Sub-District HCF, Rural)

6.5.8 Are Potency Tests necessary?

As per Section 375 of IPC, penetration of penis to any extent into a woman's genitals or a mere touching of the penis to the female genitals constitutes rape. The section does not insist on complete penetration or ejaculation. Potency tests that are carried out routinely attempt to prove whether the assailant is physically competent to have an erection and carry out penetrative sex.

Routine practices in sexual examination	**Sources of Legal provision**
Potency test of the accused is not relevant and not necessary	• Sec 375 IPC has widened the scope of definition of rape, which goes beyond peno-vaginal penetration. Insertion of objects, fingers, mouth, etc., qualifies as rape. Potency examination of male accused is in itself of no relevance.

While survivors of sexual assault are taken to the hospital for medical evidence gathering and provision of medical aid as required, the accused is examined in the hospital for collection of forensic evidence on the body and clothing, and also a routine potency is conducted to check if the accuser is capable of carrying out sexual intercourse. As per the changes in the definitions of rape, this test is redundant; however, we asked the questions to gather the knowledge of doctors on this aspect. About 70% doctors believe that potency test is not relevant. However, 30 percent of the doctors – 23 out of 76 – believe that potency test is relevant and necessary part of the investigation.

One doctor mentioned:

"No need to do potency test. Abuse has happened is happened. It is not a question of potent or impotent. Need to widen (the scope) of definition of 'abuse'." (Male doctor, State run HCF, Rural)

6.5.9 Provisional Opinion with Adequate Reasoning on the Report

At the end of the process of noting the survivor's history, medical examination and forensic evidence gathering, the doctor is expected to provide a provisional opinion on the case. This opinion and the clarity with which it is given has significant relevance when the case comes to the court for hearing.

Statements based on various provisions in CLA 2013 and Ministry Guidelines	**Sources of Legal provision**
It is legally binding for examining doctors to provide an opinion with adequate reasoning to support the stated opinion	• Sec 164A CrPC prescribes that negative evidence or lack of evidence such as absence of semen needs to be explained as part of reasoning

When the police bring a survivor to the doctor, they expect the doctor to opine on the requisition slip if there are injuries and – "*if rape has indeed occurred*", "*if the survivor seems to be habituated to having sex*", and so on. Survivors often approach the hospital or the police with varying delays after the assault and with varying experiences of the assault. Women or girls may have washed away the evidences from the body or may not have had a peno-vaginal penetration, or the assailant may not have ejaculated or had used a condom, or there are no injuries on the woman's body (to prove that she had resisted) either because she was intoxicated/drugged, or she had been threatened with a weapon or a threat of blackmail.

The medical examination and the findings vary in each case. Section 164 of CrPC states that doctors should provide a reasoned opinion. The MoHFW guidelines and protocols (pages 32, 35 and 36), specify how to provide reasoned medical opinion. With the changes in rape laws after long drawn campaigns by the women's movement in India, as per the Indian Evidence Act-Section 146, it is illegal for the doctor or anybody in authority questioning a survivor/victim on past sexual history or consensual sexual acts. However, doctors who take the history of the survivor/victim can record sexual abuse (forced or non-consensual acts). The doctor need not opine to police requisition on whether the victim is 'habituated to sex'. Presence of injuries and/or sexually transmitted infections (STIs), presence of spermatozoa upon wet smear examination provides positive examination findings.

As per the Handbook for Doctors prepared by Narayanareddy (2017) for the Government of Maharashtra, medical opinion consists of the following:

- "Any evidence of sexual violence (penetrative by penis and/or body part and/or object or non-penetrative acts);
- Any evidence to ascertain mental incapacity to give consent due to the effect of disease / ethyl alcohol / narcotic drug / psychotropic substance;
- Any evidence for medical age determination which would be crucial in deciding incapacity to give consent and /or increase in the punishment;
- Any evidence to identify assailants through medical examination in the form of collection of DNA material through collection of hair, semen, blood, nail clippings etc" (p.12)

According to the same handbook, limitations of medical evidence must be noted in medical opinion under the following circumstances:

- ✓ "If evidence is lost due to post assault activities like bathing, douching, washing, urination, defecation;
- ✓ If evidence is lost due to delay in reporting for medical examination and healing of injuries and STIs;
- ✓ Use of condom, which was not recovered.
- ✓ Final opinion should be given by the doctor on receipt of FSL reports or reports from hospital investigations." (p.12)

It is interesting to note that 82% of the doctors agree that they have a responsibility to provide an opinion on the sexual assault case and provide adequate reasoning. This provision has also come about since the medical examination reports by doctors often are held as inadequate or even biased, weakening the survivor's case in the court.

6.5.10 Sensitive Medical Care

Along with medical and forensic evidence gathering, doctors have a responsibility to provide medical care, which includes treating of injuries, STI prophylaxis, provision of emergency contraception to prevent pregnancy, prevention of tetanus and Hepatitis B, provision of post exposure prophylaxis (PEP) in high risk cases, and advice on follow up. Doctors are also expected to provide emotional support and refer the survivor for counselling support. To a question about these matters, the doctors responded with positive affirmation about the need to provide sensitive medical care to women survivors of violence, counselling support and HIV prophylaxis.

6.5.11 POCSO related guidelines

In case of attending to children, who had faced sexual violence, doctors must adhere to additional legal provisions apart from medical care and evidence gathering. A statement here pertaining to POCSO is presented below.

Statements based on POCSO Act	**Sources of Legal provision**
In case of children, it is mandatory that child's parents are present during the medical examination or guardian or any other person whom she trusts	◦ Sec 2 POCSO Act 2012 ◦ In case such a person is not available, it then it is the duty of the hospital to provide such a person

This provision in the law is to ensure that the child is not left in the hospital setting among unknown people. Further, children, who are already traumatised due to the assault, would find the process of medical examination extremely bewildering. Hence, the need of a parent during the examination. Around 98% of the doctors agreed to this provision. However, there is discomfort expressed on this issue.

Doctors and nurses spoke about cases of minor girls and occasionally, boys with evidences of sexual assault or activity. Sometimes angry relatives or parents accompany child victims. One doctor expressed this as a response to the provision in the law:

"Disagree. Many a time assault has been committed by someone from within the family. If so, it creates pressure if they are present during the examination. It is better if they are not present." (Woman doctor, State run HCF, Urban)

Bhate-Deosthali and colleaguess (2018) report traced survivors of sexual violence who had visited three Municipal hospitals where Dilaasa[12] is running its centres. Among the 66 survivors that they could trace for studying the impact of sexual violence on their lives, they observed in 63 cases, the perpetrator of the violence was a known person. They ranged from child's own father, other family members, neighbour, boyfriend, friend, and acquaintance. In another study, medico-legal forms of all survivors/victims, registered at the three hospitals in Mumbai numbering 528 between April 2008 to March 2015, were analysed to understand emerging patterns (CEHAT & MCGB, 2018). This analysis has shown that in 76% of the cases the perpetrator is a familiar person.

6.5.12 Violence and Sexual violence under the Domestic Violence Act 2005

Violence against women within their homes is an acknowledged fact in India. The Domestic violence Act 2005, a civil law, attempts to address the same and provide various reliefs through various provisions under this law. The variants of violence within homes are referred to as intimate partner violence, spousal violence or family violence. As per NFHS – 4, in India, 33% women have been subjected to physical, sexual or emotional violence from their spouse. In terms of seeking help, especially from a doctor, the information is as follows:

Table. 6.4 Help seeking to stop violence, all India (NFHS-4)

Never	Told someone	Sought help from any source
76.6	9.1	14.3

Table 6.5. Type of violence and help sought from Doctor, all India (NFH-4)

Physical	Sexual	Both	Total
0.6	0	2.8	1.3

Source: Computed from unit data, NFHS-4 (2015-16)

Table 6.6 Married women & Young women experiencing Physical and Sexual violence, NFHS -5

Category	NFHS-5		NFHS-5 Total	NFHS-4
	Rural	Urban		
Married women age 18-49 yrs who have experienced spousal violence (includes physical and sexual violence) (%)	21	28.6	25.2	21.3
Married women age 18-49 yrs who have experienced physical violence during pregnancy (%)	2.5	4	3.3	2.9
Young women age 18-29 yrs who experienced sexual violence by age 18 (%)	4.5	7.6	6.2	2.9

Source: NFHS-5 (2019-20) Fact Sheet, Phase-1, 2020.

[12] Dilaasa is a hospital-based crises centre that has demonstrated a comprehensive health system response model to address all forms of violence against women. This model is now being replicated in several states in India.

Further, as per NFHS-5 (2019-20) for Maharashtra, the figures for all violence have registered an increase, with urban women reporting higher than rural women. This data calls for our attention. As mentioned in Chapter – 1, the role of the health care provider is vital in recognising physical and sexual violence among married women, documenting the same, and complying with the mandatory provisions of the DV Act. In response to the statements on the DV related guidelines, 75% doctors agreed that they are mandated to fill a detailed information report (DIR), 88% understand that the DIR has to be sent to the Protection Officer in-charge for DV cases within 3 working days.

6.6 All statements at a glance

The aforementioned aspects are some of the most significant ones of the post-Nirbhaya reforms for they reflect the paradigm shift in the manner sexual violence is conceived; the obligations of the health care system in caring for survivors underpinned; and approach to collecting evidence towards enhancing conviction rates. The divide shows that the deficit of appropriate perspective as reflected in the legal reforms is considerable to the scale of about 30 to 40 percent of the participants.

The data on the 21 aspects covered in the study are presented in Tables 6.7 a & b. These tables highlight the percentage of providers whose views align with the perspectives reflected in the current legal framework. It is interesting and encouraging to know that all the providers acknowledge that survivors when seek care either from public or private health care facility should be provided with psycho-social care. Between 90 to 99 percent of doctors supported that in case of child survivor, child's parents/guardian/person whom she trusts should be present during the medical examination (97.4%); supported the idea that both private and public health care facilities should provide treatment to survivors free of cost (90.8%); and disagreed that presence of injuries to the survivor is necessary to arrive at an opinion that a woman has been raped. About 87 percent of the doctors disagree with the idea that medical examination of survivors can be done without their consent.

Overall, there is surely a cause of concern due to the considerable percentage of doctors' views on key aspects of reforms do not align with the current progressive thinking on response and investigations into sexual violence case and various norms to be complied with during the medical examination at health care facilities.

Table 6.7a: Health care providers' perspectives in relation to obligations of health care system and providers to survivors of sexual violence

Sl. No.	**Statements based on Legal stipulations**	**(Yes/No) or Agree/Disagree**	**(N=76)**
	Medico-legal procedural matters		
1	Medical examination of the survivor of sexual violence does not require police requisition.	Agree	63
		Disagree	37
		Partially Agree	0
2	Health care facility both private and public has to provide treatment to survivors free of cost.	Agree	91
		Disagree	5
		Partially Agree	3
3	It is mandatory for doctors/hospitals to inform police about a woman examined for sexual violence.	Agree	84
		Disagree	15
		Partially Agree	1

4	A copy of DIR ought to be sent to the Protection Officer within 3 working days.	Agree	88
		Disagree	7
		Partially Agree	5
5	It is legally binding for examining doctors to provide provisional opinion with adequate reasoning	Agree	82
		Disagree	17
		Partially Agree	1
6	In case of children, it is mandatory that the child's parents/guardian/person whom she trusts are present during the medical examination	Agree	98
		Disagree	1
		Partially Agree	1
7	DNA examination in Sexual violence is relevant and considered crucial comparable evidence.	Agree	78
		Disagree	17
		Partially Agree	4
		Do not know	1
8	Potency test of the accused is not relevant and not necessary.	Agree	70
		Disagree	30
		Partially Agree	0
	Sensitive Medical Care		
9	The aggrieved woman must receive psychological support as part of the therapeutic care.	Agree	100
		Disagree	0
		Partially Agree	0
10	The survivor of SV should be given emergency contraceptives	Agree	92
		Disagree	2
		Partially Agree	6
11	It is not mandatory for Medical Officer to hand over the information and referral pamphlet to the woman.	Agree	21
		Disagree	79

Table 6.7b: Health care providers' perspectives in relation to obligations of health care system and providers to survivors of sexual violence

	Incorrect statements	Agree/Disagree	%
1	Medical examination can be done without survivor's consent.	Agree	12
		Disagree	87
		Partially Agree	1
2	Presence of injuries to the survivor is necessary to arrive at an opinion that a woman has been raped.	Agree	10
		Disagree	90
3	Documentation of sexual activities prior to SV are required as part of medico-legal evidence	Agree	54
		Disagree	46
4	Examining doctors should provide an opinion about the case only after the reports from FSL arrive.	Agree	58
		Disagree	39
		Partially Agree	3
5	Medical opinion in the current context of various legal reforms is the only evidence.	Agree	32
		Disagree	67
		Partially Agree	1

6	It is not needed to give HIV prophylaxis to survivors of SV	Agree	25
		Disagree	69
		Partially Agree	6
7	It is not necessary to give a copy of DIR to the woman.	Agree	25
		Disagree	73
		Partially Agree	2
8	Training of the staff in DV related matters at the hospital is not the responsibility of the hospital.	Agree	18
		Disagree	82

6.7 Nurses and outreach health workers

As said earlier, for nurses and outreach health workers—ANMS and ASHAs—we covered only five aspects (Table 5.4) as opposed to 22 as we did with doctors. We did so because the roles and responsibilities of nurses are limited, whereas those of outreach health workers are not spelt out in the Guidelines. We included outreach health workers with our understanding that they could play a significant role in aiding survivors' access to health care. These outreach health care workers may serve as the first point of contact. This will be discussed in-depth later in the 'discussion' session. We administered this segment of the tool in the same manner as described above in the case of doctors.

The responses of both nurses and outreach health workers were divided when asked if medical examination of the survivor of sexual violence should require police requisition or not. For example, 47 percent of nurses and 66 percent of outreach health care workers held the view that the medical examination of the survivor should not require police requisition. This aligns with the current legal framework. One of the reasons for such divided opinion might be due to the technical nature of this aspect. All outreach health workers and about 98 percent of nurses opined that both private and public health care facilities should provide free of cost treatment to survivors. A large percent of the Nurses, ANMs and ASHAs felt that an adult has to be present when a child victim is being examined and that survivors of sexual violence have to be given psychological support. The nurses, ANMs and ASHAs are keen that their hospitals provide training opportunities for them to know the changes in the sexual violence laws and perform their roles better.

Table 6.8: Knowledge of Health care providers (nurses, and ANMs and ASHAs) about legal reforms in relation to obligations of health care system and providers to survivors of sexual and domestic violence

		Agree/Disagree	Nurses	ANMs & ASHAs
1.	Medical examination of the survivor of sexual violence does not require police requisition.	Agree	22 (46.80)	17 (65.38)
		Disagree	24 (51.06)	9 (34.61)
		Total	**47 (100)**	**26(100)**
2.	It is mandatory for health care facility both private and public to provide treatment to survivors free of cost.	Agree	46 (97.87)	26 (100)
		Disagree	1 (2.12)	0 (0)
		Total	**47 (100)**	**26(100)**
3.	In case of children, it is mandatory that the child's parents or guardian or any other person whom she trusts are present during the medical examination.	Agree	46 (97.87)	24 (92.30)
		Disagree	1 (2.12)	2 (7.69)
		Total	**47 (100)**	**26(100)**

4.	Training of the staff in DV related matters including the PWDV Act 2005 at the hospital is not the responsibility of the hospital.	Agree	8 (17.02)	5 (19.23)
		Disagree	39 (82.98)	21 (80.77)
		Total	**47 (100)**	**26(100)**
5.	The aggrieved woman must receive psychological support as part of the therapeutic care.	Agree	47 (100)	26 (100)
		Disagree	0 (0)	0 (0)
		Total	**47 (100)**	**26(100)**

6.8 Discussion

Bandewar and colleagues (2018) noted, drawing upon a report by the Center for International Private Enterprise (CIPE) (2012), that the problem of implementation gaps, in other words, the shortfall between the government's legislative commitment to addressing a particular issue and the translation of that commitment into concrete measures, is a global concern across the sectors.

Bandewar and colleagues (nd) demonstrated that the CLA 2013 and the Guidelines were the outcome of the long-standing sustained engagement of women's movement in India with the issue of GBV. Legal and policy reforms need to be complemented by robust implementation plans and necessary resource allocation to ensure that the benefits of the reforms reach the constituencies which are central to concerned reforms. There could be wide-ranging facets of implementation aspects depending upon the particularities of the reforms.

This analysis is located in the discourse on implementation gaps in legal and policy reforms. Implementation gaps could lead even robust reforms to maintain the status quo of policy deficit, the very reason that led to these reforms.

Chapter – 7 Training of health care providers (Pune)

Deep engagement with various stakeholders and constituencies is one of the central aspects of reforms and new policies as the community and the population forms the backbone of effective implementation especially in meeting the goals and objectives. In other words, engagement with the community inspires and shapes new policies and/or reforms or revisions to older policies. In any ethical discourse of policy implementation and gaps, the obligation of the capacity building of the various constituencies with respect to the content of newer or revised policies and reforms squarely rests with the government and its administrative instrument.

In the context of this research initiative, the key stakeholders with whom we interacted are doctors, nurses, and outreach health workers - ANMs and ASHAs. The obligation of the government would be to equip the health care system for responding to survivors of sexual violence in compliance with legal reforms. We approached our exploration in this domain by simply posing questions to study participants – doctors, nurses, and outreach health workers. We explored various facets of capacity building. These include training opportunities if they have had in the past; if they did, the extent to which they found it useful; their interest in participating in training programmes in the future if they were offered; their preference for the duration and place of the training; and their expectations about the content of the training.

Below we present the findings for three key constituencies – doctors, nurses, and outreach health workers – in three sub-sections.

7.1 Doctors

Of the total 76 doctors we interacted with, about 79 percent, which is 60 out of 76 doctors, reported that they never had an opportunity to undergo training or orientation programmes concerning post-Nirbhaya reforms, the Guidelines, and any PWDA 2005-related matters. Just about 13 doctors reported that they either had undergone training in all these or only matters relating to post-Nirbhaya reforms. Of those 13 who have had an opportunity to undergone training, ten of them reported that they found it useful, and three reported that it was only moderately useful.

> *"It was useful as before the training, they (those who participated in training) were not aware about the protocols of examination and treatment. But after (having undergone) training they are following it (the protocol) well. … ."* (Woman doctor, Sub-district HCF, Rural)

We also came across a facility where the overall ethos was more patient-friendly. Research participants from this HCF also reported that they have had an opportunity to go through one-day training workshop on reforms. Response from one of the doctors at this HCF about whether the training was useful in their practice indicated that indeed such training would make a difference. (Box 7.1)

Box 4 **: Training to Improve Medical Evidence Gathering**

"We did undergo a day long workshop which had many shortcomings. Meaning, many things were not clear to us. But those that we were clear about have been very helpful. For example, after the training, we knew what and how to respond to police (machinery) assertively, if they asked for things which were not correct as per the manual (copy of the Guidelines received during the training). Generally, police used to give us questionnaire for us to fill if we provided care to a survivor. The questions in this questionnaire were not appropriate as per the manual. For example, police questionnaire had a question: 'If the survivor was habituated to sex? Does this have any meaning to ask survivors? We came to know due to training that these were meaningless questions. Because this manual copy with us, we could also show it as an evidence to police if we did not agree with them and their demands of providing information on such meaningless questions. … I also feel surprised that even advocates in session courts are not aware of these things…. Then, (*due to this training*) we also got to know that sample collection from the survivor 72 hours after the incidence is of no use and therefore in such situation sample should not be collected. If police insists to do so, we can tell them that it is incorrect and against the protocol.".
(Male doctor, Sub-District HCF, Rural).

However, about 83 percent of the doctors, i.e. 63 out of 76 doctors, expressed their interest in undergoing relevant training in matters relating to both sexual and domestic violence against women. Majority, about 62 percent (47 out of 76) of the doctors preferred to undergo training for duration for up to 1-4 days. One of the doctors mentioned that it is not just about them making choices as an HCP but also about their respective seniors' decisions and willingness to agree with it. Most of the doctors, around 71 percentage (54 of 76), mentioned that district headquarters would be a preferred place for any proposed training.

There was a sentiment amongst a few doctors who undergo such training which implied that there would be an increased work after participating in a training especially in caring for survivors.

> *"It is not about attending a training, but after the training, we have to file the MLCs, our responsibilities will increase…."*. (Woman doctor, PMC run HCF, Urban)

A couple of others expressed a sense of commitment and also acknowledged that it is their responsibility to be equipped so that they can respond appropriately to survivors. For example, one doctor mentioned:

> *"Yes (I would like to undergo such training), there is no liking - disliking, if knowledge is imparted, we should take it."* (Woman doctor, PCMC run HCF, Urban).

A couple of others also qualified their affirmative response to their willingness to undergo such training by bringing forth the point regarding the current situation of the overall overcrowded public health care facilities. They reported that, in such a situation, to be able to provide specialised care to survivors implies having to make other patients wait for longer duration than usual. Therefore, they

proposed that while undergoing training would be useful, it is desirable and useful to have separate personnel to deal with sexual violence cases and the survivors.

> *"I will like to take training but a special counsellor needs to be designated for this work. We examine 10 patients in 10 minutes. So, in order to talk patiently and calmly with the patient, understand their problem there needs to be a separate person - a counsellor. We cannot do all this, there is a long que of patients waiting outside for us (to see them)…"* (Woman doctor, PMC run HCF, Urban)

> *"…and for that (to be able to respond to survivors) a specialist needs to be present."*. (Woman doctor, PMC run HCF, Urban)

Although responses indicating interest in getting trained, were only a few and rather cryptic, these shed some light on their perceptions about capacity building in responding to survivors. To some extent, it also vindicates the fact that since generally, they are not very aware of these reforms, they are unclear if they require something additional from such training, going beyond what they learn during the undergraduate studies in medicine.

> *"We are trained properly during MBBS so we do not feel the need of any training, so if there is any different kind of training and if municipal corporation agrees I am ready to undergo training."*. (Woman doctor, PMC run HCF, Urban)

7.1.1 Content of the trainings

Further, we explored what would they like to include in the proposed training programmes. Barring a few, most doctors did not offer us any details regarding what they might like trainers to coverin these workshops. One of the reasons for the sparse response could be the fact that there were just a few service providers who were aware of these reforms.

> *"Way of treating these cases, what all needs to be done while filing an MLC (medico-legal case)…the training should cover these points."*. (Woman doctor; PCMC run HCF, Urban).

Another doctor mentioned the need to include a component on counselling skills.

> *"They should teach how to counsel the patient, we need to create our own security, school going children of age 12 - 19 should be counselled."*. (Woman doctor, PCMC run HCF, Urban).

> *"The aspects such as counselling and awareness are the things she would like to know through the training. Generally (speaking), we as doctors don't realise about the trauma that has happened to the victim. We treat her just like a routine case. But counselling is very much important in these cases."*. (Woman doctor, Sub-district HCF, Rural)

Box 5 **Suggestions for Training**

"Yes, we would like to know more about say legal procedures involved *(in responding to survivors of sexual violence).* We do not know many legal matters. (Also), how to conduct examination – we don't know the details of these procedures. For example, we decide which swabs are to be collected in a particular case of sexual violence. This we do based on our own experiences (*in our practice*). Instead, if there is an universal protocol stating which swabs for which type of case then it will be very very helpful for us. It becomes easier. …

…Also, how to maintain various forms and records we fill in will also be helpful. We now know (*from the earlier training that we participated in*) what these forms are.

Will also like to know about how to providing counseling to survivors. Generally, what happens, government does feel that counsellors should be available. But (*such*) posts don't get sanctioned. (*In the meanwhile*) we keep getting patients. In such situations it is better that we are somewhat ready (*to respond to them*). …

…Yes, and I would also like to learn about what came out after 2013 (*CLA 2013*). In that sense we got to read quite a lot about it but haven't understood it that well. Trainers told us plenty, amendments and all. But it hasn't been that much clear to us. Will like to learn about it more. ….

… Also, I don't think lecture mode training is good enough. As such, lectures based training gets boring for participants. They don't come for trainings if they come to know that it is lecture based. Group discussions, and face-to-face two-way communications are required. What happens in (*most*) trainings is lunch and lecture and finished. Training is meaningful if it is how we are conversing now. Else, it is bookish, and there is not time for asking doubts etc. …"

(Male doctor, Sub-District HCF, Rural).

One doctor explained the rationale behind her view about including nurses and outreach health workers in such training.

> *"…This training should be imparted to doctors and nurses. The outreach staff of the hospital should also be trained because they are the one who do field visits so they can give information to people also they can create awareness among the community to prevent such incidents. Creating awareness only among women is not sufficient, men also need to be made aware. …"*. (Woman doctor, PCMC run HCF, Urban).

> *"… The entire staff in the hospital needs to be trained and everyone should be aware of their role."*. (Woman doctor, PCMC run HCF, Urban)

Yet another doctor mentioned the need to include in such training, information about shelter homes and related matters so that survivors could be provided such support, if necessary, when they visit the HCFs.

> *"As said elsewhere, no contact with shelter/protection homes. We don't have system in place of contacts through which we provide her proper support."*.(Male doctor, PCMC run HCF, Urban).

A few others mentioned more generally that such trainings should cover social and legal matters relating to these reforms; and that generally it ought to help them "upgrade" their knowledge on this front. One of the doctors explicitly made reference to survivors of DV and said that training should cover all aspects of care provision such as physical, mental, social, and legal aspects.

> *"Social and legal information, role of police - this needs to be included in the training. …"*. (Woman doctor, PCMC run HCF, Urban)

A doctor who had some experience in caring for survivors articulated his expectations about the content of future training programmes on this topic (Box 7.2). This particular response indicates that some doctors feel the need to get everyone trained in these matters because currently, recruiting specialized health care providers is not easy. According to him, waiting for a newer post to be created and filled, simply implies that he would not be able to respond to survivors and therefore expressed deep interest in getting himself trained and opined that doctors ought to train themselves in these matters.

We also explored if HCFs had any training organised for their staff to create awareness amongst the HCF staff about DV as per the PWDV Act, 2005. To this, 70 doctors out of 76 responded negatively. And none had ever participated in meetings invited by the protection officer in their area.

7.2 Nurses

The majority of the nurses, 91 percent (43 of 47), with whom we interacted never had any opportunities to attend training or orientation relating to either SV related reforms or DV related matters. Four nurses had said they had such opportunities in the past and that they found the training useful. Nurses were also asked about the content of such training, duration, and place of training.

7.2.1 Content in future trainings

Nurses, who responded to the question on the possible content for a future training, referred to the aspects such as definition of sexual and domestic violence, their role and how is it different from what police do, the laws concerning SV and DV, counselling care and supportive communication with survivors, how to maintain records, for how long to maintain records, specific clauses that refer to the roles of HCFs in provisions of care, about SAFE kit, any relevant government schemes, and when to refer the cases to other health care facilities.

> *"SV rules (rules about medical examination) have changed a lot now. Many don't know about these (changes). We should also know about POCSO. We need to know about what all kinds of examinations should be undertaken, hours within which the sample should be sent to forensic laboratory, and all of these. We need to have a right to know about these."*. (Woman nurse, Sister-in-charge, PCMC run HCF, Urban).

> *"Social, legal and counselling related (aspects need to be covered in training)."*. (Woman nurse, PMC run HCF, Urban).

> *"We should know what protections law offers to survivors of both domestic and sexual violence so that we can help them out… We should also know as to which places they can seek help from."*. (Woman nurse, State run HCF, Rural)

One of the nurses underscored the need for training in counselling like many others said so. However, she also offered us her rationale behind it:

> *"Counselling care is very important in such cases. Survivor needs to be told about the importance of examination. And she should also be (made to be) strong to fight the case. Many a times people don't want to file case with police as it is considered a nuisance."*. (Woman Staff nurse, District Hospital, Urban)

Two nurses, in a joint interview, expressed the need to organize a "live" training. We feel that they are inspired by their experiences from prior training programmes in medical and nursing colleges where they get to observe real-life engagement between patients and health care providers. These include bed-side learning opportunities to observe and/or assist health care providers during procedures.

> *"We would like to undergo "live" training. We shall observe by standing by side and won't intervene or talk or ask questions then. ... It should also contain information about legal aspects. ... How to talk to survivors, and to understand reasons for sexual violence (we would like to learn). ... ".* (Women nurses, Staff nurses, Gen nursing, PMC run HCF, Urban)

One of the nurses mentioned that nurses at the PHC level should be trained because it is easier for survivors to approach PHCs in the vicinity rather than travel all the way to tertiary hospital in Pune. People also feel rather daunted to visit these hospitals because they are too big and it is challenging for patients to navigate through such big establishments.

A few nurses mentioned that such training should also cover information about entities/organisations which extend legal aid and whom we can approach when there is a need. Some others mentioned that it would be helpful to know organisations which provide shelter to such women affected by violence.

Some of the nurses explicitly mentioned that such training should be organised for all the staff. In explaining the rationale behind why they consider it is important to do so, they say:

> *"Such training should be done for all the staff. And each staff should know roles of each other."*. (Woman nurse, PCMC run HCF, Urban)

> *"Such training should be organised for all staff include Class IV staff. They have different mentality. They tend to speak rashly with patients, which is not good. So, training should also cover these aspects."*. (Woman nurse, PCMC run HCF, Urban).

7.2.2 Duration of trainings and the place for trainings

Most nurses, about 70 percent (33 out of 47), said that they would prefer training for any duration between one and five days. The general sentiment was that due to inadequate human resources at the HCF where they are working, they could not be away for long periods. Some felt that it could also be done at their HCFs in the form of short sessions at a time and spread over a longer period so that the work doesn't suffer.

"Trainings can take place here only and while we are on duty. So that our work also doesn't come to a halt. Due to staff shortage here, we won't be able to participate if it (training) is organised elsewhere. It should also be conducted department- wise.".
(Woman nurse, PCMC run HCF, Urban).

Responses also reflected that the nurses could participate in training if organised at places that are convenient in terms of transportation and connectivity.

"Training should be organised at a centrally located place – within 5-10 km of distance (from here). And it should have bus connectivity." (Woman nurse, PCMC run HCF, Urban)

There was also a sentiment that participation in such training needs to be on the basis of deputation rather than having to use their ear-marked leaves/holidays.

7.3 ANMs and ASHAs

Eight out of 26 ANMs and ASHAs reported that they had had training opportunities in the past. Except one 'no response', all the other 25 ANMs and ASHAs indicated their interest in such a training in future if they were provided with such an opportunity.

Outreach health workers who responded to the question on preferrable content of for training specifically for ANMs and ASHAs, referred to various aspects such as what care should be provided to survivors and how should it be provided, legal dimensions, social organisations which provide help to survivors, woman empowerment-related matters, counselling care, information about child sexual abuse and how to care for them, and their specific role in providing care to survivors.

Conclusion

In this chapter, we discussed the status of training and orientation, one of the key components in the implementation of legal and policy reforms in the healthcare system. Health care providers—doctors, nurses, ANMs and ASHAs—are the key constituencies for the health care service provision to survivors of violence. They, in turn, facilitate justice delivery by ensuring quality forensic evidence collection. Findings demonstrate colossal gaps in capacity building efforts on part of the government, and state administration. This is particularly concerning given the fact that it had been about more than five years at the time of data collection since the post-Nirbhaya reforms happened. However, the findings are encouraging since many health care providers from across the categories expressed their interest in training and orientation initiatives if they are offered such opportunities. Some who have had opportunities in participating in some training initiatives found it useful and some thought that it does make a difference to the services they provide to survivors. Overall, the findings suggest that creating opportunities for training and orientation is urgently needed given its direct relevance to quality of care services provided to survivors of violence.

Chapter 8: Health System Preparedness: Infrastructure & Human Resources (Karimnagar)

This chapter attempts to gauge the preparedness of Indian Health System by critically examining the infrastructure available in Primary and secondary healthcare centres in Telangana especially in responding to sexual violence. With a brief description of the structure of the health system at the district level, this chapter studies aspects such as X-ray room, laboratory facilities, electricity connection and drinking water supply. In addition, this chapter examines treatment of survivors of sexual violence, especially in the medico-legal procedures, in the hospitals.

This chapter looks at two kinds of health care facilities: (1) Primary Health Centres where no such forensic examination and separate treatment take place currently and (2) Community Health Centres (CHCs) where survivors of sexual assault are examined and treated.

8.1 Details of HCFs Sampled

8.1.1 Primary Facilities

All of the primary facilities in the sample have at least 2 beds. Three PHCs are functional 24x7. Five PHCs have female doctors available at all times. All of the sampled PHCs are functioning out of government buildings that were completely functional at the time of fieldwork. None of the PHCs maintained medico-legal registers, nor had they conducted examinations in any medico-legal case. Also, none of the primary facilities had admitted or treated any survivors of sexual violence who had reported their violence at the PHC.

Table 8.1: Description of Facilities in Sampled PHCs

	PHC 1	PHC 2	PHC 3	PHC 4	PHC 5	PHC 6	PHC 7
Type of Institution	Primary Health Facility	Primary Health Facility	Primary Health Facility	Primary Health Facility	Primary Health Facility	Primary Health Facility	Primary Health Facility
No. of Beds	0 -2	0 -2	0 -2	0 -2	0 -2	0 -2	0 -2
24 x 7	No	Yes	No	Yes	Yes	No	No
Women Doctors Available	Yes	Yes	Yes	Yes	Yes	No	No
MLC Register Available	No	No	No	No	No	No	No
Sexual Assault Cases Addressed	No	No	No	No	No	No	No

8.1.2 Secondary Facilities

The district has three secondary hospitals, all of which were chosen for the study. Table 8.2 (Details of CHCs) describes the three CHCs sampled. They are all secondary hospitals with the required capacity of 30 beds, but only two of them fulfil this criterion. The third CHC sampled had, at the time of fieldwork, recently been upgraded from an Urban Primary Health Centre (UPHC) to a CHC, and

was in the process of receiving the required the staff and facilities. Only 2 of the 3 hospitals had been maintaining Medico-Legal registers. Police see them as a point of contact for survivors of sexual assault. In spite of maintaining medico-legal registers, at the time of fieldwork, only 2 of 3 secondary facilities were examining survivors of assault.

Table 8.2: Description of Facilities in CHCs

	CHC 1	CHC 2	CHC 3
Type of Institution	Secondary	Secondary	Secondary
No. of Beds	30	30	12
Specialisations Available	Surgery, Paediatrics, Anesthetist, Gynecologist (Temporary)	Surgery, Paediatrics, Anesthetist, Gynecology, Dentist	None
Women Doctors Available	Yes	Yes	Yes
MLC Register Available	Yes	Yes	No
Sexual Assault Cases Addressed	Yes	Yes	No

The Guidelines and the Criminal Law (Amendment) Act 2014 mandate all public hospitals and registered medical practitioners to respond to survivors of sexual assault however not all of them are prepared for it. The three key parameters by which the preparedness of these health care facilities to address sexual assault are assessed in this section – the availability of adequate and relevant staff in the HCF; the building and essential infrastructure available; and the preparedness of the facility to examine, diagnose and treat survivors of sexual violence in particular.

8.2 Availability of Essential Facilities in PHCs and CHCs

All of the sampled PHCs had functional water supply, refrigerators, and ambulance service available at all times. However, none of them had continuous electricity, and only have back up generators or inverters available only to function certain rooms and not the entire facility. Six of the PHCs had working landline telephones available at their facilities. Secondary facilities in the district are mandated to be 30-bedded hospitals, with specialists, whereas primary facilities whether 24/7 or only for limited hours have 6 beds and no specialist doctors. All three secondary facilities have continuous water supply and toilets that are moderately clean and available for patients. While they have interrupted electricity supply, they are equipped with back up support for select rooms (not the entire facility) only. CHC 3 falls short of its mandated bed requirement. However, a new building was being constructed at the time of fieldwork to accommodate the upgradation of the hospital.

8.3 Availability of Staff in PHCs and CHCs

In primary facilities, all doctors' posts are filled similar to the data from Telangana state's public health system staffing. In secondary facilities, MBBS doctors' posts have all been filled, but many of the specialists' posts, especially that of gynaecologist and paediatrician have been sanctioned but remain vacant. There were no gynaecologists available on a permanent basis in 2 of 3 CHCs, and no

paediatricians available in 2 of 3 CHCs. Both the primary and secondary facilities have staff nurses' positions filled. In 3 cases, however, they have been deputed to other HCFs in the district, leaving those positions in the surveyed facility empty, even though on paper these positions are filled. Lab technicians are available in 2 of the secondary facilities and 6 of the primary facilities. While all the secondary facilities have X-Ray machines available, none of them have operators. 8 ANM positions were vacant in the sampled PHCs at the time of fieldwork.

8.4 Preparedness of the HCF to Respond to Survivors

This section considers **only secondary facilities** in its analysis, since none of the primary facilities reported intake of any survivors of sexual violence in the past.

8.4.1 Essential Equipment for Sensitive Treatment and Evidence Documentation of Survivors

Table 8.2 describes the facilities available in secondary HCFs in the district for examination, diagnosis, and treatment of survivors. Standard equipment that is required in all HCFs for any medical care is present in the study sample of secondary and primary HCFs. They are also used in the treatment and examination of survivors. These include:

- Sterile cotton swabs and swab guards for biological evidence collection
- Vaginal speculums
- Urine pregnancy test kid
- Surgilube
- Toluidine blue dye
- 1% acetic acid diluted spray
- Good torch/Woods lamp
- Colposcope/magnifying glass
- Distilled water
- Tubes/vials/vaccutainers for blood samples
- Syringes and needle for drawing blood
- Urine sample container
- Microscope
- Glass slides
- Small scissors
- Disposable gloves
- Labels
- Patient gown

8.4.2 Infrastructure Gaps

As seen in Table 8.3, some essential facilities required for responding to survivors of sexual assault are not available in either of the secondary facilities where survivors are treated. Both of them use the labour room for conducting examinations. Neither of the secondary facilities has a set of spare clothing or other equipment required for systematic evidence collection and documentation (list provided below).

This essential equipment indicates basic preparedness on part of the HCF to examine survivors. In order to meet the minimum standard of care as prescribed by the World Health Organization and the MoHFW Guidelines, HCFs need to go beyond just stocking and using standard medical supplies and equipment as necessary for other treatment and examination. Simple availability of medical equipment in HCFs generally does not necessarily imply preparedness. Preparedness to respond to survivors of sexual assault implies a shift in the 'standard' availability of equipment, infrastructure, and care. On the one hand, while some equipment needs to be added (often minimal in cost, acknowledging the trauma and suffering experienced by the survivor), infrastructure created and staff trained; on the other, preparedness implies reorganizing of the existing equipment and infrastructure towards timely, quick, and sensitive response. It further entails a shift in the attitudes of healthcare professionals towards standardized and systematic care. However, these are not adequate to ensure a timely and sensitive response.

Table 8.3: Status of premises and infrastructure

Building	**Categories**	**Counts**
Designated govt Building	Yes	10
	No	0
Present observed state of the building	Building in good condition	8
	Adequate space/rooms/ facilities	2
	Clubbed categories	0
Present observed state of the premisis	Quite clean	7
	Somewhat dirty	3
	Very dirty	0
Bed capacity	5-10 beds	8
	25-50 beds	2
	100 or more beds	0
Number of wards	0-2 wards	8
	2-5 wards	2
	5-10 wards	0
	10 or more wards	**10**
Separate wards for women	Yes	0
	No	10
Waiting room with seating arrangement	Yes	9
	No	1
Sheltered waiting area	Yes	10
	No	0
Separate room for SV examination	Yes	0
	No	2

	NA	8
AV Privacy in the SV examination room (Labour Room)	Yes	0
	No	0
	NA	10
Availability of room for 24 hrs	Yes	0
	No	2
	NA	8
Facility to lock the room	Yes	2
	No	0
	NA	8
Adequate light	Yes	1
	No	1
	NA	8
Working angle lamp in the room	Yes	2
	No	0
	NA	8
One or more toilets in the facility	Yes	10
	No	0
Cleanliness of the toilets	Yes	6
	No	4
Availability of water in the toilets	Yes	10
	No	0
Cleanliness of the bed linen	Yes	10
	No	0
Changing the linen after each SV examination	Yes	2
	No	0
	NA	8

8.4.3 Facilities for Diagnosis and Treatment

None of the facilities fulfil the basic requirements prescribed by the Guidelines for sensitive treatment of survivors. They do not have diagnostic tests for Sexual or Reproductive Tract Infections, no technicians to operate X-Ray Machines, and no Counsellors available on their premises. However, they regularly conduct blood tests and a lab technician is available for any other diagnostic tests required.

Table 8.4 Facilities for Diagnosis and Treatment in CHCs

CHC 1	CHC 2	CHC 3
Diagnostic tests for STI/RTI not provided	Diagnostic tests for STI/RTI not provided	Diagnostic tests for STI/RTI not provided
X-Ray available, but no technician	No X-Ray	X-Ray available, but no technician
Counselling not provided	Counselling not provided	Counselling not provided
Surgeries conducted – C Sections	Surgeries conducted - C Sections	Only minor surgeries
Blood tests regularly conducted; storage facility and lab technician available	Blood tests regularly conducted; storage facility and lab technician available	Blood tests regularly conducted; storage facility and lab technician available

8.4.4 Facilities for Evidence Collection

The HCFs are underprepared to swiftly and systematically collect evidence from survivors of sexual violence. They do not have SAFE kits as prescribed by the MoHFW Guidelines. They do not have spare clothing available for the survivor to change into, upon arriving at the hospital. Amongst other items not present in any of the facilities are:

- Large sheet of paper for the survivor to undress over
- Paper bags for clothing collection
- Catchment paper
- Comb
- Nail Cutter
- Wooden stick for finger nail scrapings
- Envelopes or boxes for individual evidence samples
- Lac, sealing stick for sealing the envelopes
- Clean clothing and bathing items for the survivor to use after the examination
- Drying rack for wet swabs and/or clothing
- Separate wards for women are only available in CHC 1.
- In lieu of separate rooms or examination areas for survivors available in any of the facilities, in CHC 1 and 2, the labour room is used for examinations.

Table 8.5: Requirements of Examination of Survivors of Sexual Violence in Primary and Secondary Facilities

Infrastructure	Primary	Secondary
	N=7	**N=3**
Separate room for examination	NA	3
Lockable door	NA	3
Partition for privacy	NA	3
Consent forms	NA	0
Examination table with lithotomy position	NA	3
Examination table without lithotomy position	NA	3
Gown for examination	NA	3
Spare clothing	NA	0
Facility for washing hands with soap	NA	3
Facility for having bath	NA	3
Table & Chairs for documenting and labelling the evidences	NA	3
Doctor positioned right of the patient	NA	3

Table 8.6 Requirements for examination of survivors of sexual violence in secondary facilities

Equipments	Karimnagar (N=3)
SAFE kit	0
Forms For Documentation	0
Large sheet of paper to undress over	0
Paperbags for clothing collection	0
Catchment paper	0
Cotton swabs and swab guards	3
Comb	0
Nailcutter	0
Woodenstick for finger nail scrappings	0
Small scissors	3
Urine sample container	3
EDTA Tubes	3
Syringes and needles for drawing blood	3
Distilled water	3
Disposable gloves	3
Glass slides	3
Envelopes or boxes for evidence samples	0
Lables	0
Lac(sealing wax) Stick for sealing	0
Clean clothing	0
Woods lamp/Good torch	3
Vaginal Speculums	3
Drying rack for wet swabs/clothing	0
Patient gown, coversheet, blanket, pillow	3
Post-It notes to collect trace evidences	0

Camera (35mm Digital)	0
Microscope	3
Colposcope/Magnifying glass	3
Toludine blue dye	3
1% Acetic Acid diluted spray	3
Urine Pregnancy test kit	3
Surgilube	3
Medications	3
Double oxalate bulb for drug/alcohol assessment	0
Sanitary Napkins	0
Sharp containers (to dispose off needles and sharp objects	3

Table 8.7 Availability of Diagnostics and treatment in Primary and Secondary Facilities (A)

Diagnostic test and treatment	Categories	Karimnagar	
		Primary	Secondary
Diagnostic tests for STI/RTI	Available	7	0
	Provided elsewhere	0	0
	Not Provided	0	3
HIV Rapid test	Available	7	3
	Provided elsewhere	0	0
	Not Provided	0	0
Pregnancy test	Available	7	3
	Provided elsewhere	0	0
	Not Provided	0	0
Ultrasound for pregnancy/ internal injury	Available	2	3
	Provided elsewhere	0	0
	Not Provided	5	0
X-ray for injury	Available	0	3
	Provided elsewhere	0	0
	Not Provided	7	0
STI Prevention treatment	Available	4	0
	Provided elsewhere	1	3
	Not Provided	2	0
Emergency Contraception	Available	5	3
	Provided elsewhere	1	0
	Not Provided	1	0
Wound treatment	Available	7	3
	Provided elsewhere	0	0
	Not Provided	0	0
Tetanus Prophylaxis	Available	5	3
	Provided elsewhere	0	0
	Not Provided	2	0
Hepatitis B vaccination	Available	7	3
	Provided elsewhere	0	0
	Not Provided	0	0
Post exposure Prophylaxis for HIV	Available	1	0
	Provided elsewhere	4	0
	Not Provided	2	3
Counseling	Available	0	0
	Provided elsewhere	0	0
	Not Provided	7	3

Table 8.8 Availability of Diagnostics and treatment in Primary and Secondary Facilities (B)

Facilities	Categories	Karimnagar	
		Primary	Secondary
Services for which patient has to pay	Purchase of drugs	0	0
	Purchase of cotton and syringes	0	0
	Diagnosis tests	0	0
	Transport	0	0
	None of the Above	7	3
Surgeries carried out	Always	0	2
	Sometimes	5	0
	Never	2	1
Minor Surgeries	Always	0	2
	Sometimes	5	1
	Never	2	0
Major Surgeries	Always	0	0
	Sometimes	0	2
	Never	7	1
X-ray Facility	Always	0	0
	Sometimes	0	2
	Never	7	1
Blood tests	Always	7	3
	Sometimes	0	0
	Never	0	0
System to safeguard the collected samples	Always	1	2
	Sometimes	0	0
	Never	6	1

Table 8.9 Sanctioned and Filled Availability of Staff in Primary Facilities (A)

	Civil Surgeons		**Head of Facility**		**Sister-in-Charge**		**Staff Nurses**	
	Sanctioned	Filled	Sanctioned	Filled	Sanctioned	Filled	Sanctioned	Filled
PHC 1	0	0	1	1	1	1	1	0
PHC 2	0	0	1	1	1	1	3	3
PHC 3	0	0	1	1	1	1	1	1
PHC 4	2	1	1	1	3	1	3	1
PHC 5	1	1	1	1	1	1	3	3
PHC 6	0	0	1	1	1	1	1	1
PHC 7	0	0	2	2	1	0	1	1
	3	2	8	8	9	6	13	10

Table 8.10 Sanctioned and Filled Availability of Staff in Primary Facilities (B)

Laboratory Technician		Pharmacist		ANM - Regular		ANM - NHM	
Sanctioned	Filled	Sanctioned	Filled	Sanctioned	Filled	Sanctioned	Filled
1	1	1	1	5	5	5	
1	1	1	1	7	7	9	9
1	1	1	0	5	5	5	5
1	1	1	1	7	7	7	7
1	0	1	1	7	6	7	7
1	1	1	1	5	4	5	5
1	1	1	1	5	3	5	6
7	6	7	6	41	37	43	39

8.5 Broad observations:

Though the Guidelines by the Ministry of Health and Family Welfare(MoHFW) layout several specifications regarding infrastructure availability and necessary procedures to be followed, in practice, very few of the primary and secondary healthcare facilities in Karimnagar district provide care for and conduct examinations of survivors of sexual violence. Heads of these facilities offer several **reasons for their turning away of survivors**, including lack of female gynaecologists capable of examining survivors, inadequate infrastructure, and lack of experience in dealing with any medico-legal cases, not just those pertaining to sexual violence. Additionally, none of the primary facilities in the study even maintain medico-legal registers. In light of the limited intake of survivors

of sexual violence, this chapter examined the preparedness of healthcare facilities in terms of infrastructure-related facilities to respond to survivors.

None of the facilities in the study reported having a set **protocol or standard operating procedure** in place for responding to survivors of sexual violence. Their responses are based on the medical officers' knowledge and awareness of the law and legal procedures to respond to survivors on a case-by-case basis. All of the heads of facilities lamented their inability to respond to survivors, and the burden that it places on doctors in their facility.

They cited three main reasons for not being able to take in survivors:

- Heads of facilities said that either their female gynaecologist was already over-burdened with her workload (CHC 1) or they did not have any female gynaecologists permanently available on their staff (all other facilities sampled). They also cited their lack of experience in engaging with survivors of sexual violence in a healthcare setting as a challenge.
- Heads of facilities also cited inadequate infrastructure especially too few beds, no police outposts in their facilities, and no counsellors on their staff as reasons for not admitting survivors of sexual violence.
- Heads of all the primary facilities PHCs and 2 CHCs also said that they are not legally mandated to respond to survivors of sexual violence and that it is beyond their jurisdiction to do so. The primary facilities neither maintain medico-legal registers nor do they take in any medico-legal cases. Even though secondary facilities maintain medico-legal registers, they find themselves unprepared to respond to sexual violence.

The lack of Standard Operating Procedures in the district results in these misconceptions, gaps and challenges. As mentioned earlier, the above reasons cited by the Medical Supervisors for not responding to survivors are neither in accordance with the Ministry Guidelines nor with the laws that govern these issues. Individual doctors' experience, awareness, and knowledge of the law need not matter if the HCF has a clear, systematic protocol in place. It would also avoid any conflicts with the police and courts of law. The lack of uniform Protocols also contribute to the poor treatment of survivors in hospitals, and further, compromise medical evidence gathering.

All of the sampled facilities **lack uniform documentation formats** that they could share with the researchers. Documentation formats as prescribed by the Guidelines determine the kind of medical evidence that may be collected, and the manner of their presentation to the police and the courts. Researchers were able to access some of the forms used to document medical evidence from police stations in the vicinity of the secondary facilities. These forms were maintained by the police but contained the letterhead of the healthcare facility. Researchers were also able to access formats for letters issued by individual medical officers in each facility from the police stations nearby but the interviewed medical officers said that they neither were aware of nor had access to any such formats. This meant that doctors have very little control over the kind of medico-legal care they wish to provide to survivors, relying entirely on the police to determine the protocols.

None of the facilities had **systematic referral systems** in place in case they are unable to respond to survivors of sexual violence. The heads of facilities, medical officers and nurses in the same facility frequently reported completely different referral practices, implying the lack of a uniform protocol in place. None of the facilities had **uniform consent protocols** or forms available. Informed Consent

was loosely interpreted by all the doctors interviewed in the study (see the next section), often denying any agency to the survivor in their treatment, diagnosis, and documentation of evidence. Finally, none of the facilities had any **Information, Education and Communications (IEC) materials** on either sexual or domestic violence on display anywhere in the facility.

In order to respond to sexual assault, each of the HCFs in the district needs to add some equipment to their stores. It also needs to ensure that all of this equipment needs to be available in one place. This would ensure that (a) response is timely and quick; (b) all evidence/specimens required are being collected in a standardized and uniform manner – not haphazardly, and not only on the basis of what the police requests but what the health professionals need to collect as per the Guidelines.

However, the problem is not just in responding to survivors who have reported violence to the police, but in recognizing signs of abuse in patients (women and children) who come to the hospitals for medical care. None of the facilities even consider this as a possibility, and none are geared towards doing so. Sexual violence is seen as an extraordinary event that only occurs rarely. Such an approach towards sexual violence is limited and narrow. It denies many men, women, and children safe and just healthcare.

Chapter 9: Compliance to Ministry guidelines: Role and Experience of Doctors (Karimnagar)

Ministry of Health and Family Welfare Guidelines and Protocols on Medico-legal care for survivors/victims of Sexual Violence (henceforth Guidelines or MoHFW Guidelines) provide directives to all public health facilities to provide care for all survivors of sexual violence, including immediate access to health care, follow-up treatment, post-rape care including emergency contraception, post-exposure prophylaxis for HIV prevention, and access to safe abortion (5, 2013). It also provides clear directives with regard to police protection, emergency shelter, and documentation of cases, forensic services, and referrals for legal aid. The Guidelines are laid out with special emphasis on providing medical, psychological, and legal assistance to survivors. It also lays down standard operating procedures for care, treatment, and rehabilitation of survivors of sexual violence that must be followed by all public health institutions.

The Guidelines aim to provide gender-sensitive care to survivors, especially by preventing any mention of past sexual practices, and perpetration of "stereotypes about victims". It provides ways in which informed consent may be operationalised by public health institutions, especially in medical examination, treatment, and police intimation. It provides specific guidelines with respect to persons with disabilities, sex workers, LGBT persons, children, persons facing caste, class or religion-based discrimination. It also envisions protocols for psycho-social care to be provided by public health institutions.

According to the Guidelines, all healthcare facilities must have a Standard Operating Procedure in writing, printed, and available to all staff. The SOP must be envisioned in such a way that it provides comprehensive services to survivors and the staff understand their roles with clarity. It is also meant to ensure that all doctors in the hospital provide uniform services.

This chapter presents the observations emerging from interviews with the health care functionaries like the doctors and nurses. This section will examine a set of interviews researchers conducted with duty doctors and gynaecologists at PHCs and CHCs in Karimnagar district between July 2017 and January 2018. The interviews were conducted with doctors whose role, according to the MoHFW Guidelines, is to provide medical and psychological support for survivors, and assist them in their medico-legal proceedings by "collecting evidence and ensuring good quality documentation." (GoI, 2013: 8) The interviews aimed to understand doctors' experiences and challenges in responding to survivors of sexual violence, especially in performing this dual role of providing medical care and medico-legal evidence documentation. They were also aimed at understanding doctors' knowledge, opinions, and dilemmas about the laws on sexual violence.

Most interviews in this section are underlined by a lack of experience in dealing with sexual violence. Researchers had almost the same conversations with each of the male doctors as they told the team that they had not seen any cases of sexual violence so far. Moreover, they claimed that only female gynaecologists were meant to respond to cases of sexual violence; that it was not their area of expertise. Each time they were asked pointed questions about rape; there was a disavowal of responsibility. Their responses were always couched in suppositions and framed in the language of protocol, always distanced from their practice, and in hypotheticals.

Before the analysis in this section, a short note on the method of analysis. In each of the sub-sections below, the tables will present statements by doctors that are both typical and idiosyncratic. Many of the conversations that the researchers had with doctors were repetitive, banal, and mundane. Many interviews resembled each other in their content, especially since a majority of the doctors interviewed had not previously examined survivors of sexual violence. They were informative and insightful for the researchers albeit being frequently hypothetical and generic at the same time. The tabulated and in-line responses represent the range of responses received, not all of the responses received. Also, in order to anonymize the respondents and maintain gender neutrality, gender-neutral pronouns 'they,' 'them' and 'theirs' have been used throughout the chapter rather than she/her/hers and he/him/his.

9.1 Glaring Gap

Karimnagar District Hospital is the single public hospital that handles all the sexual violence cases that are directly brought to them by the Police or referred to by PHCs, or CHCs or brought there by the recently set up One Stop Crises Centre called 'Sakhi Centre'. The research team acquired the necessary permissions to research in their facility. However, despite repeated efforts to secure appointments with doctors, nurses, and administrative staff over the next two months, none was willing to discuss issues of sexual violence with the researcher. Upon repeated follow-ups, the researchers were informed that the doctors are busy with their medical obligations and are unwilling to participate in the research. Therefore, in spite of receiving written approvals from the State and District authorities to conduct interviews and research in the district hospital, the researchers were unable to make any headway due to lack of interest and cooperation.

9.2 Sample Profile

Researchers interviewed 15 doctors in Karimnagar (rural)---9 doctors were from secondary facilities, 6 doctors were from primary facilities. This sample is from all 3 of the secondary facilities and 7 of the primary facilities. One of the doctors at a primary facility, when approached for an interview, did not agree and another doctor was not available at the PHC despite multiple visits. In this study, all of the doctors provided consent in writing before interviews, and nine of the doctors allowed the researchers to record the audio. Seven of the doctors in the sample are women and eight men. Four of the doctors interviewed hold post-graduate degrees, 2 of them specialize in Gynaecology, 1 in Paediatrics, 2 are Anaesthetists, 1 is a Dentist, 2 are Civil Surgeons and the rest are graduates with MBBS degrees.

The age range, gender, education, and specialisations of the doctors interviewed are provided in Tables 9.1, 9.2 and 9.3.

Table 9.1: Number of Respondents interviewed by facility

No. of Respondents Interviewed	CHCs	PHCs	Sub-centers	Total
Doctors	9	6	0	**15**
Nurses	4	6	0	**10**
ANMs	0	0	6	**6**

Table 9.2: Age & Gender Profile of Doctors in Sample

Age in yrs [Count]								Total
20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	
1	4	6	2	2	0	0	0	**15**

Gender		Total
Female	Male	
7	8	**15**

Table 9.3: Degree and Specialisations of Doctors in Sample

Level of Medical Education (Undergraduate/Post Graduation)	Postgraduate Degree holders (MD, MS etc)	4
	PG Diploma	1
	Graduate only	10
	Total	**15**
Specialisation	Gynaecologists	2
	Pediatrician	1
	Surgeon	2
	Orthopedician	0
	Anesthetist	2
	Radiologist	0
	AnyOther (Unknown/EmergencyMedicalServices/Skin)	1
	Graduates Only	7
	Total	15

9.3 Perceived Role

This section deliberates on doctors' perceived role in caring for survivors of sexual violence. It covers three themes: first aid and emergency care, counselling and support for the survivor, and liaison with the police.

The following guidelines are for health professionals when a survivor of sexual violence reports to a hospital. The guidelines describe in detail the stepwise approach to be used for a comprehensive response to the sexual violence survivor as follows (GoI, 2013: 23):

i. Initial resuscitation/ first Aid
ii. Informed consent for examination, evidence collection, police procedures
iii. Detailed History taking
iv. Medical Examination
v. Age Estimation (physical/dental/radiological) – if requested by the investigating agency.
vi. Evidence Collection as per the protocol
vii. Documentation
viii. Packing, sealing and handing over the collected evidence to police
ix. Treatment of Injuries
x. Testing/prophylaxis for STIs, HIV, Hepatitis B and Pregnancy
xi. Psychological support & counseling
xii. Referral for further help (shelter, legal support)

9.4 First Aid and Emergency Care

Many medical practitioners at the primary level deem medical care as inadequate for survivors of sexual violence. Sexual violence, in their eyes, is immediately in the domain of criminal justice and automatically demands more than "only" medical care. The doctors at primary hospitals frequently responded that their facilities were not adequate for addressing survivors of sexual violence but that they could "only" provide first aid and emergency treatment.

One of the doctors at a primary facility said, *"Whatever happens, my duty is to care for the patient."* This duty though in the doctor's view, is inadequate for the care of survivors. Another doctor in a different primary facility also said, *"We are only a PHC. We don't deal with such cases of sexual violence. We can provide first aid if they come here, that's all. We don't have an MLC register."* Even though they see the provision of medical care as their primary duty, both doctors echo a feeling that medical care *alone* for survivors is inadequate. Their role in such cases is incomplete without a way to liaison with and report to the police.

Another primary care doctor also voiced this inadequacy of primary facilities but considered a different role for doctors. The doctor said, *"Since we [PHC] can't do medical examination of*

survivors, our role is in health education. We are responsible for conducting awareness amongst children in schools. It is the role of the police to handle cases like that [sexual violence]. We are only open till 4pm and also don't maintain a medico-legal register, so all the cases go to the CHC in Huzurabad, not here." This response highlights the multifaceted role of a medical practitioner in allowing holistic engagement with the issue at the level of primary care hospitals.

At secondary hospitals too, most doctors spoke about their lack of experience in dealing with sexual violence. One of the medical superintendents of a secondary facility said, *"The thing to do immediately of course is provide first aid. ... We first enter it into the MLC register. That is the first thing to do. There is an outpost separately in the hospital. They follow up on the cases."* Another doctor from a secondary facility also said, *"The first thing to do is treatment. We have to help them legally and medically support them with any health issues. Apart from that there is nothing much that we can do."*

Provisions for first aid, in these responses, is an immediate measure that doctors must take. It is not, however, recognised as the "first" thing they must do and not as an adequate thing to be done. They must first enter any cases of sexual violence in the medico-legal register and alert the police. This belief that doctors must immediately alert the police is both pervasive and contested amongst doctors and will be discussed in greater detail in the next section.

9.5 Counselling and Support for the Survivor

Doctors in the study frequently discussed counselling and emotional support as a part of their role. There are no counsellors on the staff in any of the facilities sampled and none have been sanctioned by the government. One of the doctors at a secondary facility commented, *"There are no facilities like counselling or psychological services or ways to give confidence to victims. It is only available if they send the case to the district hospital for examination."*

The doctor recognizes the need for building survivors' confidence and helping them deal with trauma. Another doctor at a secondary facility also says, *"Victims require clinical and psychological support, and some basic treatment like treating local injuries. That much we can do. We can speak supportively to their parents. We can also tell them to seek legal help in some cases."*

Both the gynaecologists in the study who recognised the need for counselling services see a counsellor as providing motivation and support for survivors in deciding whether or not to pursue the case with the police, or whether or not to continue having a relationship with the accused perpetrator, and what kind of social fallout to expect with reporting of violence. When asked about what they counsel survivors about they said, "*We make sure they don't go to their lover's homes. Their lives will get spoilt there. We usually get them to go home to their parents. All the cases we get are 15, 16 and 17 years old. If they finish their 10th standard, they're done for."*

Under the Protection of Children from Sexual Offences Act (POCSO), any sexual relations with children under the age of 18 years, whether consensual or not, is considered a crime. Hence young girls who come to the health care system for sexual health services or parents who bring young girls with suspected sexual activity are seen as victims of sexual assault, and their male partners are identified as 'rapists'.

There is no legal distinction possible between a boyfriend and sexual exploration with a fellow young adult or sexual assault as per this law. On the one hand, this clause with the age of consent in the POCSO Act with the negative moral value placed on pre-marital sexual relations stigmatises young girls who come to hospitals seeking healthcare in matters of sexuality. On the other hand, many cases of sexual violence with young survivors are perceived to be possibly consensual, which leads to biased investigations in the healthcare system.

9.6 Is it a Doctors' Duty to Inform the Police?

In many of the interviews, doctors discussed their role as a liaison with the police in cases of reported sexual violence. However, even within the same facility emerge often contradictory opinions about the role of the doctor in sharing information with the police (if a case has not already been reported). Tabulated here are the responses by the duty doctor, superintendent, and gynaecologist from the secondary facility.

Both the specialist and the medical superintendent, in their responses discuss that it is not the doctors' responsibility to share information with the police and that the survivors and their families must decide for themselves whether or not to report it. The duty doctor in the same facility who is often responsible for conducting examinations in medico-legal cases there, however, feels that their first responsibility is to inform the police if they come across evidence of sexual violence. This diverse range of opinions even within the same facility indicates a clear lack of protocol in dealing with survivors, as well as a lack of awareness of the Guidelines among health functionaries.

The responses above highlight the ethical and moral perspectives that accompany doctors' perceptions of their role in dealing with survivors of sexual violence. One of the doctors sees sexual violence as an extraordinary event that occurs within the community, leading to public outrage and fights. The belief that sexual violence is a rare occurrence and it is made visible by survivors and their families underscore the participants' view that rape is an "incident" that occurs and sensationalised in the community. This is contradictory to the experience of survivors. As seen earlier, rapes are quite pervasive in the district. Also, studies worldwide show that women who experience sexual violence often do not report it, are forced to deal with the consequences in silence (Fisher et. al, 2003; Tillman et al, 2010). Other studies show that the possibility of sexual violence being borne bodily and coming to the attention of an attentive doctor or a survivor seeking healthcare in the event of violence is greater than her seeking criminal/legal assistance. In this context, it is problematic when medical practitioners see their role as limited to medical care alone or even that medical care is limited to addressing medical evidence gathering.

Some of the responses discussed in the following paragraphs conclude a different understanding – that making sexual violence public brings **shame and dishonour** to the family and must be discouraged. Echoing this sentiment, another doctor in a primary facility said, "*Usually families don't like to report such things* [incidents of sexual violence] *to the police. They are afraid about the girl's honour (izzat). Even if they come to the hospital, they try to keep it secret from the police."*

One of the medical superintendents of a different secondary facility said, *"Usually, if they are young children, we ignore such things* [evidence of touching of private parts] *because we think their future should be good. We explain all that to them and say that there is no real need to record all that… why do you want to push this* [legal case] *(ivvani enduku le, malli ekkuva problems untayi kada…)"*

All of these responses are underlined by the same morality of the earlier set of responses – that sexual violence is deeply associated with violation of honour. In the first set of responses, doctors believe that such a violation results in families drawing attention to the incident; whereas in the second set of responses, doctors believe that families hide the incident and keep it secret. However, in some of the responses here, the doctors intervene in the survivor's decision-making process to counsel them against seeking legal recourse. The response of the medical superintendent indicates that they counsel survivors against filing a report with the police because it might cause problems to the survivors.

9.7 Legal Awareness and Established Practice

Most of the responses examined in this section pertain to awareness about the Criminal Amendment Act 2013 – Responses to each statement in the section are taken up here in detail below:

9.7.1 Informing the Police and Police Requisitions

"Medical Examination of the survivor of sexual violence does not require police requisition" is a statement from the interview tool. This is the first statement pertaining to the requirement of police requisition. This statement was either read out in its entirety to the practitioner and asked for an opinion, or discussed as a question, "Would you require police requisition to conduct examination of a survivor?" This statement elicited three levels of responses: whether survivors have come to the hospital without police intervention; at the level of providing first aid to survivors; and at the level of conducting a forensic examination. All doctors stated that survivors of sexual violence only come to the purview of the healthcare facility through the police. In other words, after a case is filed with the police, the survivor comes to the hospital accompanied by the police to be forensically examined by doctors. It might be pertinent to note here that the doctors do not acknowledge sexual abuse that they see in their clinics that could otherwise be governed by the Protection of Women from Domestic Violence Act (2005).. They do come across cases that qualify for consideration under POCSO or PoWDV Act but they use their discretion often linked to one's moral values.

9.7.2 Is Police Requisition Required?

A response from a medical superintendent of a secondary hospital was *"we examine the patient even if there is no requisition form from the police. Once they send the patient to us, we follow our rules and procedures. If we need to admit the patient, we admit them too. We don't wait for the police. But the survivors can only leave with permission from the outpost. We don't discharge them without informing them."* In this response, the doctor gives first priority to treatment of the survivor. They talk about not waiting for directives from the police to examine and treat the survivor. Worth noting in this response, however, is the assumption that survivors are "sent" to the hospital by the police, with or without a requisition form.

All the doctors in the sample were of the opinion that currently survivors only approach the hospital via the police after filing a report. The first interpretation of the statement is that ***in current practice,*** survivors do not directly approach the hospital but the possibility of them doing so in the future is not foreclosed. Two responses are presented here: The first response is by an anaesthetist, and the second is by the medical superintendent of a secondary hospital. In the first response, the doctor says, *"Cases always come in through the police. They bring the victim here with a requisition form. I haven't seen*

any cases come here directly." The doctor here is citing an established practice wherein the hospital sees survivors of sexual violence only through the police.

The second interpretation of the statement is that ***it is not legally possible*** for survivors to directly approach the hospital if they require anything other than medical care – they must always be routed through the police. This is exemplified in repeated statements that doctors would immediately administer first aid and any required emergency care to the survivor but would only conduct a forensic examination at the request of the police. In another response, a doctor who is also a superintendent of a secondary facility says, *"They don't come to the hospital directly at all. They always go to the police first. Medico-legal cases can only come through the police."* Here, the doctor is citing both established practice – "always go to the police" and the expected legal norm – "can only come through the police". In all these responses, practitioners consider the first point of contact for a survivor is always the police. These responses highlight how survivors of sexual violence are always seen through the lens of legality and criminal justice.

9.7.3 Approaching the Hospital without Seeking Police Intervention

Each of the doctors was prompted to consider the possibility of whether a survivor could come directly to the hospital without approaching the police. The researcher asked a few questions regarding this: "What happens if a survivor comes to the hospital directly without going to the police? Perhaps they might have injuries or visible signs of trauma? What would you do? Can this happen? What would you do?" This discussion was followed up with another discussion pertaining to one of the statements in the tool - "Is it mandatory to inform police about a woman examined for sexual violence?" The first question is a hypothetical question to discuss the opinion of doctors about the procedure they can follow. The second question is a question to understand doctors' legal awareness.

9.7.4 Would a Survivor come to the Hospital before they go to the Police?

In response to the first question about a hypothetical situation wherein a survivor approaches the hospital before she goes to the police, one of the doctors at a secondary hospital briefly narrated one such incident. They said, *"I can narrate the case of a 28 year old female with a known accused* [referring to a perpetrator who is known to the survivor before the rape occurred]. *She came straight to the hospital within 1 hour of the incident. She had a bleeding vagina with a 3cm tear on her vaginal wall. … The surgeon responded to her immediately. They conducted a surgery on her at night as soon as she came. I only saw her in the morning. She was discharged within 72 hours. We made a note in the MLC. It's not our responsibility to inform the police – the family themselves went and made a complaint."* Through their narration of this incident, the fact that survivors of sexual violence *do,* in fact, directly approach the hospital becomes obvious. Here, the process of liaison between the hospital and police in actual practice is clear.

In another instance, a medical superintendent of a secondary hospital said: *"Over the past 1 year, we haven't received any cases. They don't come to the hospital directly at all. They always go to the police first. Medico-legal cases only come through the police."* The researcher asked, *"Do you think that the hospital has a role in identifying cases?"* They responded, *"Some cases, we can identify and do a differential diagnosis and refer to higher level hospitals."*

The researcher asked again, *"Have you had any cases where women come with small injuries or small burns?"* They responded, *"We haven't received any such cases. I can't say that for sure, however, since we don't check. It's usually just a case of a differential diagnosis. If we don't inform the police when we have a doubt, it'll become a big headache for us."*

The doctor's repeated use of the term "**differential diagnosis**" to refer to their assessment of injuries caused by violence is important. It indicates, on the one hand, the separation of the cause of an injury inflicted through violence (sexual or otherwise) from the medical diagnosis of the injury. It implies that the possibility of such injuries being caused by violence are not clinically standard. On the other hand, it medicalises such possibilities, providing a framing of the issue in terminology that is familiar to medical practitioners. Finally, in this response, the doctor alludes to the sticky aspect of (not) reporting evidence of sexual violence to the police. The doctor assumes that they will be implicated legally if they do not report an instance of which they are suspicious.

9.7.5 Mandatory Reporting

This leads into another statement that doctors were asked to comment upon – whether it is **"Mandatory to inform police about a woman examined for sexual violence."** The responses to this statement are read along with the discussion in the section above on the contestation between private honour and public dishonour, "izzat" and "godavalu". In light of this dilemma, there were three kinds of responses to the statement on mandatory reporting. The first response is the unqualified affirmative. Doctors felt that it is their duty to mandatorily report any instance of sexual violence to the police. The second kind of response is a qualified affirmative that doctors are indeed required to mandatorily report evidence of sexual violence that comes to their attention but survivors usually report to the police themselves, not leaving that role to the doctors. The third response is that the doctors are only obliged to counsel the survivor and that it is up to them to decide whether they want to report to the police.

9.7.6 Informed Consent for Medical Examination

Informed consent was an unproblematic and narrow area of consideration for the practitioners interviewed. In terms of legal awareness on consent, doctors were either shown the statements, **"Medical examination can be done (/should be) without survivor's consent"**, or it was brought up conversationally during the interview with the question, "How do you seek consent from survivors before you examine them? Are there any requirements from the hospitals by way or forms or vocal consent?" After a brief discussion on the consent procedures for adults, the researcher asked the same questions in the context of children and the POCSO law. The responses received from doctors during this section of the interview are discussed below. Consent procedures have multiple functions even if perceived merely as legal instruments. They are a important individual right, meant to enable patients to make choices that are best suited to them in their capacity, given all the information available to make a healthy and holistic choice. However, even as a legal instrument, the scope of consent sought from survivors in this study is quite limited. As reported earlier, there are no formal, written mechanisms to seek consent from survivors at any of the hospitals in the study.

9.7.7 Who Can Consent?

When asked about consent procedures in their hospital, a superintendent of one of the secondary facilities in the study responded, *"Obviously we need to take consent!"* The researcher prompted them to speak further by asking, *"Who can consent?"* They replied, *"There are usually people who accompany them – their attendants can consent. If not, the police can consent. Without their consent [the police], we can't examine at all. For 12 – 18-year-old children also, they can't consent on their own."* The researcher asked, *"How do they give consent? Are there forms?"* They responded, *"There are no consent forms or anything like that in writing. Police brings them to the hospital, so we don't need any consent forms."*

This response highlights the importance attached to survivors' informed consent about examination procedures after incidents of sexual violence. The lack of standardized written protocols for consent-seeking by healthcare facilities results in a very poor understanding of informed consent as an individual right, allowing for misunderstanding of protocols by doctors in this manner. Seeking an attendant's consent in a forensic examination of survivors is neither a legally outlined procedure nor ethically sound.

One of the doctors reported that they also had seen several survivors of sexual violence who are mentally ill, especially those who are schizophrenic, depressed, prone to manic episodes, and/or on heavy medication. It was not clear what consent procedures were followed for such cases.

9.7.8 Police Requisition as Stand-In for Written Consent

The response (quoted above) by the medical superintendent reveals a belief that is consistent amongst most of the doctors in the study that the police requisition form can stand in for a consent form. Almost all the doctors were of the opinion that if the police have sent a requisition form for examining the survivor, separate consent procedures by the health system are not necessary. Only one of the doctors interviewed said, *"The police sends a requisition form and a case file. We have to take written consent in their [the survivor's] own handwriting before we examine them."* The researcher prompted them to ask, *"Is there any form or prescribed format you have to follow?"* They responded, *"There is no form… doctors and gynaecologists usually have an understanding of how to do it. They all do it in their own way."* In this response, the doctor makes a distinction between the police requisition and case file; from the doctor's own consent procedures. However, no such distinction is made in any of the other interviews with the other doctors in the study.

9.7.9 "Cooperation" and Consent

For some of the doctors in the study, consent was couched in terms of "cooperation" from the survivor for their forensic examination. It is not seen in terms of patient's rights. One of the responses from the doctors in the study highlights this attitude towards consent. *"We explain the process to the victim and tell them that they have to cooperate. Usually they cooperate because they are the ones filing the case. If they are children, it is quite difficult to conduct the examination. But for slightly older adolescents and women it is not so difficult."*

Another doctor at a primary facility responded similarly, *"We usually explain what we are about to do in a general fashion ("maamool ga"). We tell them that they have to cooperate. If it's a minor, we take permission from the adult to conduct the examination. If she has matured (attained puberty), we explain to the girl too – That this* [conducting the medical examination] *is necessary legally, this is the process and that they need to cooperate. If they are especially not cooperative there is nothing much we can do… We simply tell the HoD that it wasn't possible."*

In these responses, three things are flagged – first, information is imparted to the survivor **before** the examination. They are informed about the nature of the procedures that the doctors plan to undertake. Second, the **imperative tone** of the response – "tell them that they have to" (*"cooperate cheyyali ani cheptamu")* indicates that the practitioner does not see themselves in dialogue with the patient. Third, the information imparted is meant to solicit **cooperation** from the survivor/patient, not consent.

Informed Consent contains a positive connotation of interest in and knowledge of medical procedures. Especially in the context of sexual violence, consent of this positive nature works towards understanding the embodied nature of trauma a survivor goes through. Against such a positive

connotation, “cooperation” implies that practitioners seek consent in order to prevent opposition to the medical procedures they are about to conduct.

One of the gynaecologists in the study who had conducted several forensic examinations during the doctor’s term in the secondary hospital spoke about the discussion they have with survivors. They explain why the examination is important but also alert the survivor to the social taboos and consequences associated with the tag of being a rape survivor. Especially if their patient is a young, unmarried woman, they talk about how the concern of “having a life ahead” is more important than criminal justice.

These practices indicate the treatment of a survivor of sexual violence as merely an object of medical examination, revealing a moralistic attitude towards survivors of sexual violence. Such conversations with survivors about the dangers of going through with legal action against the perpetrator by an examining doctor further disenfranchise survivors, running the risk of increasing their trauma.

9.7.10 Consent from Accused Perpetrator of Crime

This terrain gets complex in the context of seeking consent from the accused perpetrator. Duty doctors in secondary hospitals regularly examine men who have been accused of rape. The men are brought, in handcuffs, to the hospital where they are generally examined and tested for their physical capacity to have sex and penetrate. These tests concern examination of men’s genitals, but no consent procedures are followed or even deemed required by doctors. As long as the police bring the man to the hospital with the legal paperwork in place, no further consent is sought. One of the doctors in a primary facility who reported conducting examinations of accused perpetrators quite regularly said, *“They come with a police escort. Male consent is not necessary in rape cases.”* Such a perspective from a doctor marks the importance of discussing consent practices not only in the context of sensitivity towards the survivor but also of bodily dignity in medical practice altogether.

9.7.11 Medical Evidence

This section examines interviews with doctors along with formats used by the police to record medical examinations. Medical evidence for cases of sexual violence in a court of law has been a highly contested terrain, marked by tremendous changes in the law over the past four decades. The most recent amendment to procedural and evidence laws, as well as the penal code, has come via the Criminal Amendment Act (2013). Firstly, the definition of rape has been changed by this amendment. In 375 IPC, the definition of rape and consent are broadened, from a *narrow view* of rape as peno-vaginal and penetrative to a *broader view* of rape extended to the full or partial penetration by any object or any part of the body, and application of the mouth to orifices including the vagina, mouth, urethra, and anus. Also, in the same section, the definition of consent is broadened to include “unequivocal voluntary agreement,” and to specifically outline that the lack of physical resistance *does not* constitute consent.

Four of the amendments made through the Criminal Amendment Act will be discussed here, along with the changes in definition of rape, in light of their effects on the relevance of current medical evidence collection practices. These are:

(1) the changes to the definition of "rape" and "consent" in S. 375 of the Indian Penal Code (375 IPC);
(2) The changes to section 53 of the Indian Evidence Act (53 IEA) which makes the victim's previous sexual experience irrelevant to establishing the crime;
(3) The change to section 114A of the Indian Evidence Act (114A IEA) which introduces a clause allowing courts to presume that the woman's testimony is adequate to prove lack of consent; and
(4) The change to section 146 of the Indian Evidence Act (146 IEA) which prevents questions during cross-examination regarding the victim's "general immoral character, or previous sexual experience" to establish the nature or quality of consent.

The changes to the Indian Evidence Act (Sections 53, 114A and 146) reflect the change in the definitions of rape and consent in how evidence may be considered in court as well as makes inadmissible any evidence related to the victim's past sexual behaviour. These changes make several currently practiced medical procedures highly irrelevant in the context of sexual violence. This means that medical procedures related to the presence of injuries, victims' sexual history, including the hymen test and the two-finger test, potency of the accused become highly irrelevant to the establishment of consent in rape. It also re-signifies what is to be collected and proved through other medical evidence such as oral, vaginal and anal swabs, vaginal smears, and washes.

Box 6- Ministry Medico-legal guidelines on medcal examination

According to the Medico-Legal Guidelines of the MoHFW (GoI, 2013: 10)

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

• *Whether a sexual act has been attempted or completed. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glands between the labia with or without emission of semen or rupture of the hymen.*

• *Whether such a sexual act is recent, and whether any harm has been caused to the survivor's body. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused. However, the absence of signs of struggle does not imply consent.*

• *The age of the survivor needs to be verified in the case of adolescent girls/boys. Whether alcohol or drugs have been administered to the survivor needs to be ascertained."*

It is more than clear even through a cursory examination of the available evidence that the changes in the law are not reflected in any of the facilities in the study area, neither through the police nor the public health system. In many of the key areas of medical evidence examined below, it is seen that the requisition forms issued by the police continue to follow the older laws and evidentiary practices in rape. To collect the evidence, doctors use the police requisition forms uncritically. Despite the highly legalistic and procedural language used by doctors to discuss the following issues, it is clear that there is a profound lack of awareness about the law and legally outlined practices around sexual violence. There is also very little reflection either on the part of the police or the doctors to make medical

evidentiary practices more relevant to the laws presently in force. The compartmentalization of the actors of the state into medical (hospital) and legal (police) makes neither party responsible for these practices. A detailed examination of doctors' legal awareness and current practices is conducted below.

Forms to record the medical examination are maintained with the police, although the letterhead on these forms belongs to the hospitals conducting the examination. None of the medical superintendents in the study reported having a copy of these forms in their facilities; they all reported that that the police sends the form to them, along with a standard requisition form and a standard form for a medical opinion to be signed by the examining doctor. The researchers viewed samples of the forms in two police stations. These two police stations are within a 1 km radius of two of the secondary hospitals in the study and regularly refer rape victims for medical examinations to these hospitals. The content of the fields required to be filled in these forms will be analysed below, next to the opinion of the doctors in the study.

9.7.12 Presence of Injuries

The Requisition form used for medical examination contains the following fields regarding the presence of injuries (the items are reproduced as is):

- "Injuries on his/her person particularly in the neighbourhood of grantives [sic]
- Injuries to the male organ
- Examination (Each painful) [sic]
- Note: draw the injuries if any in the diagram"

During the interview, doctors were asked to comment upon a statement relating to the presence of injuries in rape – **"Presence of injuries is necessary to arrive at an opinion that a woman has been sexually violated/raped."** This statement was either discussed via the checklist on the tool or through a question, "Do you think there need to be injuries for rape to be established in court?" The responses to this question were mixed. All of the doctors unequivocally said 'No' to this question or disagreed with the statement, but at other points in the interview some doctors asserted the opinion that recording injuries is central to establishing rape.

One of the gynaecologists who regularly conducts medical examinations of survivors of sexual violence said, *"I get cases from five Mandals*[13]*. I have seen at least 25 cases in the past four years. Out of this, I have only seen one or two cases that have been forcible and genuine. It is very rare for me to see cases where a man forcefully rapes a woman (balavantam ga ededo cheyyadam)."* Another gynecologist similarly opined, *"Many of the cases I see are just love affairs. ... There is no medical evidence in such cases. There is simply a lack of injuries"*

In both of these responses, the doctors conducting the medical examination imply that "genuine cases" of rape can only be discerned by its forcible nature and the presence of injuries. They both implicitly assume that if there is no evidence of forcible penetration, it is not a case of rape. This assumption is directly oppositional to the definition of rape in Sec 375 IPC. Even though the doctors' reports do not require them to attest to whether the case is "genuine" or not, doctors' opinions about the rape only being rape if it is forcible, colour not only what tests they deem necessary, and the remarks they make on the examination report but also their testimony in court. Their impression of the

[13] Mandal refers to an administrative unit at the sub-district level

importance of the presence of injuries, along with the importance of type and location of them makes a difference in how the medical examination is conducted. The two responses here also make an explicit assumption that if a sexual act is not "forcible," then it is a consensual act between two people who are in a love relationship with each other. It is taken for granted that women who are in such a relationship would automatically consent to sexual intercourse. This point is examined further in a section below.

9.7.13 Two-Finger Test and Hymen Test

The Requisition form used for medical examination contains the following fields regarding the status of women's sexual and menstrual history and physical status of their genitals:

- "Time of onset of puberty
- Pregnancies
- Presence of VD [vaginal discharge]
- Uterus
- Labia major or labia minor
- Hymen
- Vaginal (1, 2, 3 fingers)
- Centals [sic] female pubic hairs"

One of the statements that doctors were asked to comment upon relates to the past sexual history of the survivor. The statement in the interview reads, **"Documentation of sexual activities prior to sexual violence is required as part of medico-legal evidence."** This was discussed along with the question, "Do you think two-finger test is needed or useful in the case of sexual survivors? In what way?"

All of the doctors interviewed were of the opinion that the two-finger test and the hymen test are standard and required in medical examinations. One of the medical superintendents of a secondary facility said, *"It is good to document such things. It will be very useful in court."* Another doctor at a primary facility also said, *"It is very important [to do the PV test]. It is basically useful to determine sexual history."* Many doctors expressed the relevance of the two finger test but some also expressed doubts regarding their efficacy in the context of women who are married or older.

One of the responses by a doctor who has conducted examinations of survivors of sexual violence in the past said, *"Of course we do PV test and hymen test!"* The researcher asked, *"What does it prove though?"* They said, *"We will know whether the walls have become loose. We will know whether penetration has occurred. Especially in the case of minors, it is very useful. In court, using this we can say whether she is habituated [to sex] or not."* Another doctor who also conducts examinations said, *"I don't know too much about why it's done. I just know that they do it. If it's a virgin or a newly married woman, it is useful. It basically determines whether the orifice is loose or tight. Only that, according to my knowledge."*

This test, along with the medical determination of the presence of injuries, determines whether sex is "forced" or not. In all of these responses, doctors reiterate their assumption that the two-finger and hymen tests are mandatory in medical examinations of survivors of sexual violence. This question of whether the survivor is "habituated" is used in court to comment on the sexual history of the survivor but this has become irrelevant in determining the crime after the Criminal Amendment Act (2013). This medical norm in conducting examinations is far removed from the law in this case, and irrelevant.

9.7.14 Seizure of clothes

In the two interviews with the doctors who conduct medical examination of survivors, they said that they were only responsible for conducting the medical examination and that the police would collect any other evidence including clothes. The lab assistants also were not really informative about any of the procedures with regard to evidence collection and management.

Again, unfortunately, no formalised informed consent procedures are used in any of the hospitals. There is no clarity about evidence management since neither the medical superintendents of the hospitals nor the doctors were able to clearly articulate how medical evidence is handled. There are no clear standard operating procedures or manuals available in any of the hospitals. There are no SAFE kits in any of the hospitals, and there are no extra clothes or toothbrushes available for women. Women police do accompany the victim.

9.7.15 Potency Test of Accused

A statement in the interview tool pertaining to the medical examination of the male accused reads, **"Potency Test of the accused is not relevant and not necessary."** Doctors were asked to discuss whether they agreed or disagreed with this statement, and a discussion ensued regarding why they provided that response. The Requistion Form used by the police for medical examination contains the following fields regarding the accused male perpetrator:

- "Injuries on his person particularly in the neighbourhood of grantives [sic]
- Injuries to the male organs
- Penis circumcision or not
- Note:- Draw the injuries if any in the diagram"

Two of the doctors in the study reported that they regularly conduct medical examination of the male accused in cases of sexual violence. One of the doctors responded,

> *Doctor (D): "If male kids come here, they come here just for potency examination – just we can say that he is potent and he is able to have sexual act. We do a general examination – is he healthy or diseased, whether there is any disability.*
> *Researcher (R): "Do you require any equipment for this?"*
> *D: "Male examination does not require any equipment since we are only doing general examination and local examination. Beyond that we don't do DNA testing etc because we don't have any equipment for it. For all those examinations, the police takes them separately to places where forensic facilities are available."*

An excerpt from the discussions follows.

> *R: In men's cases, how many have you seen in the past one year?*
> *D: Around 10.*
> *R: What kind of tests do you do?*
> *D: We look for… What is the size of penis? What is the size of scrotum? Is there any discharge from the genital areas? Is he actually able to do that? Is he able to perform a sexual act?*

R: What is the age range of accused you have examined?
D: Mostly age 25 to 30. I haven't seen any younger than that.
R: Do you know what kind of cases they are? What is the background of the kind of cases you see?
D: Actually we don't go into those matters. We just examine them and send them away. We just see what are the crime number and case number and then send them away. Usually they come to us within two or three days of their arrest and the act. We don't check for any injuries – they wash off any of their discharges.
R: How about nail filings or scratches on their body?
D: We don't do any of that. We should do… you're right. But we don't do anything like that here.
R: If you had to do that kind of test, what kind of equipment would you need?
D: Nothing much… We would need smears and swabs.
R: What are the consent procedures in such cases? Do you need to take consent?
D: They come with a police escort. Male consent is not necessary in rape cases.

Another specialist doctor spoke about the difficulty of conducting medical examinations of accused perpetrators. They said, *"Medical examination of the accused is not necessary. It has both pros and cons. It can be used against the victim in court."*

There are several considerations to be made from these conversations.

First, as discussed earlier, the doctors assume that if the accused perpetrator is escorted by the police for a medical examination, medical and informed consent procedures are not required to be followed.

Second, the medical examination is focused only on the ability of the male accused to penetrate using his penis. However, the broadening of the definition of rape by the Criminal Amendment Act (2013) to acts beyond peno-vaginal means that these tests are not the only ones that are relevant in proving such cases in court.

Thirdly, doctors reported not regularly examining male accused of other samples such as skin or dirt under nails or injuries on the body specifically connected to rape. Such injuries, even if not required by law, could go a long way in doctors' testimony in court. This is not done in spite of the limited resources by way of swabs and smears it would require to execute.

Fourthly, in stark contrast to medical examinations conducted with survivors, doctors show little or no interest in the details or background of the cases the accused perpetrators are charged with.

As we will see in the next section of the report, when medical examinations of survivors are conducted, doctors familiarise themselves with the history and background of the survivor. The details they include in their discussions of past cases elaborately focus on the relationship that the woman and the accused share, woman's families and the family of the accused, as well as concern with the survivors' "future". No such interest is displayed by any of the doctors who examine male accused or perpetrators. Indeed, the profound lack of interest in their lives could be interpreted as gendered. Despite the law putting the onus of proving lack of guilt on the male accused (as opposed to the female survivor having to prove that the perpetrator is guilty), the accused have very little say in the kind of evidence they would like to have collected to prove their innocence.

Two major concerns emerge from these considerations. On the one hand, conducting medical examinations of the accused in such a blasé manner opens up the question of whether there is adequate information to prosecute the accused perpetrator. If there is not enough medical evidence about the state of the accused's body at the time of the crime, they may not be found guilty in a court of law. On the other hand, the opposite concern also emerges. There is very little possibility that the accused perpetrator to prove their innocence in court could use evidence from the medical examination. This makes it difficult for the courts to follow due process of law if accused perpetrators are treated as if they are already convicted during the investigation period. This concern emerges especially through the lack of consent procedures and the paucity of evidence concerning foreign material and injuries on their body. Both of these concerns are important in ensuring the fair treatment of survivors of sexual violence within a criminal justice system.

9.7.16 Medical Evidence for Child Sexual Abuse

Two of the doctors in the study reported that they had conducted medical examinations on child survivors. Other doctors gave their opinion on the general procedure to be followed in case they have to examine child survivors.

When asked about the evidence collected from children, one of the gynaecologists in the study said: *"I check for pain on urination and defecation, abdominal pain and generalized body ache. Regarding their mental status a general examination and evaluation is done and a complete urine examination is always done. Children also come with fever and anaemia. I also check vaginal discharge."*

Another doctor said, *"We look for evidence about any touching of private parts. Especially if they are young and have no words to express any touching we look for evidence. Usually, if they are young children, we ignore such things because we think their future should be good. We explain all that to them and say that there is no real need to record all that… why do you want to push this ("ivvani enduku le, malli ekkuva problems untayi kada…") We don't write down evidence about touching of private parts. There is high level of trauma amongst children if they face such violence. There is also very obvious bruising and lacerations. These also indicate violence. Because their vaginas are very small, there is a lot of bruising in the 6 o clock position between the vagina and the anus. If there are any cases like this, I think the gynecologist should conduct the examination in the presence of a peadiatrician especially to be careful about handling the child and taking their psychological state into consideration. In infant cases, the injuries, the scene and the situation can together determine the case."*

Several points emerge from the two above statements. Firstly, both of the doctors making the above statements view child sexual abuse holistically, looking at both physical and mental factors in their examinations. They also express concerns with regard to the long-term effects, including trauma and malnourishment. They look at medical evidence rightly as only one of the factors to be considered during prosecution, along with other circumstantial evidence. Secondly, both doctors see the experiences of child survivors as distinct from adult survivors and express a different set of concerns for both separately.

However, especially in the second response, there are several problematic concerns. The doctor in the second response highlights the dangerous possibility of doctors' role in medical evidence, giving themselves the position to assert sexual morality associated with rape. They discuss the refusal on part of doctors to record important medical evidence in the context of child sexual abuse citing a concern

for the survivors' future. The doctor here imagines that the child survivor would be better placed if a strong case cannot be made through medical evidence, because it might cause more problems if evidences are documented. The doctor makes a trade-off between care and criminal justice to the survivor that is due by law, against the moral and cultural codes that the doctor assumes binds the child survivor. It is not clear whether the doctor is citing accepted medical practice in the hospital they work in or simply their own practice in the context of child sexual abuse. In either case, this is a violation of the mandatory reporting clause in POCSO Act.

A similar moral positioning continues amongst other interviews. One of the doctors in a secondary hospital gave the extreme opinion that child sexual abuse does not occur in this district. They said, *"Child abuse cases only happen in developed cities like Hyderabad or Delhi." When asked about girls who marry early and come to the hospital with pregnancies",* they responded, *"Actually those are illegal marriages technically. It happens everywhere. Even within the marriage, if there is sex – it probably would be rape. But such cases don't come to us."* This response reveals a distancing from the issue of child sexual abuse. It is also an issue that features regularly in local newspapers, especially at the time of fieldwork. Other doctors, however, were more moderate in their opinion. One of the doctors interviewed said, *"I haven't seen any cases of children… Usually if there are any children, it is assigned to the specialist or sent away to Hyderabad based on the severity of the case. Medical officers are not asked to do these cases."* Even though this doctor did not say that such cases do not occur in their district, they said that they are examined only in the capital city.

9.7.17 Medical Opinion and Specialist Opinion

Section 164A of the Criminal Procedure Code mandates that any registered medical practitioner employed by a public hospital, whether male, female, graduate or specialist, may examine a survivor with her consent and prepare a report of their examination within 24 hours of commencement of the investigation. The Section stipulates that such a report must contain the name and address of the survivor, her age, a brief description of the material taken from her for DNA profiling, any injuries that are present on her body, a comment on her general mental condition and any other particulars in detail. The report is mandated to include all the reasons for arriving at each conclusion. The report must also record the consent of the survivor (or the person competent to give consent in cases where she is deemed incapable of doing so). It also must note the exact time of commencement and completion of the examination. This report is then forwarded to the investigating officer, who subsequently forwards it to the magistrate.

A brief discussion about some of the provisions in this Section was conducted with the respondents, including whether only female gynaecologists can examine cases of sexual violence; whether doctors should provide an opinion about the case only after the forensic science labs arrive; and whether it is legally binding for examining doctors to provide a provisional opinion with adequate reasoning. Predominantly, doctors believed that either only female doctors may examine survivors of sexual violence or female gynaecologists may only conduct such examinations. It is believed that survivors require to be sensitively treated and that if male doctors examine them it may add to their trauma. Some of the doctors also said that any medical practitioner registered with the State Medical Council (Registered Medical Practitioner) may examine survivors because they are all adequately trained to do so, but that female doctors are preferred by the police.

There were three kinds of opinions about the question of whether a doctor may only issue a report after the forensic science lab (FSL) report arrives, or whether they may issue a provisional report with adequate reasoning even without the FSL report.

One of the doctors in the study confirms the procedure in the law and says, *"It's not possible for two doctors to be there. The person giving the opinion is obliged to conduct the examination. It's not possible for me as a specialist to comment on somebody else's examination report."*

However, others disagreed with this statement. One of the doctors in the study said, *"Only female doctors can examine. The medical opinion has to be provided by gynecologist or specialist. This can be done based on the medical exam report and samples provided by the duty doctor or the medical officer. I don't think the gynecologist/specialist has to do the examination herself.*" Here, the doctor draws a distinction between a report issued by the examining doctor and a report issued by a specialist. Both of these reports, in their opinion, can only be provided after the Forensic Science Lab (FSL) report is finalized.

These three varying opinions about how medical examination reports have to be written and based on what evidence, further, points to the need for standard operating procedures in hospitals to respond to survivors of sexual violence.

9. 8 Speaking Legally

In this section, we look at the procedural nature of doctors' responses to the researchers' questions against the previous section, which laid out their knowledge and awareness about the law. Doctors' responses to several of the discussions were couched in a legal and procedural language, using terms such as "false case," "love affair case," "minor case"; and logic that they feel is consistent with procedural law, especially as examined above in the context of consent-seeking in medical examination, collection of medical evidence and liaison with the police. Survivors were always referred to as "victim" or "case," never as "patient" or "survivor".

At the same time, all of the doctors interviewed reported that they know very little about the letter of the law, especially the Criminal Amendment Act (2013), which changed many of the legal definitions and requirements for medical evidence. However, the perceived closeness of medicine with legal procedure leaves doctors in an ambiguous position when they deal with survivors of sexual violence. They are caught between their role as healthcare providers and their role as medical officers of the state, constantly walking a tight rope between medical care and forensic evidence.

This section examines the contradictions in doctors' legal speech in two ways. It firstly looks at "love affair" cases, or cases in which the survivor is underage and is presumed to have had a consensual sexual relationship with her partner. Secondly, it looks at doctors' challenges in testifying in court. Together, these two issues point to how doctors appropriate the language of legal reasoning in their medical examinations, and at the same time, use their status as doctors while in a court of law.

9.8.1 "Love Affair" Cases

There is a simple narrative told to the research team about "love affair" cases. An adolescent girl, aided by mobile phones and the internet, falls in love with a man, elopes with him and has sex with him. The man either refuses to marry her after having sex, or her parents don't agree to the relationship. In either case, her parents file a case with the police, usually listing it as kidnap and rape

as the charges against the man. Such cases are filed with two motives – first, to bring the girl back to the parents' home and second, to punish the man for eloping with their daughter. Both of these motives are shrouded within the idea that the family's honour must be maintained, and the girl's future marriageability must not be affected.

In the two responses by the doctors below, there is a blanket generalisation of such instances of adolescent girls that come to them. Usually called a "love affair" case, these are not seen as "genuine" cases of rape. Rape, here, is understood as a forceful and penetrative act by a stranger. The question of consent does not arise in this context. For example, this excerpt from one of the doctors' responses demonstrates this view: *"We mostly get 16 and 17 year-olds. Tenth pass, intermediate, degree first year: these are the ages at which most of the girls are in. They're all minors. 99% cases are such love affair cases. Last month, I got a girl who ran away with someone who was married. She was with him for five months. She was seventeen years old."*

This narrative repeatedly came up through the interviews with doctors, with very few variations, from doctors, nurses, and police officers. There is no line drawn between violence and consensual sex in such a narrative. Sexual violence, in this story, is no longer violence but a consensual act of sexual intercourse by an underage girl. The crime committed here is not the violation of the adolescent girl's bodily integrity, but the immorality of the act of having pre-marital sex.

Doctors find it tricky to conduct medical examinations in cases that they feel are "love affair" cases. The view of rape as peno-vaginal, penetrative, and forced (even though inconsistent with the law) continues to permeate their judgment in such cases to determine the efficacy of conducting a medical examination. One of the specialists in the study said, "*There is no medical evidence in such cases. It's simply lack of injuries. They wait for the DNA test. If the girl is pregnant, they try to prove paternity and then either sue the boy or compromise for marriage. Oral swabs* [of the survivor] *are taken only if they want to determine the paternity of the baby later. Anal swabs are taken in case of minor rapes."* It is clear from this response that medical evidence is considered irrelevant if there are no physical signs of force. Another specialist also said, while talking about love affair cases, *"I haven't received a single case where there is bleeding or injuries."* In such cases the presumption that survivors have consented to sex, along with the belief that sexual violence is necessarily accompanied by injuries, affects the procedures conducted by doctors.

There are several contradictions that arise from this rather simple narrative. On the one hand, the Prevention of Children Against Sexual Offences (POCSO) Act is poised within a liberal legal tradition which views all sexual acts by individuals under the age of 18 as criminal. This law negates any agency and control over body that an adolescent child might try to hold, and criminalizing any expression of bodily desire.

In the same vein, medical evidence is considered a neutral and scientific factor in the legal process, morally unfettered, and unaffected by culture. On the other hand, using such narratives, sexual offences are culturally placed within a patriarchal framework of humiliation and shame that attacks a woman's embodied self and her family's honour. Both of these views together build that any sexual acts (whether consensual or not) by adolescent girls as criminal and immoral. In the narrative above, the criminality and immorality of sexual violence clashes with the supposed neutrality of medical evidence in the legal process. Doctors and police officers do this – individuals acting on behalf of the state, using language, and procedures that are deemed required by it.

9.8.2 Providing Testimony in Court

Doctors who conduct medical examinations in medico-legal cases are frequently called upon to testify in court based on their examination reports. This section examines some of the challenges they face as they perform this role. This section will examine the responses of one of the doctors in a secondary facility who spoke at length at their challenges in providing testimony in court.

The biggest challenge to doctors who are summoned to testify in court is its conflict with the time they have for seeing patients in out-patient (OP) care. They have to attend to a backlog of cases the next day or later in the day if they miss the clinic's timings. One of the doctors in the study said, *"If I don't attend the OP I have a huge backlog… If I have to be there at 2PM in the afternoon, when will I have time to attend to my OP? They are just not considerate. I sometimes have to tell the Magistrate, 'Sir I can't just come here at any time.'"* They feel that the officers of the court are not considerate and respectful of doctors' time when they summon them for hearings.

The doctor here finds that their priority is to attend to patients who need their attention at the moment, and not to people they have seen a long time ago. The long periods of time between medical examination and the court hearing also affects the quality of their testimony. They say, "*Even cases I saw four years back are still coming back to court. Sometimes it gets really late at night by the time I come back. Some of them are not even local – I had to go to Adilabad court once. … If a patient comes today and then the next day immediately sometimes I have trouble recognizing them. It is the same with an injured person. How can I remember something that happened so long back? I see so many people everyday! Even if I write down identification marks etc., sometimes I don't remember. I'm not going to take their picture and keep it with me! So much change is required… More than examining the case, this is a big hassle."* As seen here, the high number of patients they see on a daily basis also results in the low retention of the details of the patients.

They receive very little institutional support in performing this role. In order to testify in court, doctors have to request a fellow medical officer to take over their shift at a hospital, spend their own money to travel to the court, and often do not get reimbursed for their expenses. They also find it difficult to get permission from their supervisors to leave their shifts for a day. The doctor, when asked about this said, "*They don't allow us leaves for anything – even if it's an emergency or a strike or a dharna. They tell us it's not ethical. But doesn't the same rule apply to this? They don't give us half-day leave, they don't give us TA or DA. They say "Aren't you local? Why do you need TA/DA?" How am I local if I am coming all the way from here?"*

The cases I have to testify for in court are over long back. Shouldn't this be the priority? Our work is proceeding on time and efficiently but they are the ones who are slow and creating problems." Here again, the doctor highlights patients in the out-patient clinic as "real" emergency cases and high priority than cases requiring court testimony, especially when courts are slow.

Also evident in the narration of these incidents is the lack of any mechanisms to support doctors if they face any issues from police constables, stenographers or other officers of the court. They find it difficult to navigate the complex court system, including the way it is spatially organized, the process of cross-examination, repeated adjournments, and long waiting periods. Another incident narrated by the doctor highlights these challenges: *"Whatever I get summons for, whether it is for a post-mortem or an MLC or a rape case, if I get a summon I have to go searching for the court. Sometimes they don't even send someone. They just call up on the phone. If it's a PC, I tell them you stay close to me*

and tell me where to go. I have to find the court and the room in the court. Then I have to wait for two or three hours. Some PPs [public prosecutors]*, sometimes even stenographers make you wait. Once, I went at 10 AM and had to wait there till 3PM. All that is such a waste of time. Sometimes they don't communicate with each other – the PP doesn't communicate with the PC, and I am caught in the middle."* Discussing the issues they have with cross-examination, they said "*Once, I issued a certificate saying "No Injuries"- The lawyer questioning me was trying to establish that I didn't issue the certificate myself. If they thought I didn't issue it, why ask me to come? It's such a hassle."*

The doctor in these responses expresses their frustration and mistrust in the criminal justice system, just as they argue that their priority is in attending to patients who need immediate medical attention and care. They see a clear distinction between their role as a doctor and their role in providing testimony, and even though they express willingness in performing the latter role, they find it to be an uphill task. Their views here demonstrate the difficulties of being an expert witness in a court of law, especially given the different ways of approaching survivors of sexual violence in medicine and law. Doctors acting as medical officers in public hospitals find it difficult to reconcile the two approaches. When called upon as doctors to conduct medical examinations, their partial perspective on the law allows them to carry out the medical evidence gathering but when called upon to testify in court, their medical practice takes priority over their role as an expert witness in court.

9.9 Conclusion

In conclusion, it is seen that none of the facilities sampled in the district are prepared to respond to in a sensitive, timely, and systematic manner to survivors of sexual violence in accordance with the Guidelines and Protocols established by the Ministry of Health and Family Welfare. Their infrastructure gaps include the lack of SAFE kits, written standard operating procedures and documentation formats, clear chain of custody for medical evidence, and informed consent protocols to protect privacy of the survivor. Very few of the primary and secondary facilities in the district provide care for and conduct examinations of survivors of sexual violence, in spite of being mandated to do so by the Guidelines.

While the health care facilities are prepared to provide infrastructure for examination, diagnosis, and treatment of the survivor, there is very little legal awareness across the board even to deal with cases that are reported. None of the staff in any of the facilities sampled are equipped to provide holistic, gender-sensitive counselling to survivors. Instead, doctors and nurses who do talk to the survivors about their legal and social options tend to apply their own moral judgement from within a patriarchal framework of considering rape as tainting the survivors' honour. Doctors are legally bound to reconcile their role as a doctor and an officer of the state who is legally obligated to assist in medical examinations and offer testimony. However, we find that doctors have very little idea about the law. They find their role in assisting survivors legally to be cumbersome and a burden to what they see as their medical work.

Chapter 10: Experiences of Nurses and Auxiliary Nurse Midwives (Karimnagar)

This chapter observes the role of nurses in the treatment of survivors of sexual violence in the healthcare facilities in the primary and secondary level. In addition, the chapter examines the training of the nurses in medical examinations and their awareness of law regarding sexual harassment treatments in the hospitals. Broadly, it aims to study the responses and interventions of the nurses in cases of sexual violence. This section will examine a set of interviews researchers had conducted with staff nurses and head nurses at primary and secondary facilities in Karimnagar district between July 2017 and January 2018. According to the MoHFW Guidelines, role of nurses is to care for and collect forensic evidence from survivors of sexual violence.

10.1 Nurses Profile

Researchers interviewed a total of 10 nurses in Karimnagar (rural), 4 of whom were nurses at secondary facilities and 6 at primary facilities. This sample is drawn from all of three the secondary facilities, and chosen six of 16 primary facilities. All of the nurses interviewed provided consent for the interview in writing and two of the nurses also agreed to have the interview audio-recorded. Researchers also interviewed one ANM for every primary health center selected in the sample, thus, a total of 6 ANMs. The interviews consisted of open- and close-ended questions covering general information about their encounters with physical and sexual violence in the course of their work as ANMs, their legal awareness, and any training received regarding response to sexual violence specifically. All of the ANMs interviewed were women.

The age range, education, and years of service of the interviewed nurses are provided in Tables 10.1 and 10.2. Four of them have been employed as nurses for over 15 years, two for 6 to 10 years, and four under 5 years. A majority of the nurses interviewed are diploma holders and further, three of them hold undergraduate degrees.

Table 10.1: Age and Sex Profile of Nurses in the Sample

Age in yrs [Count]				Total	Sex [Count]		Total
20-29	30-39	40-49	50-59		Female	Male	
2	4	3	1	**10**	10	0	**10**

Table 10.2: Study-Sitewise Profile of the study participating nurses

Eeducation		Total	Years of service				Total
Diploma (ANM, GNM)	First Degree (Gradutes)		Upto 5 yrs	6-10 yrs	11-15 yrs	< 15 yrs	
7	3	**10**	4	2	0	4	**10**

10.2 Experience of Responding to Survivors

Two of the nurses in secondary facilities discussed the kind of sexual violence cases they receive in their facility. One of them said, "*A lot of the cases I have seen come to the hospital have been between the ages 15 – 18, but I have not assisted in any examinations myself. The doctors usually do everything themselves during the examination."*

Another nurse also confirmed the high number of cases in this same age group. She was the only one of the nurses in the study who has ever played a role in treatment and evidence documentation of a survivor of sexual violence. "*Over the past one year, we have received 6 – 9 cases of sexual violence, of which 6 have been below the age of 18 and only 2 or 3 have been above the age of 18."* She reported that the procedures for treatment and examination are the same, regardless of the age of the survivor.

Nurses in primary facilities spoke about their lack of experience in responding to survivors. One of the staff nurses at a primary facility said, "*I have been a staff nurse in this PHC for almost 10 years now. I have not seen any cases of sexual violence in all this time. We don't even have time for all the patients who come during OP hours, how can we have the time to care for women who face sexual violence? If we have to do that, we need much more staff."* Here, she highlights the perceived need for more staff if they are to respond to survivors. They see it as a burden over and above their regular out-patient hours. Echoing this sentiment, another staff nurse at a different PHC also said, "*We have not received any cases so far. We are only concerned with medical care. We don't handle cases like that."*

Other staff nurses at primary facilities also spoke about their experience of treating survivors of domestic violence. One of them said, "*Recently we got two women who had faced a lot of violence from their husbands. We gave them first aid and the doctor saw them too. I think that there are conflicts in the family because men and women both have illicit relationships outside their marriage."* She reasons her perception that women face violence from their husbands because indulgence in extra-marital affairs.

Another staff nurse at a different PHC said, "*Some women came with burns a few months back. We gave them first aid and sent them home. I didn't ask her how it happened."* Both of these positions, whether discussing the perceived reason for violence, or not deliberating on the violence at all, are problematic in the course of responding sensitively to survivors of violence.

10.3 Perceived Role in Responding to Survivors of Violence

This section will look at nurses' perceived role in caring for survivors of sexual violence. It covers three themes: first aid and emergency care, counselling and support for the survivor, and assisting doctors in treatment and evidence collection.

10.3.1 Mandatory Police Requisition and Providing First Aid

When asked whether they thought police requisitions were mandatory in responding to survivors of sexual violence, many of the nurses said that they thought it was. When asked about police attitude towards nurses, one of the nurses said, "*They are very respectful towards us. They give us a checklist for us to fill for any MLC. They don't hurry us. They understand that we are busy."*

Most of the nurses in the study said that their role would include providing first aid and emergency care to survivors. One of the staff nurses at a secondary facility said, "*We would administer first aid, give her some psychological support, give her confidence and then send her to the police station. We compulsorily give care, but it is not our role to intimate the police or conduct any forensic examinations without the police requisition."*

A head nurse of a secondary facility also said, "*If they come to us for first aid, we have to give first aid. We tell them that we will start treatment but they have to first go to the police and make a complaint. We sometimes send a note with the attendant to the police station for them to send someone, but usually it's their responsibility to make the complaint. There's nothing we can do if there's no complaint."* However, one of the nurses had a different opinion. She said, *"In such cases, we are not allowed to do first aid. Only the Medical Officer is allowed to treat the patient. We are only nurses. It is not our job."*

10.3.2 Counselling and Pscyological Support for Survivors

Several of the nurses identified the need for counselling and psychological support for survivors. Commenting on the need for counsellors in her facility, a staff nurse at a primary facility said, "*Over the past month, I have seen 5 or 10 women with injuries come to PHC. For everyone who comes here, we give them treatment and ask them how it happened and who did it to them. We don't have anyone who can counsel them, but it would have been really useful if we did."* She mentions the frequency of survivors of domestic violence approaching the health system and recognizes the inadequacies of the system to respond to survivors.

Another nurse at a secondary facility also recognizes the need for counselling but sees it as her own role. She said, "*Whenever we get a rape case, I do counselling and motivation. I say to them 'why did it happen, why did you go as soon as they called you? You shouldn't go as soon as they call you… Your life will get spoilt if you do such things'. We have to tell them to be very careful."* While she is well-intentioned, her response highlights the need for training in the law and understanding of sexual violence. Nurses are expected to, and do provide counselling to survivors. But if their counselling treats survivors as if the violence was their own fault, it might be counter-productive.

One of the nurses who had assisted doctors in medical examinations spoke about what is expected of her during the process. She said, "*We assist the women in taking off their clothes and changing into*

their gown. I do any dressings if they are needed. I then prepare the slides and swabs for examination. During the examination I stay next to the doctor and assist her if she needs anything. They do all the work during the examination. We don't do anything." Here, she describes the limited role of a nurse in current practice in assisting the doctor and treating the survivor.

Table 10.3: Nurses understanding and knowledge of legal reforms in relation to obligations of health care system and providers to survivors of sexual and domestic violence

	(Yes/No)or Agree/Disagree	**Karimanagar (N=10)**
Are you aware of the Criminal Law Amendment Act 2013?	Yes	0
	No	10
Are you aware of the 'Guidelines & Protocols for Medico-legal care for survivors/victims of Sexual Violence' brought out in 2014 by Ministry of Health & Family Welfare Government of India?	Yes	0
	No	10
Are you aware of SAFE kit?	Yes	0
	No	10
Are you aware of PWDV Act 2005?	Yes	0
	No	10
Medical examination of the survivor of sexual violence doesn't (/would not) require police requisition.	Agree	2
	Disagree	8
It is (/would be) mandatory for health care facility both private and public to provide treatment to survivors free of cost.	Agree	0
	Disagree	10
In case of children, it is (/would be) mandatory that the child's parents or guardian or any other person whom she trusts are present during the medical examination.	Agree	0
	Disagree	10
Training of the staff in DV related matters including the PWDV Act 2005 at the hospital is not (/would not be) the responsibility of the hospital.	Agree	4
	Disagree	6
The aggrieved woman must (/should) receive psychological support as part of the therapeutic care.	Agree	10
	Disagree	0
	Total	10

10.4 Training and Legal Awareness

The Ministry guidelines and the Acts dealing with sexual and domestic violence stipulates certain compulsory actions from healthcare facilities in the treatment of survivors of sexual and domestic violence. This segment discusses questions posed to the nurses regarding the knowledge of medico-legal obligations. It is pertinent to observe that the nurses have poor knowledge of all these important matters. They have not received any inputs or the establishments where they work does not use any Standard Operating Procedures.

None of the nurses said that they were aware of any of the laws on sexual or domestic violence. When asked specifically about some of the provisions in the law that deal with medical examination in sexual and domestic violence, 9 out of 10 nurses declined to comment on the issues saying that they were not aware. Only one nurse who has prior experience of assisting in medical examinations said that even though she had assisted, her role was only to prepare the materials and that it did not require any awareness of the law to do so. On domestic violence cases, nurses in one secondary facility and two primary facilities said that they have treated women who have faced domestic violence but they are not aware of the laws on domestic violence. They had only provided treatment in such cases and not made any referrals to counselling centers or government-run crisis centers. They were also not aware of the process of filing Domestic Incident Reports (DIRs) and they had never filed one.

The nurses in the study have received training neither for an examination of cases of sexual violence nor for dealing with cases of domestic violence. All of them expressed interest in being trained in these areas, saying that they think they should know the law on the issue, and understand what to do when they find out that someone has faced violence in their practice. Three of the nurses stressed that they would be interested in learning how to be a first responder in such cases, from a paramedical perspective. Two of the nurses also said that they would be interested in understanding how medical evidence plays a role in cases of sexual violence. Some of them said that they would attend the training programme for however long it took, provided they were given an honorarium and a place to stay. Others said that they would only be able to attend workshops if it was during the day and not if it is a residential programme. They all preferred the training programme to be conducted in either Karimnagar town or the town in which the facility is located.

10.5 Auxiliary Nurse Midwives (ANMs)

This section briefly looks at the experiences of Auxiliary Nurse Midwives (ANMs), village-level health workers associated with selected PHCs in recognizing and responding to sexual violence. ANMs are employed at the sub-centers of Primary Health Care centers. Each subcenter is sanctioned to have one permanent and one contractual ANM colloquially referred to as the first and second ANM respectively. An ANM is expected to be technically competent in assessing and caring for a normal pregnant woman, measuring blood pressure, pulse, fetal heart rate, providing iron-folic acid supplements, and administer TT injections. They are also trained to conduct pelvic examination[14]

[14] A pelvic examination is the physical examination of the external and internal female pelvic organs.

(PV) in order to assess pregnant women and assist in conducting deliveries either in the hospital or in the community. These technical nursing and midwifery skills make her role distinct from the role of an Accredited Social Health Activist (ASHA). ANMs are primarily responsible for monitoring, evaluating, and caring for pregnant women through regular antenatal checkups.

ASHA is a community-based woman trained to mobilize the community and women to demand and utilize services for maternal, reproductive, and newborn care. They are supposed to be the first point of contact at the village level to facilitate access to health care services.

10.6 General Information about Survivors

ANMs' role as a liaison between the village-level subcenter and the Primary Health Center through weekly meetings allow them greater access to the women in the community, potentially allowing them to take immediate cognizance of women facing physical and sexual violence. Researchers interviewed one ANM for every primary health center selected in the sample. The interviews consisted of open and close ended questions covering general information about their encounters with physical and sexual violence in the course of their work as ANMs, their legal awareness, and any training received in effect to respond to sexual violence specifically. Their responses will be summarized and examined in order to consider the possibility of working at the lowest possible rung of the health system to reach survivors of sexual violence (who might otherwise not approach the police or report the violence they face). Some of the ANMs' responses were sensitive, aware, and informative about their field areas. Many other ANMs were not as cued into sexual or domestic violence field areas. They felt that it was not their job to intervene or otherwise did not discuss their experiences with the researchers.

Researchers received very little information about ANMs' personal experiences of responding to violence or even their awareness about sexual violence in their field area. When asked about whether they had heard of or come across any such instances, respondents in the study mentioned that they had heard about incidents of sexual violence through newspapers and television, or their colleagues and others in the village. One of the ANMs said, *"I have heard about sexual violence and domestic violence through newspapers and TV. I have not come across anything like that in my field area."*

Several of the respondents said that they had come across several rumours about couples having fights and domestic violence perpetuated by the husband. In one of the ANMs' words, *"I have heard about sexual violence and attacks between husband and wife and other persons also. Women frequently face violence from their husbands. It is not anything new. Violence is certainly there, but none of them come to us with visible injuries."* She recognizes the ubiquity of violence but also expresses her helplessness at the issue. She went on to narrate an incident that took place in a neighbouring village, *"5 years ago, a 25-year-old man in a nearby village raped two elderly women. One of those women died and another woman was seriously injured. The man was punished and went to jail, but he was released after that."*

One of the ANMs, commenting on the wide prevalence of domestic violence said, *"Our own ASHA workers are facing violence from their husbands. What can we do?"* Another ANM also discusses

working with women who face domestic violence. *"Domestic violence keeps happening in families, it's not seen as something uncommon. Women often come to ask me for tablets to help them deal with body aches and injuries. But I haven't really thought about it more deeply."*

Commenting on women having alcoholic husbands, another ANM said, *"Many women, whose husbands are alcoholics, come to meet me when they are pregnant. I tell them to be careful… What else can we do?"* Commenting on the ASHA workers who they supervise, one of the ANMs said, *"ASHA workers tell us a lot about their financial issues, but otherwise they don't tell us about what happens with their husband. I don't tell anyone about my fights with my husband either…"*. The nurses neither reported any case of domestic or sexual violence in the past three months nor do they maintain a register for it.

Two of the ANMs, when asked whether they see a correlation between caste and violence, they had said that they did. One responded, "*Sexual violence will be there irrespective of caste or religion but in my village it is higher amongst SC castes."* Another responded, "*In my village I see the BC* [Other Backward Castes] *men being more violent than others."* However, another ANM said, *"It has nothing to do with anybody's caste. Anybody can face violence."*

10.7 Intervening in Domestic and Sexual Violence

When asked about what they would do if a survivor of sexual violence approaches them, one of the ANMs said, *"We are only available in the village subcenter on Thursday mornings. They only know that we do immunisations and assist pregnant women. Why will anyone come to us to talk about violence?"* They felt that women of the village do not confide in them regarding matters of domestic or sexual abuse merely because ANM's presence in the village is not of a duration long enough to merit women's trust in them. Echoing this sentiment, another ANM also said, *"These kinds of things happen all the time, but nobody really tells us about this. We come from outside the village, so nobody trusts us."* One of the respondents said that they would first administer first aid and then speak to their family members. *"If they ask for help, I will give first aid and then speak to the family members. But it has not happened so far."* Another of the respondents said that she would listen to what they have to say while also ask them to be careful and take care of themselves.

When asked what is the first place that they think a survivor of sexual violence ought to go to, a majority of the respondents said that they ought to ideally go to the hospital. One of the ANMs said, *"They probably have injuries so they should go to the hospital. But people don't do that. They think they should go to the police first."* Another ANM said, *if they face violence from their husbands, I think they should first go to their parents. Then they should approach their friends and neighbours. If they are injured, they should go to the hospital, then to the police to file a case. Usually people just adjust. They don't do much when they face violence. They just bear the pain, that's all. If they face any sexual violence from a stranger, it depends on whether they are married or not. If they are married, they usually don't face any sexual violence from strangers."*

Only one of the respondents said that they should go to the police station before they approach a hospital. This opinion is fairly consistent with the experiences of both doctors and nurses.

None of the ANMs were aware of any of the laws on sexual or domestic violence. When asked specifically about some of the provisions in the law that deals with medical examination in sexual and domestic violence, they declined to comment on the issues because they were unaware. None of the ANMs in the study had received any training either for an examination of cases of sexual violence or for dealing with cases of domestic violence. All of them expressed interest in being trained and know the procedure in case they come in contact with someone who faced violence in their village. Some of the nurses had claimed that they would attend training programmes if there was honorarium and place to stay during that time. Some others had claimed that they will be unable to attend these programmes if the workshops are residential or away from their town/villages.

Conclusion

The Guidelines require all medical professionals in all public health facilities including doctors, nurses, counsellors, social workers, and outreach workers to be aware of the law and best practices around sexual violence. None of the doctors, nurses or outreach workers who were interviewed for this study received any training after the publication of the Guidelines. Nurses have the capacity and the inclination to play a larger role in the care of survivors but do not have adequate training to do so. Auxiliary Nurse Midwives (ANMs) are also poised at an important position where they may be the first point of contact for survivors at the village level, but they are yet to receive any training to adequately respond. Overall, there are miles to go before public health facilities in Karimnagar can be transformed into a safe environment for survivors to seek and receive sensitive, timely, and empathetic care.

Chapter 11: Summary & Recommendations

This study contributes to important discussions on policy, programmes and action in the area of gender equality particularly, gender-based violence. Eliminating all forms of discrimination and violence is part of several global and national mandates to which India is a signatory. This final chapter of the report comprehensively presents the findings of the study carried out in Pune, Maharashtra and Karimnagar, Telangana to understand the preparedness of health systems to deal with sexual violence cases. The chapter also provides a broad set of recommendations to strengthen and enhance the capacity and preparedness of all health systems to provide necessary health care and also carry out robust medico-legal evidence gathering.

11.1.1 Health care systems obligations: Global Mandate

In May 2014, the Sixty-seventh World Health Assembly adopted resolution WHA67.15 on "Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children" (WHO, 2014). India is a signatory to this resolution along with more than twenty countries that have agreed to the resolution. WHO has unveiled the "Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls and against children" (World Health Organization, 2016). The global plan of action elaborates on the role of the health sector in responding to violence against women, girls and children and also functioning within a multi-sector response system.

Achieving gender equality is SDG 5 among the 17 Sustainable Development Goals released in 2015. Gender is a cross-cutting goal that is present in 53 targets within the 23 unique goals of the 17 SDGs. The SDG Goal 5 encompasses a multi-dimensional approach to gender equality and empowerment of all women and girls. Among the 14 targets of SDG 5, some include ending discrimination and VAW, including trafficking and sexual (and other types of) exploitation; ending child, early and forced marriage and ensuring universal access to sexual health and reproductive rights, which have direct relevance to the present research.

11.1.2 National mandate

The legal reforms such as Criminal Amendment Act 2013, the Protection of Children Against Sexual Offences Act, 2012 and the Protection of Women from Domestic Violence Act, 2005 (PWDVA) which cover sexual violence against women, girls and children and spousal violence, respectively. Responding to these legal changes, the Ministry of Health and Family Welfare (MoH&FW) issued Guidelines in 2014, for medico-legal care for survivors of sexual violence keeping the inter-sectoral response, medical evidence collection and survivor centric medical care.

The most recent National Health Policy (MoH&FW, GoI, 2017) and Guidelines (MoH&FW, GoI, 2014) provide an explicit mandate that the health care system has towards survivors of violence. We have discussed at length earlier the mandate defined in the Guidelines. Below is the mandate reflected in the National Health Policy:

> *"Women's access to healthcare needs to be strengthened by making public hospitals more women friendly and ensuring that the staff have orientation to gender – sensitivity issues. This policy notes with concern the serious and wide ranging consequences of GBV and recommends that the health care to the survivors/ victims need to be provided free and with*

*dignity in the public and private sector.". (*National Health Policy 2017, Ministry of Health and Family Welfare, Govt of India; pp:14).

The recently published Voluntary National Review 2020 by NITI Aayog submitted to the UN High Level Political Forum for Sustainable Development 2020 with reference to SDG 5 recommends that "evaluation of government programmes with the objective of ensuring gender equality at state, central and local level is essential in making policies adaptive and responsive to change." (NITI Aayog, 2020: 150).

11.3 Present study

The present study attempts to understand the preparedness of the health systems and the capacities of the health care providers in achieving the broader objectives of the global and national mandates with regard to addressing violence against women, girls and children.

This study aimed to understand infrastructure and human resources availability, assess health care providers' knowledge of the Ministry Guidelines and recent legal reforms in rape laws, and examine their attitudes towards these reforms. Best practices of health care consist of medico-legal examination, clinical treatment, preventive therapy, empathetic listening, psychosocial support, provision of information and referral networks to the survivors (García-Moreno et al., 2014).

A gender-sensitive and integrated care to survivors of sexual violence must respond to the legal requirements of medical/forensic evidence gathering as well as attend to mental, physical, psychological and reproductive health consequences of the assault. This report presents the medico-legal practices and responses to survivors of sexual assault within the public health care system and, in addition, the preparedness of the sector to respond to the same.

11.4 Context of the Ministry Guidelines

As per the Ministry guidelines, a healthcare facility must be equipped in terms of essential facilities and infrastructure for examination, have clear protocols for care and foster gender sensitive environment. In the case of children, medico-legal response is mandated in the Protection of Children Against Sexual Offences Act, 2012. POCSO Act redefined sexual assault against children (both male and female) by including all forms of penetrative and non-penetrative actions, aggravated sexual assault, sexual assault for purposes of pornography and attempt to commit sexual assault. The act holds that personnel in any institution providing service to child-victims of sexual abuse must mandatorily report the case. Protection of Women from Domestic Violence Act, 2005 (PWDVA) considers different forms of intimate partner violence and the role of health care providers in such cases are discussed.

11.5 Study Design

A set of four comprehensive tools were administered. The tools were as follows: (1) Observation checklist for collecting information on the health infrastructure; Structured Interview guides for (2) Doctors (3) Nurses and (4) ANMs and ASHAs. The tools were reworked versions of similar tools used by Pitre and Pandey (2008) which were augmented with several questions on the changed laws and the mandatory provisions given in the laws and in the Guidelines. The tools were finalized after pilot testing in the field. A mixed methods approach was adopted with both quantitative and qualitative research components. This study did not engage with survivors of sexual violence or

observe the handling of sexual assault cases in the hospitals. This study used KAP method to note that policy implementation gap includes stakeholders' awareness of the issue, their attitudes toward the issue and the policy/legislation and the compliance of their practices with the legislation or Guidelines.

11.6 Study sites

The states of Telangana and Maharashtra were the two sites for this study. Maharashtra is placed in the category of 'high incidence' while Telangana falls in 'medium-high incidence' of crimes against women. Maharashtra is considered to be one of the progressive states in terms of performance on health indicators and access to health services. Both the states have wide rural-urban gap among healthcare facilities (HCF) in number and quality. These states also have a high number of private hospitals in the urban areas as compared to the rural areas and unfilled vacancies in the public hospitals. Pune district in Maharashtra and Karimnagar district in Telangana were selected based on the district crime against women statistics. We covered both urban and rural health care facilities from Pune and Karimnagar.

11.7 Study Findings from Pune District

The data was collected from public healthcare facilities in Pune. In the rural-Pune, 8 PHCs, 25 Secondary Hospitals were chosen. In the urban-Pune, 9 hospitals run by Pune Municipal Corporation or Pimpari Chinchawad Municipal Hospitals, two Tertiary Hospitals and one secondary hospital were selected.

11.7.1 Health care facilities' preparedness

- **Physical infrastructure in HCFs:** Out of the 45 HCFs, 44 had designated government buildings as the hospital space. 60% of the buildings were in good condition and eight HCFs had adequate rooms and facilities to handle cases of sexual violence.
- **Health Facilities to handle Sexual Violence cases:** Only 3 HCFs had separate room for medical examination. While 21 facilities had the facility to lock the room and also had auditory and visual privacy, only 12 HCFs had the room available for 24 hours each day. All the facilities had a toilet in the building, which was clean and had water. 13 HCFs changed the linen after each SV medical examination while 9 facilities did not.
- **Clinical Competence:** Out of the 45 sampled HCFs, 27 facilities reported that surgeries take place frequently. The competency for surgical intervention depended on the size of the hospital and almost all Secondary Health care facilities had the necessary competency to handle sexual violence cases, though they may not. Around 40 hospitals had the facility to test blood samples; only 30 had a system to safeguard the collected samples.
- **Medical Equipment and Supplies for evidence gathering:** Out of the 31 hospitals that reported handling sexual violence cases, all the facilities had syringes and needles, distilled water, disposable gloves and containers to dispose needles; and 30 had EDTA Tubes[15] and Vaginal speculums. While 26 hospitals had medications to provide to the survivors, 28 had Pregnancy Test kit. With regard to forensic examination, **only two hospitals had SAFE kits**,

[15] When blood is collected during the medical examination of the sexual assault survivor, it is supposed to be transferred into three 3 sterile vials for the following purposes: Plain Vial for - Blood grouping and drug estimation, Sodium Fluoride - Alcohol estimation and EDTA vial for - DNA Analysis.

or camera to capture evidence, and only five facilities had Toluidine blue dye[16]. Only half of the hospitals (15) had clean clothing for the survivors and only 10 hospitals had documentation forms for medical examination. Around 28 hospitals had microscope and 19 had colposcope while all the hospitals had glass slides.

- **Diagnostic tests, treatment medicines and contraceptives:** This information was gathered from all the HCFs surveyed (45). Around 44 facilities had provisions for HIV Rapid Test, Pregnancy Test and Tetanus Prophylaxis. While 28 hospitals provided STI prevention treatment, 38 hospitals had emergency contraceptives for the survivors.
- **Counselling:** About half of the facilities provided counselling for the survivors.

11.7.2 Protocols and Procedures in HCFs

- **Doctors who examine SV cases:** Only 27 HCFs accepted and provided care to survivors of Sexual Violence though 31 hospitals had received such cases. In the sample, there were only two woman doctors and two gynaecologists who had examined a survivor. Most times the Medical Officer-On-Duty performs the examination (23 responses). Further, 10 responses noted that male doctor in the presence of a female nurse attends to the survivors of SV cases and two responses noted that male doctor with female attendant handles the SV case.
- **Reporting to Police:** Healthcare Providers (HCPs) were of the opinion that filing FIR is not mandatory. If the survivors did not want to file a complaint, a general sentiment among the doctors was to honour their decision (or rather get a written statement stating the same). HCPs preferred to inform the police of the SV case to safeguard the concerned HCF.
- **Referral practices:** 28 HCPs referred their SV cases to tertiary hospital (Sassoon Hospital) in Pune. Most responses claimed that if the particular HCFs are inadequately equipped for examination then the cases are referred to neighbouring HCFs or tertiary centres, especially when the survivor needs medico-legal care as that requires gynaecologist or specialist.
- **Consent seeking:** Only 20 HCPs reported that they seek consent for a medical examination in treatment of survivors while only 16 HCPs said that their HCFs seek consent for collecting samples. However, only one doctor sought consent from the survivor for informing the police about the incident. In case of children, consent is sought from the children and the forms are signed by the accompanying adults.
- **Availability of Standard Operating Procedures (SOPs) & Consent forms:** Only 7 HCPs declared to have SOPs to handle survivors of Sexual Violence and three did not know the existence of SOPs. Almost two-third (20) participants noted that their HCF did not have any standard template for seeking consent from the survivors. Other 10 HCPs were not aware of any such standard documentation of consent.
- **Practice of Two-Finger-Test (TFT):** Around 20 doctors had performed TFT as part of examination and 10 had never performed TFT. Some doctors asserted the importance and essentiality of TFT in eliminating an occurrence of sexual assault (the general assumption being that the assault is a false claim). A couple of doctors also mentioned that TFT is performed because the police require it and force them to comply. A few doctors had mentioned that TFT is necessary to identify nature of injuries or infections and therefore, it has to be decided on a case-to-case basis.
- **Availability of IEC materials:** No facility had any Information, Education and Communications (IEC) materials on either sexual or domestic violence on display.
- **Presenting Evidence in the courts:** 10 doctors had attended the court to present the case. However, the doctors believe that the court discounts their opinions and evidence and the

[16] Toluidine blue dye is used for identifying and highlighting micro injuries.

opposition lawyers demand expert opinions. Further, the doctors mention that their entire day is lost in the court and at times, court raises questions on incomplete papers or missing signatures.

11.7.3 Knowledge, Attitudes and Practices

- Out of the 76 doctors, nine knew about CLA 2013 and four were aware of CLA 2013 but not in much detail. 14 doctors knew about PWDV Act 2005 with two who knew it but not in much detail. Only 12 doctors were aware of MoH&FW Guidelines and three knew it sketchy. Only 6 doctors knew about Maharashtra government's Guidelines on PWDV Act while 70 did not know.
- 91% of the doctors, ANMs & ASHAs, and all nurses except one, believed that both private and public HCF must provide treatment to SV free of cost.
- 63 percent of doctors had believed that medical examination of SV does not require police requisition. Around 47 % nurses and 66% outreach health care workers supported the same. However, in the case of responding to child survivor, 84% of the doctors felt that it is mandatory to inform the police of the case.
- 82% of the participating doctors agreed that it is their responsibility to provide an opinion on the sexual assault case and provide adequate reasoning.
- Although 70% of doctors found the potency test to be irrelevant, 30% believed that potency test of the accused is necessary.
- All participating doctors, nurses and outreach workers asserted that women must also receive psychological support and 92% believed that the survivors must be given emergency contraceptives.
- In case of child survivors, guardians/parents must be present during examination, according to 98% of the doctors, 46 responses of the nurses and 24 of ANMs & ASHAs. However, some of the doctors noted that at times, angry adults accompany survivors and their presence makes the children uncomfortable.
- About 65 percent doctors reported that it is essential to have a woman gynaecologist examining a survivor, as the survivors might not feel comfortable otherwise.
- About 89.5 percent of the participating doctors disagreed that presence of injuries is necessary to arrive at an opinion that a woman has been SV/raped. Few doctors did comment that doctors must not judge the survivors and rather believe the survivors as it is the job of the court to judge a narrative as true or lie.
- 41 out of 76 doctors believed that documentation of prior sexual activities is required as evidence. A few responses believed that this information would be helpful in learning the status of vagina and as evidence of sexually transmitted diseases.
- Around 80-83% of the nurses and outreach workers believed that it is the responsibility of the hospitals to train them to handle Domestic Violence (DV) related matters. In handling DV cases, 75% doctors agreed that they are mandated to fill a detailed information report (DIR) and 88% of doctors understand that the DIR has to be sent to the Protection Officer in-charge within 3 working days.
- 60 out of 76 doctors reported that they never had an opportunity to undergo training or orientation programmes concerning post-Nirbhaya reforms, the Guidelines, and any PWDA 2005-related matters while 13% had participated in such workshops/training.
- About 83% of the doctors expressed their interest in attending relevant training to handle both SV and DV cases.

- Some doctors believed that more staff should be trained and recruited to deal with SV and DV cases due to the already overcrowded nature of the HCFs.
- 91% of the nurses never had opportunities to participate in training sessions related SV or DV cases. Most responses underscored the necessity of training in counselling apart from legal aspects of care. Among ANMs & ASHAs, 8 out of 26, reported that they have had training. All outreach workers, except one, were interested in more training.
- Many responses from doctors, nurses and outreach workers suggested social and legal aspects of care must be the focus of these training programmes and also, awareness about the network of organisations that provide shelter and legal aid for the survivors.

11.8 Study Findings from Karimnagar district

The data was collected from public healthcare facilities in the newly-formed Karimnagar District. 7 PHCs and 3 CHCs (secondary level) were selected according to the number of reported rape cases. None of the PHCs reported accepting cases of SV.

11.8.1 Institutional preparedness

- **Physical infrastructure** in HCFs- All HCFs had designated government building and had adequate facilities and rooms to handle SV. Two HCFs had a bed capacity of 25-50 beds but 8 others had 5-10 beds.
- **Health Facilities** to handle Sexual Violence cases- only 2 HCFs had separate room for medical examination and none had Auditory and Visual privacy or separate wards for women. In two of CHCs, labour room was used as examination area for survivors. Only 2 centres had the facility to lock the doors or change the linen after SV examination. All the facilities had a toilet with water supply but only 6 of them had clean water supply. Only two CHCs handled SV cases and had MLC Register.
- **Clinical Competence**: While 2 of the CHCs carried out C-section surgeries, one had provision only for minor surgeries. None of the CHCs provided diagnostic tests for STI/RTI. All the three CHCs had facilities to conduct blood test, a storage facility and a lab technician. Although two of them had X-Ray facilities, they had no lab technician.
- **Medical Equipment and Supplies for evidence gathering**- the HCFs are underprepared to handle SV cases. With regard to forensic examination, none had SAFE kits, spare clothes, or camera to capture evidence. All of them had Toluidine blue dye, EDTA Tubes, urine sample container, microscope and colposcopy.
- **Diagnostic tests, treatment medicines and contraceptives:** Both PHCs and CHCs had provisions for Pregnancy test kit, HIV Rapid Test and Hepatitis B Vaccination. While only 5 PHCs had emergency contraceptives, all of the CHCs had stock of contraceptives. While STI Prevention treatment was available in four PHCs, secondary health facilities referred patients to neighbouring facilities for the same.
- **Staff and Team-** Only five PHCs had women doctors while they were available in all secondary facilities. According to the heads of the facilities, either their gynaecologist was already over-burdened with her workload or they are not available in the facility and that is the reason to turn away survivors.

11.8.2 Protocols and Procedures in HCFs

- **Standard Operating Procedures:** None of the facilities in the study reported having a set protocol or standard operating procedure in place for responding to survivors of sexual violence.

- **Police Initiated Examinations:** Medical officers who were interviewed did not know about any such format for documentation. They document their observations on forms given by the police.
- **Lack of Referral:** None of the facilities had systematic referral system in place for survivors of SV whom they could not handle in the facility premises.
- **Consent Forms:** None of the facilities had uniform consent protocols or forms available.
- **IEC materials:** No facility had any Information, Education and Communications (IEC) materials on either sexual or domestic violence on display.
- **Counselling services:** None of the facilities provided counselling for the survivors.

11.8.3 Knowledge, Attitudes and Practices

- **Informed Consent:** With reference to consent most doctors said that in the case of child survivors consent has to be given by the survivor's attendants or the police. They also claimed that since the police bring the survivor, one does not need any consent forms. Almost all the doctors were of the opinion that if the police have sent a requisition form for examining the survivor, separate consent procedures by the health system are not necessary. Further, some respondents interpret Informed Consent as equivalent to cooperation to medical treatment and examination. The doctors note that they explain the procedure to the survivor and that they need to cooperate. In case of seeking consent from the accused, the doctors believe that consent from the accused is not necessary.
- **Practice of Two-Finger-Test:** The two-finger test is also known as the virginity test that examines the elasticity of the vagina and the presence of hymn. All of the doctors interviewed were of the opinion that the two-finger-test (TFT) and the hymen test are standard and required in medical examinations. In the context of married or older women, a few doctors question the efficacy of the TFT. The police requisition for filing the MLC has a point in the form asking information if the vagina is permitting one/two/three fingers.
- **Presenting evidence in court:** Doctors state that the officers of the court are not considerate and respectful of a doctor's time when the doctors are summoned for a hearing. The doctors feel that their current patients require their attention than a survivor examined some years ago.
- **Counselling Support:** Many doctors at the primary level deem medical care as inadequate for survivors of sexual violence. Doctors in the study frequently discussed counselling and emotional support as a part of their role. A counsellor provides support to survivor especially in matters such as deciding whether to pursue this case with the police or to continue relationship with the perpetrator.
- **Reporting to Police:** All doctors stated that survivors of sexual violence only come to the purview of the healthcare facility through the police and most often after filing a report. According to them, it is not the doctors' responsibility to share information with the police and that the survivors and their families must decide for themselves whether or not to report it. Some doctors also held that families hide the incident and keep it secret to secure the future of their children or young women. However, the duty doctor in the same facility, often dealing with medico-legal cases, feels that their first responsibility is to inform the police in cases of SV.
- **SV seen as violation of Honour:** Doctors associate SV to violation of honour. Some of them counsel the survivor against seeking legal recourse to avoid problems for the survivors and further, by making it public, bringing shame and dishonour to the family.
- **Presence of Injuries:** All the participant doctors disagreed that presence of injuries would be necessary to declare being sexually violated but at times, some doctors asserted the opinion that recording injuries and their location is central to establishing rape. Some doctors hold the view

that only when there are signs of 'genuine' force, then it is rape, in its absence, there is no medical evidence and they are just 'love affairs'.

- **Collection of clothes:** Doctors did not have much clarity regarding seizure of clothes of the survivors or broadly, evidence management. They believed that their duty is to conduct medical examination and the police would collect any other evidence including clothes.
- **Potency Test:** With regard to potency test of the accused, the doctors examine the male accused to check if he is healthy. Doctors reported that they do not collect other samples such as skin or dirt under nails or injuries on the body specifically connected to rape.
- **Child cases:** In the case of child survivors, doctors' responses emphasise on a holistic examination of the child abuse survivor inclusive of physical and mental consequences. The respondents note that child survivor's experience is different from adults and their long-term effects include malnourishment and trauma.
- **Woman Doctor:** Predominantly, doctors believed that either only woman doctor may examine survivors of sexual violence or female gynaecologists may only conduct such examinations. Some of the doctors also said that any medical practitioner registered with the State Medical Council may examine survivors but the police prefer women doctors.

11.9 Common Issues across Pune and Karimnagar

Across both the sites of our study we have observed serious lacunae in providing comprehensive and sensitive services and the presence of organisational constraints. Below we present select key observations:

11.9.1 Health Infrastructure

Health care providers complain about the lack of adequate infrastructure. With the current infrastructural constraints, health care providers feel that privacy cannot always be guaranteed due to the lack of space required for proper examination of survivors. Shortages of equipment, supplies, facilities for storage of forensic samples and essential medications are common.

11.9.2 Work Loads

The discussions with health care providers revealed a lack of prioritisation of violence against women in general, as they do not perceive it as a regular clinical issue. Their daily caseload and commitment to other patients is often projected as a priority. Healthcare professionals feel that the health systems are under resourced in terms of infrastructure and human resources, hence great deal still has to be done to ensure that adequate resources are available to offer survivors proper standard of care. Doctors suggest the need for more human power like woman gynaecologists, social workers and counsellors to personalise care to survivors as well as spend more time offering proper psychosocial support and counselling. The need for providing psychological and trauma support to the survivor is acknowledged, however, it is often referred to as a task to be taken care of by non-medical people.

11.9.3 Lack of Protocols

HCFs at the primary and secondary levels do not maintain any protocols. HCFs receive cases through the police and they follow outdated formats given by the police, which is not in consonance with the changed guidelines and law.

11.9.4 Lack of Training

Health providers expressed dissatisfaction about the lack of training on forensic evidence collection in primary and secondary level health centres. Since the changes in the law and the stipulations are not

clearly known, they prefer to refer the survivors who present themselves to the hospitals or are brought by the police to the tertiary hospital at the district. Due to lack of availability of trauma care, counselling and follow up care, most of the survivors do not return to the hospital. Across all levels of health functionaries – Doctors, Nurses, ANMs and ASHA workers expressed the desire to receive training on the guidelines and also the changes in laws that has implications to their practice.

11.9.5 Sexual assault cases handled mostly at the Tertiary level

Other than the doctors at the secondary health care settings, in none of the other health care facilities in Pune or Karimnagar receive or provide services to women and girls who come on their own or are brought in by the police for medico-legal examination. Across both the states, tertiary hospitals handle most of the sexual assault cases since the police prefer to take them there. We could not get permissions to study the tertiary hospital in Pune and could not get cooperation to study the tertiary hospital in Karimnagar.

When sexual assault cases are handled only at the tertiary hospital which is generally also the district hospital or the one that is in an urban centre, it is likely to be disadvantageous to women and girls from distant tribal and rural habitations to reach a police station and then a tertiary hospital. If they approach a police station with a complaint of rape, they are referred to or transported to the tertiary hospital. This is done with very little information on how to preserve the evidences on the body and clothing. This is likely to lead to under reporting or time-lag between the assault and the evidence gathering and provision of health care. The first point of contact at the village level could be the ASHA and/or ANM, and the Primary Health Centre for women survivors. However, women do not approach them and moreover, the health care providers at this level are also not equipped to handle these cases.

11.10 Broad Recommendations

Maharashtra and Telangana are ranked 9th (0.696) and 16th (0.669) on the 2018 Human Development Index[17]. According to NITI Aayog's ranking of states on progress being made on several Health Indicators[18], Maharashtra is considered as a high performing state and Telangana as a medium performing state. The districts chosen for this study, Pune from Maharashtra and Karimnagar from Telangana are also ranked high on the HDI of the respective states and ironically also record higher crimes against women. Drawing upon the study findings, we noted in the report less than adequate responsiveness of the public health care system to sexual violence cases, across the two study sites. Based on the study findings and our experience of carrying out this study, we wish to forward the following recommendations to the Ministry of Health and Family Welfare and other significant ministries like the Ministry of Women and Child Development.

11.10.1 Mainstream the Guidelines

The post-Nirbhaya reforms and Ministry Guidelines ought to apply across the country uniformly. However, we observe, with health being a state subject, the Ministry guidelines to guide and strengthen the health system's response to sexual violence is not adopted uniformly by all states. A Parliamentary question posed to the Health Ministry in the Lok Sabha on 9th March 2018, enquiring about (a) whether the Government has taken any steps to train medical practitioners in States about

[17] Cf. (2018). Indices 2018: *Subnational Human Development Index (4.0).* Global Data Lab. https://globaldatalab.org/shdi/2018/indices/IND/?levels=1%2B4&interpolation=0&extrapolation=0&nearest_real=0

[18] NITI Aayog (2019). Healthy States: Progressive India- report on the Ranks of States and Union Territories. NITI Aayog, MoH&FW and The World Bank. Available at: http://social.niti.gov.in/

the Guidelines for Medico-Legal Care for Survivors of Sexual Violence; (b) whether there is any mechanism with the Government to monitor the effective implementation of these guidelines in the States which have adopted these guidelines and; (c) whether the Government has any State-wise figures of the number of complaints wherein the medical practitioner failed to comply with the standardised procedures for dealing with survivors of sexual violence? To these questions, the Health Minister gave a written reply - that through a letter vide 17th April 2014, all the States and Union Territories were informed about the guidelines; the Ministry had conducted few workshops in collaboration with the WHO and since health is a state subject, the Ministry has no data about implementation of the guidelines[19]. As per an ICRW report (Bhate-Deosthali, Rege, Pal, et.al.,2018) about nine states in India, have adopted the guidelines and have sent out necessary Government Orders guiding their state health facilities to follow the guidelines.

The Ministry of Health and Family Welfare, has to evolve a robust strategy where the guidelines are officially adopted by the states and health care providers are trained; standard operating procedures are in place and the health infrastructure is augmented to meet the requirement of attending to sexual violence cases.

11.10.2 Enhance Budgetary Allocations to deal with GBV

The Guidelines released by the MoH&FW to address sexual assault on women, girls and children is not being implemented and complied with since no budgetary allocations are tied to the implementation. It was perhaps assumed by the MoH&FW that the availability of guidelines will enhance the practices of the doctors in carrying out sound medical evidence gathering, documentation and extension of care and support to the survivors. However, this cannot happen unless it is systematically addressed in terms of infrastructure of health care facilities and awareness, knowledge and practices of health care providers.

It is recommended that separate allocations be made within the National Health Mission to facilitate the implementation and compliance to the guidelines. In addition to seeking an increase in budgets for health in the Union Budget, MoH&FW may seek funding through the Nirbhaya Fund to attend to the following requirements:

- Capacity building of all casualty medical officers, gynaecologists, paediatricians and doctors in charge of medico-legal work, paramedics and counselling staff for providing sensitive care for all survivors
- To set up a special room as per standards with protocols and SAFE kits in the hospital for examination of sexual violence survivors.
- Create child-friendly examination rooms
- Necessary provisions for collection and transfer of forensic evidence.
- All the necessary medical requirements to provide services to the survivor and
- Compensating survivor for any tests not undertaken at the hospital.

Within the Union Budget, there needs to be an increase in the overall funding for women and particularly to address gender-based violence on women, girls and children. A recently published Oxfam report (2021) estimated an annual budgetary requirement of INR 10,000 to 11,000 crores for just women-specific programming to address GBV in India. As per this report the figures for women and girls facing domestic violence and sexual violence are as follows:

[19] http://164.100.24.220/loksabhaquestions/annex/14/AU2392.pdf Accessed on 1st February 2021

Table No 11.1 : Estimated affected population for designing VAWG response services in India	
Domestic Violence	**Sexual Violence outside Marriage**
There are an **estimated 8.44 crore women and girls** affected by Domestic Violence in India	There are an estimated **0.54 crore women and girls** affected by sexual violence in India
All these 8.44 crore need emotional support, and integrated socio-legal responses such as those provided by helplines and One Stop Centres	These are women who complained of sexual violence outside of spousal violence
Of these => 1.83 crore also need medical attention =>1.20 crore additionally require access to protection officers and service providers =>0.05 crore would also be in need of temporary shelter and free legal aid services	All these 0.54 crores need emotional support, and integrated socio-legal responses such as those provided by helplines and One Stop Centres
	Of these, =>0.27 crore would additionally require child protection services =>0.01 crore also need medico-legal care, crisis intervention centres, prosecution and judicial services.

Source: Oxfam, 2021, Table 1: p. 23

In 2019-20, the Ministry of Finance provided an amount of INR 4357.62 crores under the Nirbhaya Fund (MWCD Annual Report, 2019-20). It has been observed that most of the schemes approved under the Nirbhaya Fund are under-utilised. Further, nearly 73% of the fund is allocated to the Ministry of Home Affairs (Police). It is unclear how these funds have been utilised to address GBV directly by the Ministry of Home Affairs[20]. Initial reports of utilisation focused on several technological solutions like mobile phone apps, installation of CCTV cameras and so on. The funding for Sakhi centres (One Stop Crisis Centres) comes from the Nirbhaya Funds. According to this report, Nirbhaya funds allocated to deal with GBV need to be augmented and the allocations for schemes and programmes have to be for initiatives that have direct relationship to mitigating GBV and alleviating the lives of survivors.

11.10.3 Integrate Violence against Women related indicators in Health sector monitoring

To motivate States to improve population health and reduce disparities NITI Aayog had brought out a publication in 2019 titled[21], "Healthy States: Progressive India" in collaboration with the Ministry of Health & Family Welfare (MoH&FW) and with technical assistance from the World Bank. This publication presents the performance of States and Union Territories on specific indicators. The Health Index is a weighted composite Index based on 23 indicators grouped into domains of Health

[20] https://scroll.in/article/987314/nirbhaya-fund-could-help-improve-womens-safety-but-money-allotted-for-schemes-is-underutilised#:~:text=All%20ministries%20and%20department%20implementing,for%20the%20department%20of%20justice.

[21] NITI Aayog (2019). Healthy States: Progressive India- report on the Ranks of States and Union Territories. NITI Aayog, MoH&FW and the World Bank. Available at: http://social.niti.gov.in/

Outcomes, Governance and Information, and Key Inputs/Processes. The MoH&FW had decided to link a part of NHM funds to the progress achieved by the States on the Index. This index is being monitored on a regular frequency.

It is suggested that MoH&FW advocate with the NITI Aayog to include health systems preparedness to respond to Sexual Violence cases in the Key Input/Processes data points. Suggested in indicators are:

- number of hospitals (tertiary and secondary) that have Safety kits & the infrastructure to address sexual assault cases
- number of staff trained to handle sexual violence cases as per the guidelines
- number of staff trained to provide information and referrals at the sub-centre & PHC levels
- primary prevention of violence against women being done by the State health department by building collaborations with civil society groups
- number of hospitals (tertiary, secondary and primary) where IEC materials are displayed

This kind of prioritisation will enable the adoption and implementation of the Ministry guidelines. Otherwise, it will continue to remain an aspiration rather an actuality.

11.10.4 Enhance Response Strategies in a Graded Manner

There are no concrete studies in India, to show reporting of sexual violence and its relationship to the geographical distance of the habitation from a police post or a tertiary hospital. It is likely that further away is the habitation from the police station and a tertiary Government hospital, the less likely is the reporting of sexual violence case. NCRB does not provide data on reporting on crimes against women with reference to distance the victim/survivor covered to lodge that complaint. A paper based on a robust secondary data set and statistical data analysis proved that women living farther away from health facilities have a lower probability of institutional delivery (Kumar et al., 2014). On similar lines, in the absence of supportive health care services, family and neighbourhood, women and girls living physically far away from district facilities and urban hubs are less likely to report assaults on them.

Very similar to the current research, a pilot study done in Zambia (Dennis et al., 2019) observed that even if a woman overcomes all of the barriers to seek medical care after a sexual assault, she will have difficulty in accessing services as recommended due to inadequate facility preparedness, particularly at the lower levels of care and the limited geographic availability of time-sensitive post-sexual violence services. This research mapped the availability of health facilities, their preparedness to address sexual violence cases and the presence of police stations across 4 districts and 10 police stations. The study observed, *"...less than one in four women lived within 15 km of comprehensive services, and 60– 70% of women lived further than 15 km away from a facility offering at least one domain of clinical sexual violence services"* (p.98).

Given the above observations from other studies and the findings of this present study, health system response has to be organised in a graded manner, with identification of response strategies at the Primary, Secondary and Tertiary levels. The following Table 11.2 elaborates the responses that can be programmed at every level of the system providing incrementally higher levels of support and care to domestic and sexual violence survivors.

This kind of programming for addressing GBV needs a focal point in the Ministry at the Central level and at the State levels to facilitate the programming and monitor its functioning.

Table 11.2: Level-wise Recommended Health System Responses	
Level	**Response**
Primary	• Create community awareness on zero tolerance to violence • Create community awareness on the types of violence against women, particularly IPV; the health consequences of violence; legal rights and services available • Create awareness and provide information about crisis intervention services at the secondary and tertiary hospitals and other services available such as livelihood, shelters, etc. • Ensure trained staff to provide first-line psychological support to women reporting violence • Set up a referral mechanism • Medical Officers and ANMs at the Public Health Centre level, should be trained to provide first-line treatment to women who may access services for violence- related problems
Secondary	• Identification and reporting of violence • Provision of clinical and forensic care and linkages with legal, police and social support services • Provision of crisis intervention services through a dedicated department or designated trained staff • Crisis intervention departments could also be set up
Tertiary	• Identification, provision of clinical and forensic care • Setting up of crisis intervention departments or actively collaborating with Sakhi centres and NGOs • Train personnel for provision of crisis intervention, rehabilitation, long-term care • Training to also be offered in drafting a medical opinion based on clinical findings as • well as recording circumstances in which the assault took place • Court appearance and presentation of expert medical opinion • Medical and nursing colleges should include training on VAWG in their curriculum • Role of convergence of health with education departments on initiative of adolescence education and prevention of violence

Source: Adapted from Bhate-Deosthali et al. (2018: p. 27)

11.10.5 Inter-sector Coordination: Need to build additional support

The study clearly demonstrated that inter-sectoral coordination is limited to the health facility and the police. Despite awareness of the medico-legal implications when children or women present themselves at a health setting with evident signs of sexual assault, most doctors and nurses, do not want to take any proactive action. While there is sympathy in the case of children, there is a lot of suspicion about younger women and indifference when it comes to married women, when they present themselves with injuries and complain of assault. The health facilities that carry out medical evidence gathering at the behest of the police do not provide any referral for non-medical support, like women or children's shelter or the District Legal Aid Services. Among the healthcare providers, there is also reluctance to appear in courts due to long delays in court proceedings and poor understanding of interpretation of medical documentation in courts.

The Sakhi centres set up by the Ministry of Women & Child Development are mandated to play an active role in working with the police, hospitals, shelter homes, protection officers and legal aid cells. However, the acknowledgement of the role of the Sakhi centres by the hospitals and health care

providers is still weak and uneven. Sakhi centres are handling domestic violence cases and few POCSO cases, while the police handle the sexual assault cases with little engagement of the Sakhi centre's staff for assisting the survivor.[22] The provision of medico-legal care must avoid further victimization and trauma of survivors. The hospital in coordination with the Sakhi centres should minimize the number of contacts the survivor has with multiple agencies that have to be summoned to support her. The multi-sectoral coordination introduced through OSC minimizes contacts.

11.10.6 Recognize Domestic Violence as a Public Health issue

Actively involvement of the health system in primary prevention of violence against women, with emphasis on safety and well-being of women, should be recognised as a public health priority. The health system has a pivotal role to play in the multi-sectoral response to VAW which should not be confined to secondary prevention of violence. Recruitment of counsellors or building active collaborations with the Sakhi Centre or NGOs to attend to survivors—women and children—will be an important way the health system builds its response beyond medical evidence documentation and care.

Across many states for which data is available in the first round of the NFHS-5 (2019-20), rural India has recorded higher figures for spousal violence and also violence during pregnancy. Hence, active collaborations with community-based organisations, women's collectives and NGOs are important to screen and address domestic violence linked health conditions and outcomes.

SWATI, a rural based organisation in Gujarat, had trained ASHAs to detect women experiencing violence and refer them to CHCs to enable rural women access services for domestic violence. The organisation observed that of 1,181 women whom ASHA workers suspected of facing violence, in the case of 89% (1,056 of the 1,181) women, ASHA workers' assessment of whether or not a particular woman faced domestic violence matched with what women reported. The acceptance of ASHA as the first point of contact to address domestic violence was also observed. While this additional responsibility will add the workload of ASHAs, the advantage of having an early detection and avoidance of repeat violence seems to be the advantage of this initiative, in collaboration with other women and panchayats, at the institution level to secure and safeguard ASHA from facing a backlash.

11.10.7 Sensitivity to Social Inequalities and Cultural Differences

Focus on building awareness and understanding of the changed legal framework among health care providers has to also factor in building in social sensitivity. Caste, class, religion and gender-based inequalities play out subtly as key barriers to how health care providers from ASHAs at the bottom to the Doctors at the top of the pyramid ignore GBV. Unless there are initiatives like that of SWATI (covered in the earlier section) ASHAs and ANMs fail to acknowledge domestic violence that they witness at the community level as a problem that requires their intervention. They are often worried about backlash they might face if they take up this issue.

Doctors and Nurses, recognise domestic violence and sexual violence on the bodies of women and girls but choose not to acknowledge it as their priority. They have a misplaced understanding that it is part of the culture among the people who come to use public hospitals, who generally are poor,

[22] Field observations and discussion with Sakhi centre staff.

marginalised and also may belong to religious minority communities. Further, health providers are concerned about the potential increase in their workload if they take personal interest in the issue. Due to biased or lack of training on GBV and on social inequalities within medical textbooks, health providers end up honouring gender biased social norms that effectively deny women their dignity and bodily integrity (Agnes, 2005; Rakhal, 2005).[23][24] Hence along with building health care providers knowledge and awareness on the Ministry guidelines there is need to address the issues of social inequalities and gender justice. Kapilashrami (2018) observes – *"health systems are social institutions embedded in prevailing gender norms and power relations that must be tackled alongside addressing imminent needs of women victims of abuse. To this end, feminist approaches to counselling and relational perspectives to social justice can strengthen responsiveness (and transformative potential) of integrated sector-wide interventions."* (p.2).

Box 7 **Tertiary hospitals with NGO Collaboration**

Our observations from other settings in Mumbai, are positive. The presence of a feminist counselling centre 'Dilaasa' within public hospitals in Mumbai, where doctors and nurses are trained to ask screening questions to detect domestic violence to refer women to provide psycho-social support, is a successful model (Bhate-Deosthali et al., 2012). Further, development of comprehensive health response systems to sexual violence were set up in three public hospitals run by the Municipal Corporation of Greater Mumbai. With trainings on crucial aspects of the Ministry guidelines, on issue of medical evidence gathering, informed consent, dealing with personal biases, counselling support, full-proof documentation of the case history, it is observed that there is an overall improvement in usefulness of medical evidence in the legal progress of the rape cases (Rege et al., 2014; CEHAT, 2020). The presence of a one-stop crisis centre within the Lokmanya Tilak Municipal General Hospital (popularly known as Sion hospital) premises with health, welfare and legal support services, was found to be an efficient and dynamic model of health care delivery to sexual assault survivors. It promotes a woman/victim-centred approach. The presence of the NGO SNEHA contributes in psychosocial support and legal aid. Being a tertiary health facility, fewer issues are reported with inter-sectoral collaboration and referral, which is facilitated by SOPs. Health/social workers believe that the existence of clear protocols brought structure to the system of referrals, and they expressed a general feeling of satisfaction about this system (www.snehamumbai.org)

[23] Text book chapters on Rape examination have recently undergone change in line with the MoH&FW guidelines (mentioned in CEHAT, 2020)

[24] The Maharashtra University of Health Sciences (MUHS) while revising and updating its syllabus for the subject 'Forensic Medicine and Toxicology' taught to second-year medical students, has removed the topic 'Signs of Virginity.' Chk: https://timesofindia.indiatimes.com/blogs/legally-speaking/virginity-test-why-the-two-finger-test-is-unscientific-illogical-and-illegal/

11.10.8 Fund and Support Technology enabled Capacity Building on VAWG

MoH&FW has to actively collaborate with Medical and Nursing Councils to integrate gender and VAWG within the curriculum of medical and nursing colleges. NGO Initiatives on building gender sensitivity in medical curriculum has been met with positive responses (Shrivastava and Rege, 2021). It will be useful to go to scale with use of videos of best-practices-models of providing Gender sensitive care to Sexual Assault and other forms of Violence and online learning materials to enable in-service training of Health Care Professionals. These materials can also be made available with multiple Indian language voice over and/or sub-titles. s

Conclusion

MoH&FW has to support research to expand evidence based on gaps between policy and its implementation. Though the Ministry guidelines elaborate on the provision of care and support to transgender, gender non-conforming individuals and people with disabilities, in this study we did not come across information and observations on how the guidelines are being implemented with these groups. This research had been done with a lot of commitment and against several challenges. There is a greater need to provide support to social sciences research to strengthen health programming to eliminate violence and discrimination and achieve gender equality.

References

Chapter-1

Agnes, F. (2005). To Whom Do Experts Testify? Ideological Challenges of Feminist Jurisprudence. In *Review of Women Studies, Economic and Political Weekly,* 40(18), 1859-1866.

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.

Arifin, 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,36, 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*, 11(1), 10-8.

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

Bandewar, S., Pitre, A., & Lingam, L. (2018). Five Years post Nirbhaya: Critical insights into the status of response to sexual assault. *Indian Journal of Medical Ethics,* 3(3). [Online].

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* (pp. 268-311). New Delhi: Women Unlimited.

Bhate-Deosthali, P. (2013).Moving from Evidence to Care: Ethical Responsibility of Health Professionals in Responding to Sexual Assault. *Indian Journal of Medical Ethics*, X(1), 2-5.

Bhate-Deosthali, P. & Rege, S. (2020, October 10). Hathras rape Case: Right TO MEDICO-LEGAL care for survivors has a long way to go... *The Leaflet.* Retrieved from https://www.theleaflet.in/hathras-rape-case-right-to-medico-legal-care-for-survivors-has-a-long-way-to-go/#

Bhate-Deosthali, P, Rege, S, Arora, S, Avalaskar, P, Chavan R and Bavadekar A (2018). Surviving Sexual Violence: Impact on Survivors and Families, CEHAT, Mumbai, India.

CEDAW (1992). *CEDAW General Recommendation No. 19: Violence against women.* The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). https://www.refworld.org/docid/52d920c54.html

CEHAT (2011). *Responding to sexual assault: A study of practices of health professionals in a public hospital.* Mumbai: Centre for Enquiry into Health and Allied Themes.

CEHAT (2012). *Establishing comprehensive health sector response to sexual assault.* Mumbai: Centre for Enquiry into Health and Allied Themes.

Christofides, N., Webster, N., Jewkes, R., Penn-Kekana, L., Martin, L., Abrahams N., Kim, J. (2003). The state of sexual assault services: findings from a situation analysis of services in South Africa. *Criminal Justice and Behavior*, 30(1), 6-38.

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

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*, 332(7535), 209–213.

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

Dubey, V. (1998). *Voices From The Silent Zone: Women's Experiences of Incest And Childhood Sexual Abuse*. New Delhi: RAHI Foundation.

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*, 166(1), 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. *Criminal Justice and Behaviour,* 30(1), 6-38.

Garcia-Moreno C., Hegarty K., et al. (2015). Series on Violence against women and girls no 2: The health-system response to violence against women. *Lancet,* 385(9977), 1567–1579.

Garcia-Moreno C., Zimmerman C., et. al. (2015). Series on Violence against women and girls no 5: Addressing violence against women: a call to action. *Lancet,* 385(9978), 1685-1695.

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*, 24(3), 1-17.

Hill A, Pallitto C, McCleary-Sills J, Garcia-Moreno C. (2016) A systematic review and meta-analysis of intimate partner violence during pregnancy and selected birth outcomes. *International Journal of Gynaecology & Obstetrics,*133(3), 269-76. doi: 10.1016/j.ijgo.2015.10.023.

Himabindu, B.L., Arora, R., & Prasanth, N. S. (2014). Whose Problem is it anyway? Crimes against women in India. *Global Health Action,* 7(23718). [Online]. Doi: 10.3402/gha.v7.23718

Houry,D., Feldhaus, K., Nyquist, S., Abbott, J., & Pons, P. (2000). Emergency department documentation in cases of intentional assault. *Annals of Emergency Medicine*, 34(6), 715-719.

Human Rights Watch (2017). "Everyone blames me": Barriers to Justice and Support Services for Sexual Assault Survivors in India. [Report] Retrieved from

https://www.hrw.org/report/2017/11/08/everyone-blames-me/barriers-justice-and-support-services-sexual-assault-survivors

Jagori & UN Women (2011). *Safe Cities Free of Violence Against Women and Girls Initiative: Report of the Baseline Survey Delhi 2010*. New Delhi.

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

Jewkes, R. (2002). Sexual Violence. In *World Report on Violence and Health* (pp. 149-181). Geneva: World Health Organisation.

Jina, R. & Thomas, L.S. (2013). Health Consequences of Sexual Violence against women. *Best Practice & Research: Clinical Obstetrics & Gynaecology,* 27(1), 15-26.

Justice Verma, J.S. (retd), Justice Seth, L. (retd), & Subramanium G. (2013). *Report of the Committee on Amendments to the Criminal Law.* New Delhi: Government of India.

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

Kilonzo, N., Ndung'u, N., Nthamburi, N., Ajema, C., Taegtmever, M., Theobald, S., & Tolhurst R. (2009). Sexual Violence Legislation in sub-Saharan Africa: the need for strengthened medico-legal linkages. *Reproductive Health Matters*, 17(34), 10-19. doi: 10.1016/S0968-8080(09)34485-7

Koss, M. (1994). The negative impact of crime victimization on women's health and medical use. In Dan, A.J. (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*, 9(1), 85-96.

Kruger, J., Butchart, A., Seedat, M. & Gilchrist, A. (1998). A Public health approach to violence prevention in South Africa. In Eeden, R. & Wentzel, M. (Eds.). *The dynamics of aggression and violence in South Africa* (pp. 399-424). Pretoria: Human Sciences Research Council

Kulkarni S., Jesani, A., & D'Souza, L. (1997). *Investigation Report: 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*. Chandigarh: Institute for Development and Communication. p.56.

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,* 105(1), 99-108.

Human Rights Watch (2018). Invisible Victims of Sexual Violence: Access to Justice for Women and Girls with Disabilities in India. [Report] Retrieved from https://www.hrw.org/report/2018/04/03/invisible-victims-sexual-violence/access-justice-women-and-girls-disabilities

MOHFW (2014). *Guidelines & protocols: Medico-legal care for survivors/victims of sexual violence.* Ministry of Health & Family welfare, Govt of India.

Nagarajan, R. (2012, December 21). Seven out of ten women SEXUALLY harassed. *The Time of India*. [Survey]. Retrieved from https://timesofindia.indiatimes.com/india/Seven-out-of-ten-women-sexually-harassed/articleshow/17711598.cms

NCRB (2012). *Crime in India-2012*. National Crime Records Bureau, Government of India. Available from: http://ncrb.nic.in/CD-CII2012/cii-2012/Snapshots-5312.pdf#page=1&zoom=auto,0,605.

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*, 14(5), 263–267.

Pitre, A. (2006). Caring For Survivors of Sexual Assault. *Indian Journal of Medical Ethics,* 3(3), 90-92.

Pitre, A., & Lingam, L. (2013). Rape and Medical Evidence Gathering Systems, Need for Urgent Intervention, *Economic and Political Weekly*, 48(3), 16-17.,

Pitre, A., & Pandey, M. (2009). *Response of Health System to Sexual Violence: An Exploratory Study of Six Health Facilities in Two Districts of Maharashtra*. Mumbai: CEHAT

Plichta, S.B., Clements, P.T., & Houseman, C. (2007). Why SANEs Matter: Models of Care for Sexual Violence Victims in the Emergency Department. *Journal of Forensic Nursing*, 3 (1), 15–23.

Prakash, P., George, A., Panalal, R. (1993). Focus Issue, Patients Rights. *The Indian Journal of Social Work,* 54(2),199-201.

Prasad, S. (1999). Medico-legal Response to Violence Against Women In India. *Violence Against Women,* 5(5), 478-506.

Rennison, C. M. (2002). *Rape and Sexual Assault: Reporting to Police and Medical Attention, 1992-2000*. Washington, DC: USGPO. NCJ 194530.

Sarvanan, S (2000). Violence Against Women in India: A Literature Review. ISST, New Delhi.

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, 165-72.

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, 750-755.

Sheperd, J., Shapland, M. & Schully, C. (1989). Recording violent offences by the police: an accident and emergency department perspective. *Medical Science and Law, 29, 251-257.*

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

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.* [Policy Brief]. Tygerberg, South Africa: South Africa Medical Research Council.

UNECOSOC (2016). *Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators (E/CN.3/2016/2/Rev.1), Annex IV*. Statistical Commission, United Nations Economic and Social Council.

WHO (2002). *World Report on Violence and Health*. Geneva: World Health Organisation.

World Health Organisation/London School of Hygiene and Tropical Medicine (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organisation.

WHO (2013a). *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: World Health Organisation, London School of Hygiene & Tropical Medicine and South African Medical Research Council.

WHO (2013b). *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: World Health Organisation.

Chapter – 2

Cleland, J. (1973). A critique of KAP Studies and Some Suggestions for Their Improvement. *Studies in Family Planning,* 4(2), 42-47. Doi: 10.2307/1964829

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2014). The health-systems response to violence against women. *The Lancet, 385*(9977), 1567-1579. Doi: 10.1016/S0140-6736(14)61837-7

Germain, A. (2009). Integrating gender into HIV/AIDS programmes in the health sector : tool to improve responsiveness to women's needs. 1. Basic steps in gender-responsive programming. *Bulletin of the World Health Organization, 87*(11), 883-883. Doi:10.2471/BLT.09.071522

Goswami, N., Gandhi, A., Patel, P., & Dikshit, R. (2013). An evaluation of knowledge, attitude and practices about prescribing fixed dose combinations among resident doctors. *Perspectives in Clinical Research*, 4(2), 130-135. Doi: 10.4103/2229-3485.111797

Higuera-Mendieta, D.R., Cortés-Corrales, S., Quintero, J., & González-Uribe, C. (2016). KAP Surveys and Dengue Control in Colombia : Disentangling the Effect of Sociodemographic Factors Using Multiple Correspondence Analysis. *PLOS Neglected Tropical Diseases,*10(9). Doi : https://doi.org/10.1371/journal.pntd.0005016

Rege, Sangeeta (2016) Violence against women and Role of Health Care Professionals. *Health Action*, January, pp. 10-12.

Van den Ameele, S., Keygnaert, I., Rachidi, A., Roelens, K., & Temmerman, M. (2013).The role of healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morrocco: a study of knowledge, attitude and practices of healthcare workers. *BMC Health Services Research,* 13(77). Doi: https://doi.org/10.1186/1472-6963-13-77

Chapter – 3

Jejeebhoy, S. J., Santhya, K. G., & Acharya, R. (2013). Violence against women in South Asia: The need for the active engagement of the health sector. *Global Public Health*, *9*, 678-690. doi:10.1080/17441692.2014.916736

Kannabiran, K., Jeyaranjan, J. & Swaminathan, P. (Eds.). (2017). *Telangana Social Development Report 2017.* Hyderabad: Council for Social Development.

Lingam, L., Pitre, A. (2008). *Gender Inequities in Health Access and Outcomes, in 'A Report on Health Inequities in Maharashtra*'. Pune: SATHI.

MOHFW (2014). *Guidelines & protocols: Medico-legal care for survivors/victims of sexual violence.* Ministry of Health & Family welfare, Govt of India.

NCRB (2019). *Crime in India 2019: Statistics.* (vol. 1). New Delhi: National Crime Records bureau, Ministry of Home Affairs, GoI.*National Family Health Survey(NFHS-5):Fact Sheets 2019-20.* International Institute for Population Studies (IIPS), MoFHS.

Niti Aayog (2019). *Health Index: Healthy States, Progressive India- Report on the Ranks of States and Union Territories.* Niti Aayog, MoHFW & The World Bank.

Raj A., McDougal L. (2015). Associations of intimate partner violence with unintended pregnancy and pre-pregnancy contraceptive use in South Asia. *Contraception*. 91(6):456–463

Chapter – 4

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

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

MOHFW (2014). *Guidelines & protocols: Medico-legal care for survivors/victims of sexual violence.* Ministry of Health & Family welfare, Govt of India.

Pitre, A. (2005). *Sexual Assault care and Forensic Evidence Kit: Strengthening the case for use of the kit.* Mumbai: CEHAT.

Pitre, A., & Pandey, M. (2008). *Response of Health System to Sexual Violence: An Exploratory Study of Six Health Facilities in Two Districts of Maharashtra*. Mumbai: CEHAT.

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

Chapter – 6

Bandewar, S.V.S., Pitre, A., & Lingam, L. (2018). Five years post Nirbhaya: Critical insights into the status of response to sexual assault. *Indian J Med Ethics*. [online] DOI: 10.20529/IJME.2018.025

Barnhizer, D. (2013). The Implementation Gap: What Causes Laws to Succeed or Fail? Available from: https://works.bepress.com/david_barnhizer/79/ [Accessed 2018, July 10].

CEHAT & MCGM (2018). *Understanding Dynamics of Sexual Violence: Study of case record.* Mumbai: Centre for Enquiry into Health and Allied Themes, Municipal Corporation of Greater Mumbai

Cleland, J. A. (1973). Critique of KAP Studies and Some Suggestions for Their Improvement. *Studies in Family Planning*, 4 (2), 42-47. Published by Population Council. http://www.jstor.org/stable/1964829. [Accessed: 2018, July 10]

Erasmus, E., Orgill, M., Schneider, H., & Gilson, L. (2014). Mapping the existing body of health policy implementation research in lower income settings: what is covered and what are the gaps?. *Health Policy and Planning,* 29,35–50. doi:10.1093/heapol/czu063.

Gopichandran, V. (2019). Ayushman Bharat National Health Protection Scheme: An Ethical Analysis. *Asian Bioethics Review,* 11, 69-80. https://doi.org/10.1007/s41649-019-00083-5.

Goswami, N., Gandhi, A., Patel, P., & Dikshit, R. (2013). An evaluation of knowledge, attitude and practices about prescribing fixed dose combinations among resident doctors. *Perspectives in Clinical Research,* 4,130-135.

Higuera-Mendieta, D.R., Cortés-Corrales, S., Quintero, J., & González-Uribe, C. (2016). KAP Surveys and Dengue Control in Colombia: Disentangling the Effect of Sociodemographic Factors Using Multiple Correspondence Analysis. *PLoS Neglected Tropical Diseases*, 10 (9): e0005016. doi:10.1371/journal.pntd.0005016

Human Rights Watch (2017). "Everyone Blames Me": Barriers to justice and support services for sexual assault survivors in India. Available from: https://www.hrw.org/sites/default/files/report_pdf/india1117_web.pdf

Human Rights Watch (2018). "Invisible Victims of Sexual Violence: Access to Justice for Women and Girls with Disabilities in India". Available from: https://www.hrw.org/sites/default/files/report_pdf/india0418_web.pdf [Accessed: 2018 April 3]

Humpage, L., & Fleras, A. (2001). *Social Policy Journal of New Zealand,* 16, 37-54.

Inoue, S. (2020). The Sate of Gender-Based Sexual Violence Against Women in India: Current State and Future Directions. *South Asian Journal of Law, Policy, and Social Research,* 1(1), 1-17.

Justice Verma, J.S. (retd), Justice Seth, L. (retd), & Subramanium G. (2013). *Report of the Committee on Amendments to the Criminal Law.* New Delhi: Government of India.

Khan, S. A. (2019). Ayushman Bharat Hurdles to Implementation One Year On. *Economic & Political Weekly, 54(47), 13-15.*

Khosla, R. (2016). Building Energy Code Lessons from Andhra Pradesh: Closing the Policy Gap. *Economic & Political Weekly,* 51 (2).

Lapsia, T. P. (2015). Impact of the "Nirbhaya" Rape Case: Isolated Phenomenon of Social Change? *Honors Scholar Theses, 453. https://opencommons.uconn.edu/srhonors_theses/453*

Meier, P. and Celis, K. (2011). "Sowing the Seeds of Its Own Failure: Implementing the Concept of Gender Mainstreaming." *Social Politics: International Studies in Gender, State & Society*, 18(4), 469–89. http://sp.oxfordjournals.org/cgi/doi/10.1093/sp/jxr020.

Mergaert, L., & Lombardo, E. (2014). Resistance to Implementing Gender Mainstreaming in EU Research Policy. *European Integration Online Papers (EIoP),* 18, 1–21. doi:10.1695/2014005.

Mazur, A.G. (2015). Does Feminist Policy Matter in Post Industrial Democracies? A Proposed Analytical Roadmap. LIEPP Working Paper. *Research group "Discrimination and Social Inequalities.* Available from: https://spire.sciencespo.fr/hdl:/2441/21oa3mu1pb80sa3vajm19hov60/resources/liepp-wp42-mazur.pdf. [Accessed:2019 December 1].

Ministry of Law and Justice (Legislative Department). (2015). The Protection of Women from Domestic Violence Act, 2005. Government of India.

MoHFW (2014). *Guidelines & protocols: Medico-legal care for survivors/victims of sexual violence.* Ministry of Health & Family welfare, Govt of India.

MOHIM (undated). Proposed Guidelines and Reporting Formats to Medical Facilities for Implementation of PWDV Act in Maharashtra. Women & Child Development Commission and Majlis Legal Centre. https://arogya.maharashtra.gov.in/Site/Uploads/GR/Guidelines%20to%20Health%20Services.pdf

Moulick, J., Pradhan, T., & Sarkar, P.K. (2020). The Dynamics of Counselling as a victim Management Strategy in cases of Domestic Violence in India. *Humanities and Social Sciences Reviews,* 7(6), 1090-1111. Doi: https://doi.org/10.18510/hssr.2019.76159

Reagan, C.(2015). Recognition and Justice. *Ricœur Studies,* 6 (2), 118-129.

Sarin, A., Dongre. A., Khanghta, P., Varshney, N., Gaur, A., & Sengai, A. (2018). Implementation of Section 12(1)(c) of the Right to Education Act. *Economic & Political Weekly,* 53(8), 31-38.

Sharma, P., Unnikrishnan, M.K.., & Sharma, A. (2014). Sexual violence in India: addressing gaps between policy and implementation. *Health Policy and Planning,* 30(5), 656-659. doi:10.1093/heapol/czu015

Sheikh, K., Saligram, P.S., & Hort, K. (2015). What explains regulatory failure? Analysing the architecture of health care regulation in two Indian states. *Health Policy and Planning*, 30, 39–55. doi:10.1093/heapol/czt095

Starrs, A, M., Ezeh, A, C., Barker, G., Basu, A., Bertrand, J.T. et al. (2018). Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *The Lancet,* 391(10140), 2642-2692. https://doi.org/10.1016/S0140-6736(18)30293-9

The Centre for International Private Enterprise (CIPE). (2012). Improving public governance: Closing the implementation gap between law and practice.

Available from: http://www.cipe.org/ sites/default/files/publication-docs/GI%20CIPE_Implementation%20 Gap_for%20web.pdf [Accessed: 2018 January 23].

The Criminal Law (Amendment) Act, 2013. (2013). New Delhi: Ministry of Law and Justice. 2013 April 2

van den Ameele, S., Keygnaert, I., Rachidi, A., Roelens, K. & Temmerman M. (2013). The role of the healthcare sector in the preservation of sexual violence against sub-Saharan transmigrants in

Morocco: a study of knowledge, attitudes and practices of healthcare workers. *BMC Health Services Research, 13, article number 17*. http://www.biomedcentral.com/1472-6963/13/77

Chapter-9

Government of India, (2013). *Guidelines and Protocols: Medico-Legal Care for Survivors/Victims of Sexual Violence.* Ministry of Health & Family Welfare.

Fisher, B. S., Leah D. E., Cullen, F. T., & Turner, M.G. (2003).'Reporting Sexual Victimization To The Police And Others: Results From a National-Level Study of College Women.' *Criminal Justice and Behavior,* 30(1), 6–38. https://doi.org/10.1177/0093854802239161.

Tillman, S., Bryant-Davis, T., Smith, K., & Marks, A. (2010). 'Shattering Silence: Exploring Barriers to Disclosure for African American Sexual Assault Survivors.' *Trauma, Violence, & Abuse,* 11(2), 59–70.

Chapter-11

Agnes, F. (2005). To Whom Do Experts Testify? Ideological Challenges of Feminist Jurisprudence. In *Review of Women Studies, Economic and Political Weekly,* 40(18), 1859-1866.

Bhate-Deosthali, P., Ravindran, T.K.S, & Vindhya, U. (2012). Addressing Domestic Violence within Healthcare Settings: The Dilaasa Model. *Economic and Political Weekly,* 47(17), 66-75.

Bhate-Deosthali, P., Rege, S., Pal, P. Nandi, S., Bhatla, N. & Kashyap, A. (2018). *Role of the Health Sector in Addressing Intimate Partner Violence in India: A Synthesis Report.* New Delhi: International Center for Research on Women

CEHAT (2018). *Guidance documents for Police, Judiciary, Public Prosecutor: Demystifying medical evidence, enabling access to justice for survivors/victims of sexual violence.* Mumbai, India.

CEHAT (2020) Role of Medico-legal Evidence in Rape Trials: A Review of Judgments at the Sessions Court in Mumbai, Mumbai India

CEHAT and Municipal Corporation of Greater Mumbai. (2018). *Understanding dynamics of sexual violence: Study of case records.* Mumbai, India.

Dennis, M.L., Owolabi, O.O, Cresswell, J. A., Chelwa, N., Colombini, M., Vwalika,B., Mbizvo, M.T., & Campbell, O.M.R. (2019). A new approach to assess the capability of health facilities to provide clinical care for sexual violence against women: a pilot study, *Health Policy and Planning*, Volume 34, Issue 2, March, Pages 92- 101. https://doi.org/10.1093/heapol/czy106

Gaitonde, R. (2005). Community Medicine: Incorporating gender sensitivity. *Economic and Political Weekly.* Vol. 40, Issue. 18, p. 1887–92.

Kapilashrami A. (2018). Transformative or Functional Justice? Examining the Role of Health Care Institutions in Responding to Violence Against Women in India. *Journal of Interpersonal Violence*. October, p 1-30. doi:10.1177/0886260518803604

Kumar, S., Dansereau, E.A., & Murray, C.J.L. (2014) Does distance matter for institutional delivery in rural India? *Applied Economics*, 46:33, 4091-4103. DOI: 10.1080/00036846.2014.950836

Oxfam (2021). *Towards violence free lives for women: Tracking of union budgets (2018-21) for Violence Services*. Oxfam India, February 2021.

Shrivastava, S., & Rege, S. (2021). Breaking the mould: Redefining gender in medical education in India. *Research & Humanities in Medical Education*, *8*, 25-28. Retrieved from https://www.rhime.in/ojs/index.php/rhime/article/view/433

SWATI (2020). Making Rural Healthcare System Responsive to Domestic Violence: Notes from Patan in Gujarat. *Economic and Political Weekly*, 55(17). Available from: https://www.epw.in/engage/article/making-rural-healthcare-system-responsive-to-domestic-violence

World Health Organization (2014). Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children. Sixty-seventh world health assembly. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R15-en.pdf?ua= Cited 2021 April 2

Annexures

Annexure – 1: Health Care Facility Tool

Tool 1

Observation Checklist for Health Care Facilities

Enhancing the quality of response of the Health Care System to Sexual Assault
Supported by
Indian Council for Medical Research (ICMR) and the Department of Health Research (DHR), New Delhi, India
Hosted at
Tata Institute of Social Sciences, Mumbai

Date of administering the checklist: Date _____

Time : _____

Schedule No. _____

Name of the interviewer (s) _____

Note:
Kindly put a tick mark (√) 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			
8	Sister in Charge			
9	Social workers/counselors			
10	Staff Nurses			
11	X – Ray Technician (Fill up once for the hospital)			
12	Laboratory Technician			
13	Pharmacist			
14	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?

Sr. No	Post	Yes	No	If yes, how many
1	Paediatrician			
2	Gynaecologist			
3	Surgeon			
4	Anaesthetist			
	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? ***(Observation)***
- 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

Sr. No	Facilities	Yes	No	Intermittent supply (please specify)

1	Continuous water supply			
2	Uninterrupted electricity supply			
3	Refrigerator			
4	Working Telephone line			
5	Generator/ Inverter			
6	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?

Sr. No	Equipment	Present	Not Present	Alternative Equipment If Used
1	Forms for documentation			
2	Large sheet of paper to undress over			
3	Paper bags for clothing collection			

4	Catchment Paper			
5	Sterile cotton swabs and swab guards for biological evidence collection			
6	Comb			
7	Nail Cutter			
8	Wooden stick for finger nail scrapings			
9	Small scissors			
10	Urine sample container			
11	Tubes/ vials/ vaccutainers for blood samples [Ethylenediaminetetraacetic acid (EDTA), Plain, Sodium fluoride]			
12	Syringes and needle for drawing blood			
13	Distilled water			
14	Disposable gloves Glass slides			
15	Envelopes or boxes for individual evidence samples			
16	Labels			
17	Lac(sealing wax) Stick for sealing			
18	Clean clothing, shower/hygiene items for survivors use after the examination			
19	Woods lamp/Good torch			
20	Vaginal speculums			
21	Drying rack for wet swabs &/or clothing			
22	Patient gown, cover sheet, blanket, pillow			
23	Post-It notes to collect trace evidence			
24	Camera (35mm, digital with colour printer)			

25	Microscope			
26	Colposcope/ Magnifying glass			
27	Toluidine blue dye			
28	1% Acetic acid diluted spray			
29	Urine Pregnancy test kit			
30	Surgilube			
31	Medications			
32	Double Oxalate bulb for drug/alcohol assessment			
33	Sanitary napkins			
34	Sharps container (to dispose off needles and sharp objects)			
35	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:

Sr. No	**Diagnosis Test and Treatment**	**Available in the room/ facility (specify)**	**Provided elsewhere**	**Not Provided**	**If provided, type of test /drug**	**Time duration**
1	Diagnostic tests for STI/RTI					
2	HIV rapid test					
3	Pregnancy test					
4	Ultrasound for pregnancy/internal injury					

5	X-ray for Injury					
6	STI prevention treatment					
7	Emergency contraception					
8	Wound treatment					
9	Tetanus prophylaxis					
10	Hepatitis B vaccination					
11	Post exposure prophylaxis for HIV					
12	Counseling					
13	Other					

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*) _____

Annexure-2: Health Care Providers: Doctors Interview Schedule

TOOLS OF DATA COLLECTON

Tool 2

Interview Guide for Health Care Service Providers
(PHCs, Secondary and Tertiary Hospitals)

Enhancing the quality of response of the Health Care System to Sexual Assault

Supported by
Indian Council for Medical Research (ICMR) and
the Department of Health Research (DHR), New Delhi, India
Hosted at
Tata Institute of Social Sciences, Mumbai

Schedule no:

Date of the interview:

Place of the interview:

Name of interviewer:

Informed consent obtained:

1. Yes, written

2. Yes, verbal (please document the reasons)

3. No (pl document the reasons)

Section 1: Personal Information

[for interviewer: this section can be filled by the interviewee, if s/he prefers it.]

1.1) Name

1.2) Age

1.3) Sex

1.4) Education/Specialty

1.5) Designation

1.6) Department

1.7) Years of Service

Section 2

General Information about survivors of gender based violence, such as, domestic violence, wide ranging sexual violence approached your health care facility in the last 12 months period

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. (can have cards for this)

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:-

_____

_____

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?

_____

_____

_____

2.7a) If survivor decides against reporting to the police, how do you/this facility respond/s to such situations? Pl explain to help us understand.

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?

_____

_____

_____

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?

_____

_____

_____

Section 3
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
16-18 years
Adults

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?

_____

_____

_____

Section 4
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 equipments available in one place?

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?

4.7) If such preparation is required, who does it?

4.8) Who guides the preparation?

4.9) Do you have a ready-made checklist available? Will you share it with us?

4.10) When do you conduct age estimation?

_____

_____

4.11) Where is it conducted?

4.12) Which tests do you use for the purpose of age estimation? [Probe: are they age specific? do you follow these norms?]

4.13) please list the routine tests involved in age estimation?

_____

_____

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

Yes ☐ No ☐

4.15) If yes, how many times?

4.16) Under what circumstances?

_____

_____

4.17) please describe the problems you faced while testifying in the court?

_____

_____

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

Yes ☐ No ☐

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

_____

_____

_____

Section 5: About a Specific survivor

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

_____

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

5.3) Age of the survivor: _____

5.4) Sex of the survivor _____

5.5) Marital status: Married ☐

Unmarried ☐

Divorced ☐

Widowed ☐

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

_____

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

_____

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

_____

5.9) If referred, where was she referred from and who referred her?

Organization/Department: _____

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

Yes ☐ No ☐

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

_____

5.12) What was the reason for the time lapse?

_____

5.13) 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 ☐

5.14) Were you the only doctor examining?

Yes ☐ No ☐

5.15) If more than one doctor was involved, how many doctors were involved in the examining?

_____

Designation:

_____

Department:

_____

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

5.17) how was the examination divided between doctors?

_____

5.18) What was the procedure of examination?

_____

5.19) Where did the examination take place?

_____

_____

5.20) Were referrals to other departments made?

Yes ☐ No ☐

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

Department referral made to _____

Reasons:

_____

_____

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

Yes ☐ No ☐

5.23) Was an FIR filed?

Yes ☐ No ☐

5.23) If yes, was it filed before or after examination of the survivor?

_____

5.24) Who signed as witness?

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

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

Yes ☐ No ☐

5.26) How much time did the examination take?

Quality of examination

5.27) 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*				

5.28)What were your findings on examination?

_____

_____

_____

5.29) What was your opinion after that examination?

_____

5.30) What findings do you specifically look for before forming an opinion?

_____

_____

_____

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

Designation: _____

Department: _____

When carried: _____

Diagnosis and Treatment

5.32) Were diagnostic tests for STD done?

5.33) If yes, which? Please specify

5.34) Did you treat her for injuries or infection?

Yes ☐ No ☐

5.35) If yes, please specify treatment

5.36) Did you give her emergency contraception?

Yes ☐ No ☐

5.37) If yes, please specify

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

Yes ☐ No ☐

5.39) Was she given a discharge card?

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

Yes ☐ No ☐

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

_____

5.42)Why did you call her for a follow-up?

_____

5.43) 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				

5.44) Were referrals to other departments made?

Yes ☐ No ☐

5.45) Were you shown the reports from forensic laboratory?

Yes ☐ No ☐

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

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

5.48) What documents do you share with the survivors upon completion of examination and treatment? [probe: do you you give copy of the final medical examination and medical opinion report to the survivors?

5.49) How much are they charged for receiving these documentation? [

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

_____

_____

_____

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

_____

_____

_____

Section 6: 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 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?

_____

_____

_____

Section 7: 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?

_____

_____

_____

Section 8
[this section will also be administered to nurses with necessary changes]

Informed consent: knowledge, attitudes and practice Informed consent as a legal and medical ethics obligation of health care providers

1. Do you think, generally speaking, health care providers acknowledge the significance of ensuring quality of seeking informed consent from the person who is receiving health care intervention?
2. Does this health care facility has any standard operating procedures – SOPs for seeking consent from persons receiving health care intervention in general in this set up? [instruction for interviewer: please request for a copy of these SOPs and any standard templates of informed consent used in this facility. please collect such documents, if needed pl photocopy it]
3. What do you think it is important to seek consent and document the response for providing health care intervention in general? [probe: if medical ethics aspect is not referred to, please ask, according to you what relevance it has for medical ethics and health care providers health care ethics obligations to persons receiving care? – the idea is to understand her/his understanding of medical ethics as well as her/his commitment to meeting this obligation]
4. Who in the hospital shoulder this responsibility? Why? Please kindly help us understand the system which is in place in this hospital for this purpose.
5. Do you encounter problems in seeking consent and meeting this obligation? What are they? How do you address them to make sure that quality of the processes involved in seeking consent is satisfactory?
6. What suggestions you would like to offer towards improving quality of seeking informed consent processes? What makes it a meaningful exercise to both the person receiving care and those providing care?
7. Please tell us how this process plays out in the context of seeking consent from survivors of gender based violence.
8. Use a card exercise to tap into their knowledge about an ethical obligation and legal obligation regarding consent seeking [consent mandatory for three things: examination and evidence collection, treatment, and intimating to police. Section 164 A of CrPC)
9. Please tell us more about the system you/your HCF follows about reporting the case of gender based violence to police?
10. Do you face any specific challenges in doing so? What are they? How do you address them? [it is expected that
11. **Debrief the research participant** about the contradiction in the existing legal framework to help them understand that there is inherent contradiction regarding reporting of the cases to police – both intra-CrPC (164 A CrPC vs 35 C CrPC) and intra POCSO (Rule 5 Vs Section 19 and section 21); and across relevant acts (eg: the MTP Act; the 166B IPC; and between 164 A CrPC and Section 19 and 21 of POCSO; and). [for the team: ideally, we shd have any information material already available with other organizations, that we can hand over these facilities. If these information is not available, it is worthwhile to make posters as part of our project which can displayed at HCF, courts, and police chowkis].
12. In your assessment does the process of consent seeking has impact – adverse or favourable – on survivor? Please explain. [possible content of response may cover: consent process helps open the space for dialogue and conversation between health care providers and survivors; can discuss

apprehensions; and even expresses fears, anxiety and other concerns including those about medical examinations]

13. In your experience what have been the reasons for survivors to not willing to report it to the police? Could you tell actual cases if you might have come across in your practice?
14. Please kindly comment on women's refusal to report the case to police in terms of reasons for the same, your approach to help survivors understand the importance of the same and how documentation of the same.

Section 9: Monitoring and Evaluation system

1. How do you as a team monitor as assess that survivors of gender based violence care for at your facility received the optimum quality of care? Please elaborate/explain it to us.
2. Is someone entrusted with such a responsibility?
3. What are elements and dimensions of care provision are monitored through such a system?
4. How do you use this system and outcome of ongoing monitoring and assessment at operational level? [probes: does this inform on an ongoing basis to the processes involved in caring for survivors]
5. Please tell the highlights of the learnings from such an exercise of monitoring and assessing the quality of care provided to survivors undertaken over this past year?

Annexure-3: Nurses Interview Schedule

Tool 3

Interview Guide for Nurses
(PHCs, Secondary and Tertiary Hospitals)

Enhancing the quality of response of the Health Care System to Sexual Assault

Supported by
Indian Council for Medical Research (ICMR) and
the Department of Health Research (DHR), New Delhi, India
Hosted at
The Tata Institute of Social Sciences, Mumbai

Schedule No: _____ Date Of Interview: _____

Name of Interviewer: _____

Informed Consent

Personal Information

1) Name
2) Designation
3) Department
4) Age
5) Sex
6) Years of Service

General Information About Cases

1) On an average how many cases of sexual assault are referred here for examination at this hospital, in a month?

2) What is approximately the age distribution? Rank the age groups in descending order of frequency. (Can have cards for this)

- 0 to 5 yrs
- 5 to 10 yrs
- 10 to 16 yrs

- 16 to 30 yrs
- 30 to 50 yrs
- More than 50 yrs

Please Comment

3) Approximately how many such examinations have you been a part of until now?

4) How many nurses are usually present during the process of examination? If more than one, what is the role of each nurse?

5) What is the procedure generally followed for examination in the hospital? (Open ended)

i. Who refers the case to you?

ii. Do any cases come directly to hospital?

a) No, almost never
b) Yes, sometimes
c) Yes, many times
d) Any other

iii. Are they accepted/ rejected?

a) No, never accepted
b) Yes, sometimes
c) Yes, many times
d) Any other

iv. If rejected, why?

v. Is filing of FIR compulsory before cases are accepted for examination?

a) Yes, always
b) Yes, sometimes
c) No, it is not necessary
d) Any other

vi. What is the procedure followed if FIR or police request is not there?

vii. Who examines?

viii. How many referrals are made and to which departments?

ix. Do you have a checklist or a printed form to follow for examination?

x. If no, what do you use?

6) Who is the first contact person in the hospital when the survivor comes in or is brought for examination?

i. What do you do when you first come in contact with a survivor of sexual assault?

ii. Do you assist the family? If yes, in what way?

7) What are your specific roles during the process of examination, evidence collection in cases of sexual assault?

i. Which steps/procedures do you carry out independently during medical examination?

ii. Which steps/procedures do you assist the doctor/s with during medical examination

8) Are all the equipments necessary for medical examination and evidence collection available in one place?

9) If no, how much time does it take to assemble everything to start medical examination and evidence collection?

10) Who does the sealing of evidence and handing over of the evidence to the police?

11) Are you involved in the process?

12) If yes, what is your role?

13) Does the hospital have all facilities required to handle cases of sexual assault?

14) Can you specify if there are facilities lacking in dealing with cases of sexual assault?

15) What measures do you take to ensure privacy to the survivor?

16) Is there some preference given to who should conduct examination of the survivor

i. Male doctor

ii. Female doctor

iii. No such thing

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

18) What are the routine tests involved in age estimation? Please list

19) Have you ever signed as a witness?

20) If yes, under what circumstances?

i. Compulsory

ii. Absence of other witness and of female witness when survivor was female

iii. Specify other reasons, if any

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

22) If yes, how many times and under what circumstances?

23) Did you have any problems in testifying in court?

24) Did you face any other problems in court? Please specify. If yes, why?

25) Does the police / court inform you about the legal outcome of the case?

i. Yes, always

ii. Sometimes

iii. Only when asked for

iv. Never

v. Any other

26) According to you, to what extent does efficient documentation of injuries/ collection of medical evidence influence legal outcome?

a) Always results in positive legal outcome (conviction)

b) Mostly leads to positive legal outcome

c) Sometimes leads to positive legal outcome

d) Never leads to positive legal outcome

e) Any other

27) Would you like to share any cases where you have been involved?

- Common cases
- Rare cases

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

29) What kinds of examinations are carried out for accused? Please list

30) Who conducts this examination?

31) Is there some preference given to who should conduct examination of the accused?

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

IV. About Specific Case

1) When was the last time a case of sexual assault was brought for examination?

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

3) Can you describe the case and the management of it at the hospital level? (Probes listed below)

i. Who referred the case to you?

ii. Did the case come directly to hospital or was she referred here from elsewhere?

iii. How much was the time lapse before it was brought to the hospital?

iv. Was an FIR filed?

v. If yes, was it filed before or after examination of the case?

vi. Where did the examination take place?

	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				
a. History taking in patients own words				
b. Collection of specimen for treatment purposes				
c. Collection of clothes. How did you collect?				
d. Recording physical injuries. How did you record?				
e. Which details of the injuries did you record? Please list				
f. Did you record the following				
g. Location, size, shape, duration, (filled with/ contaminated with) and possible cause of injury				
h. Which samples did you take for forensic examination? Please list.				
i. Did you take any of these samples				
j. Oral sample				
k. Stains on the body				
l. Four vaginal samples				
m. Anal samples				
n. Urine sample				
o. Blood sample for blood group				
p. Blood sample for alcohol/ drug estimation				
q. Blood sample for DNA				
r. Nail clippings				
Matted hair				
Matted hair if any				
Head hair combing, public hair combing				

vii. Who examined the case?

viii. How many doctors were involved in the examination process?

ix. If more than one doctor examined, how was this accomplished?

x. How was the examination divided between doctors?

xi. Were referrals to other departments made, if yes which departments and why?

xii. What was the sex of the survivor?

xiii. Who signed as witness?

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

xv. How much time did the examination take?

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

5) If known, what was the relationship?

6) Had the survivor (before medical examination)

i. Bathed or washed
ii. Brushed or washed mouth
iii. Eaten
iv. Drunk fluids
v. Changed clothes/ washed the clothes she was wearing during the incident
vi. Passed stools and voided urine

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

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

V. Training

1) What training are you given to handle cases of sexual assault?
2) Please share what your problems are in giving such services?
3) Would you suggest any changes/ recommendations to the training?

Annexure-4: ANMs & ASHAs Interview Schedule

Tool 4

Interview Guide for ANMs and ASHAs

Enhancing the quality of response of the Health Care System to Sexual Assault

Supported by
Indian Council for Medical Research (ICMR) and
the Department of Health Research (DHR), New Delhi, India
Hosted at
Tata Institute of Social Sciences, Deonar, Chembur, Mumbai

Schedule no:

Date of the interview:

Place of the interview:

Name of interviewer:

Informed consent obtained:

Yes, written

Yes, verbal (please document the reasons)

No (pl document the reasons)

Section 1: Personal Information

[for interviewer: this section can be filled by the interviewee, if s/he prefers it.]

Name

Age

Sex

Sub-centre/PHC name

Length of service as ANM/ASHA

1. Please tell us what have been your experiences in relations to case of VAW during your work at as ANM/ASHA. Do you get to hear about cases of VAW from your community, your staff working in the community, or your own interactions with community?

2. How often have you heard of VAW cases in this work context from the community? [Or is it very common? Or do you perceive it as rare incidences? How would you explain the scale of it – rare or otherwise?
3. What happens when such cases are brought to your notice or survivors approach you?
4. Do you know of cases of sexual assault in your field area? Again, how big is the issue? For example, in last one year, have you come across or heard of such a case? How many?
5. If any such cases of VAW including cases of sexual violence you might have dealt with, according to you which is the first place for them to approach – health care facility or police chowkis?
6. What do you or would do if survivor approached/approaches you?
7. Do you have experiences to share with us as to how the health care system and police machinery respond to these cases?
8. Which health care facilities have been approached by these women in distress? Could you please share with us those experiences?
9. Do you know or have experiences about how government hospitals generally have responded to these cases from your communities?
10. Have you had any experiences with private hospitals in such context?
11. Have you come across or heard of child sexual abuse? Tell us a little more about it?
12. Any cases of males being sexually abused?
13. Do you find any correlation of caste and religion in cases of sexual assault in your field area?
14. (if the person has interacted with the health care system) What would you generally like to mention about your experiences with government health care system in relation to its response to VAW cases?

Annexure-5: TISS IRB Certificate

टाटा सामाजिक विज्ञान संस्थान
Tata Institute of Social Sciences

TISS

INSTITUTIONAL REVIEW BOARD

Chairperson
Prof. Indra Munshi

External Expert-Sr. Scientist and Researcher
Dr. Kamal Hazari

External Expert-Social Sciences
Prof. T. V. Sekher

External Expert- Bioethics
Dr. Amar Jasani

Member
Prof. Anil Sutar
Prof. Shalini Bharat
Prof. Moulesri Vyas
Prof. Satyajit Majumdar
Prof. Siva Raju
Prof. Bino Paul

Member and Medical Expert
Prof. Kanchan Mukherjee

Member and Legal Expert
Ms. Monica Sakhrani

Community Representatives
Ms. Pallavi Palav
Mr. Bhaskar Kakad

Member Secretary
Prof. Surinder Jaswal

Institutional Review Board
Ethics Clearance Report

Serial No. of IRB Meeting	2016-17	02
Project Title	Enhancing the Quality of Response of the Health Care System to Sexual Assault	

Name of Faculty In-charge/Project Coordinator/Principal Investigator :
Prof. Lakshmi Lingam

Date of Submission to the Committee	0	2	0	9	2	0	1	6
Date of Submission to other IRB's (if applicable)								
Date of First Review	1	3	0	9	2	0	1	6

The IRB appreciates that it is a 'minimal risk' research project involving health care facilities from the public health care system in Pune (urban and rural), Hyderabad (urban) and Karimnagar (urban and rural districts) in selected tehsils. The IRB appreciates the focus of the study and acknowledges that the proposal is detailed.

The IRB made the following recommendations/suggestions regarding the ethical component of the study:
1. A greater elaboration of the standard protocols of anonymizing medical records is needed.
2. A greater elaboration of the measures which will be taken to protect the confidentiality of the public health care system is needed.

The IRB also suggested that a report of the pilot study must be submitted.

All suggestions have been sucessfully incorporated.

Signature of the Chairperson

Signature of Member Secretary

Date of issue: March 6, 2017

डाक पेटी क्रमांक 8313
देवनार मुम्बई 400 088
Post Box No. 8313
Deonar, Mumbai 400 088

दूरभाष Telephone: 022 2552 5000
फैक्स Fax: 91 22 2552 5050
वेबसाईट Website: www.tiss.edu

A Deemed University established under Section 3 of the UGC Act, 1956, vide Notification No. F11-22/62-U2, dated 29th April, 1964 of the Government of India, Ministry of Education

Annexure 6: Crime Statistics

Crime against women (NCRB 2014)

Incidence of crime against women during 2014 (All India 3,37,922)
And Rate of crime against women during 2014 (All India 56.3)

Incidence of Crime against Women during 2014 (All India 3, 37,922) State level crime Incidence: Categories of states described in NCRB 2014 as per crime Incidence against women		
Slabs	**Name of State**	**No. of Cases**
Very High incidence >30,000 cases in a year	Uttar Pradesh	38,467
	West Bengal	38,299
	Rajasthan	31,151
High incidence 20001-30,000 cases	Madhya Pradesh	28,678
	Maharashtra	**26,693**
Medium high incidence 10001-20000 cases	Assam	19139
	Andhra Pradesh	16512
	Bihar	15383
	Delhi	15265
	Odisha	14606
	Telangana	**14136**
	Karnataka	13914
	Kerala	11380
	Gujarat	10837
Medium incidence 5001-10000 cases	Haryana	8974
	Tamil Nadu	6325
	Chhattisgarh	6255
	Jharkhand	5972
	Punjab	5425
Relatively Lower incidence 1001-5000 cases	Jammu & Kashmir	3321
	Tripura	1615
	Himachal Pradesh	1517
	Uttarakhand	1395
Low incidence Up to 1000 cases	Goa	488
	Chandigarh	432
	Meghalaya	388
	Arunachal Pradesh	351
	Manipur	337
	Mizoram	258
	Andaman & Nicobar Islands	115
	Sikkim	110
	Puducherry	77
	Nagaland	67
	Dadra and Nagar Haveli	21
	Daman and Diu	15
	Lakshadweep	4

Rate of Crime against Women during 2014		
(All India 56.3)		
Slabs	**Name of State**	**Rate**
Above 90.0	Delhi	169.1
	Assam	123.4
	Rajasthan	91.4
70.1 to 90.0	Tripura	88
	West Bengal	85.4
	Madhya Pradesh	79
	Telangana	**78.3**
	Haryana	73
	Odisha	70.4
50.1 to 70.0	Andhra Pradesh	65.1
	Kerala	63
	Arunachal Pradesh	57.4
	Jammu & Kashmir	57
	Goa	53.9
	Mizoram	51
40.1 to 50.0	Chandigarh	62.3
	Chhattisgarh	49.6
	Maharashtra	**47.6**
	Karnataka	46
	Himachal Pradesh	44.4
	Andaman & Nicobar Islands	44.2
	Punjab	41.1
20.1 to 40.0	Uttar Pradesh	38.3
	Jharkhand	37.4
	Gujarat	37.2
	Sikkim	36.9
	Bihar	31.3
	Meghalaya	28.8
	Uttarakhand	27.4
	Manipur	26.7
Up to 20.0	Tamil Nadu	18.4
	Daman and Diu	14.6
	Dadra and Nagar Haveli	11.1
	Puducherry	10.6
	Lakshadweep	10
	Nagaland	6

Source: Crime in India -2014/Chapter 5/pp:81-92 Available from: http://ncrb.nic.in/

Annexure 7 A – District level Crime Statistics, Maharashtra, 2013

Districts with high levels of Crimes against Women in Seven categories listed in Maharashtra

District	Maharashtra State Crime Incidence in 2013						
	Rape	Kidnapping and Abduction	Dowry Deaths	Assault on women with intent to outrage her modesty	Insult to modesty of Women	Cruelty by Husband or his Relatives	Importation of Girls
Ahmednagar	105	54	10	243	34	397	0
Akola	46	24	4	200	35	121	0
Amravati Commr.	26	22	2	96	27	38	0
Amravati Rural	78	45	1	317	35	175	0
Aurangabad	22	35	5	173	38	151	0
Aurangabad Rural	36	15	14	167	31	273	0
Beed	92	52	5	230	12	382	0
Bhandara	40	13	0	74	41	52	0
Buldhana	56	15	20	185	66	140	0
Chandrapur	88	25	8	179	123	180	0
Dhule	40	25	6	58	9	228	0
Gadchiroli	33	5	0	53	6	14	0
Gondia	52	21	1	94	10	55	0
Hingoli	15	12	4	55	2	86	0
Jalgaon	58	53	2	238	42	425	0
Jalna	35	29	50	132	6	351	0
Kolhapur	84	43	14	117	37	204	0
Latur	37	38	4	116	3	297	0
Mumbai Commr.	391	251	21	1163	444	602	0
Mumbai Rly.	6	5	0	41	5	0	0
Nagpur Commr.	91	80	4	209	52	218	0
Nagpur Rly.	2	2	0	15	3	1	0
Nagpur Rural	75	29	4	149	28	82	0
Nanded	64	48	30	135	6	341	0
Nandurbar	23	19	1	44	13	75	0
Nasik Commr.	20	16	7	96	9	181	0
Nasik Rural	85	36	9	224	21	405	0
Navi Mumbai	69	36	8	138	55	139	0
Osmanabad	48	26	4	127	12	166	0
Parbhani	40	37	4	132	6	271	0
Pune Commr.	**171**	**125**	**9**	**304**	**128**	**344**	**0**
Pune Rly.	**3**	**2**	**0**	**6**	**1**	**0**	**0**
Pune Rural	**150**	**76**	**6**	**277**	**72**	**224**	**0**
Raigad	42	14	4	92	45	80	0
Ratnagiri	27	8	0	82	26	39	0

Sangli	77	33	8	141	15	141	0
Satara	88	47	4	297	45	201	0
Sindhudurg	11	5	0	50	12	12	0
Solapur Commr.	37	25	1	53	23	63	0
Solapur Rural	82	25	1	149	28	109	0
Thane Commr.	182	178	14	467	119	423	0
Thane Rural	133	52	8	246	100	217	0
Wardha	73	47	1	227	35	116	0
Washim	26	21	10	153	22	142	0
Yavatmal	104	105	12	388	750	381	0
Total	**3063**	**1874**	**320**	**8132**	**2632**	**8542**	**0**

https://data.gov.in/resources/district-wise-crimes-committed-against-women-during-2013/download
Accessed on May 28, '16

Annexure 7 B: District Level Crime Statistics – Undivided Andhra, 2013

Districts with high levels of Crimes against Women in Seven categories listed in Undivided Andhra Pradesh (2013)

Districts	Rape	Kidnapping and Abduction	Dowry Deaths	Assault on women with intent to outrage her modesty	Insult to modesty of Women	Cruelty by Husband or his Relatives	Importation of Girls
Adilabad **(T)**	61	47	12	197	138	464	0
Hyderabad City	**101**	**52**	**39**	**225**	**90**	**1480**	**0**
Karimnagar (T)	**57**	**103**	**39**	**354**	**276**	**670**	**0**
Khammam **(T)**	100	104	15	254	297	768	0
Mahaboobnagar	117	63	33	219	98	234	0
Medak **(T)**	64	38	25	169	73	476	0
Nalgonda **(T)**	77	110	27	367	313	327	0
Nizamabad **(T)**	49	33	17	142	295	732	0
Ranga Reddy **(T)**	37	25	14	69	23	168	0
Warangal **(T)**	52	63	20	206	10	129	0
Total	**715**	**638**	**241**	**2202**	**1613**	**5448**	**0**
Anantapur	28	84	23	337		161	0
Chittoor	31	27	13	119	84	435	0
Cuddapah	19	50	9	318	163	207	0
Cyberabad	138	129	43	350	338	1526	0
East Godavari	74	33	15	352	222	483	0
Guntakal Rly.	0	0	0	3	2	0	0
Guntur	38	54	16	296	135	608	0
Guntur Urban	28	34	7	124	93	326	0
Krishna	58	37	14	387	274	708	0
Kurnool	26	50	11	374	199	203	0
Nellore	26	81	8	263	221	374	0

Prakasham	39	57	8	298	26	484	0
Rajahmundry	14	4	2	67	68	209	0
Secunderabad Rly.	0	2	0	11	0	0	0
Srikakulam	42	23	3	207	129	361	0
Tirupathi Urban	10	15	7	45	31	133	0
Vijayawada City	48	45	12	249	456	1227	0
Vijayawada Rly.	1	1	2	6	5	0	0
Visakha Rural	32	23	8	139	79	210	0
Visakhapatnam	67	50	8	149	100	548	0
Vizianagaram	42	25	10	165	95	383	0
Warangal Urban	36	47	16	127	81	195	0
West Godavari	123	86	16	342	245	855	0
Total	**1635**	**1595**	**492**	**6930**	**4702**	**15084**	**0**

Annexure - 8 Maharashtra Public Health Department, Office circular – Guidelines for medical examination in POCSO cases

(English translation)

Official Govt logo **NHM logo**

Additional Director **Telephone No (personal)** **Office Telephone No**	 **26058996 (Personal)** **26058739** **26058139** **26058476** **(office)**	**Additional Director,** **Health Ministry,** **Family Welfare, Mother and Child Welfare and School Health, Family Welfare Office, Rajabahadur Mill road, Behind Railway Station,** **Pune – 411001**
Health Ministry Official Circular		**Medical/Judicial Help Circular/** **For survivors of sexual assualt/2019** **Date 03/-1/2019** **508-78**

Subject: Guidelines for conducting medical examination of women and children (Boys/Girls) under the age of 18 years who have suffered sexual assault

Reference- Public health department, Maharashtra, GR No- 2014/ 240/health -3, dated 7th August 2015.

For reading- According to the ruling by the Public health department, Maharashtra state GR dated 7th August 2015, the following guidelines have to be implemented for the medico-legal examination of the victims/survivors of sexual violence.

Preface- The Government has been planning the creation of a booklet with guidelines for women and minors who are the victims of sexual violence. With that intention, the Department of Family and Health care, Mantralaya, New Delhi had instructed State governments to create guidelines and according to the reference provided, in 2015, the Public Health department, Maharashtra implemented the guidelines.

According to the instructions thus received by the government, some important points are being reiterated in this GR.

Some important points according to the government's directives:

1. Any victim of sexual violence or minors who are under the age of 18 cannot be denied 'Comprehensive care' by any doctor/ registered medical practitioners. The legal proceedings in such examinations and medico-legal matters should follow the Section 164 A CRPC. In such cases, the following points should be noted.
   a. The written informed consent is required by women who are victims of sexual violence or minors under the age of 18.
   b. The history of the sexual violence needs to be asked.
   c. After the victim gives consent, the medical examination can follow.
   d. Medico-legal proofs have to be gathered.

e. Along-with medical care, psychological assistance and social assistance needs to be provided.
f. The Police administration needs to be informed but the medical care has to be started, this is important.

2. According to the IPC section 89 and 90, the age of consent by the victim is 12 years and above.
3. According to the Section 164 (A) of CRPC, any registered medical practitioner can examine the victim of sexual violence. If the Medical practitioner is a male, then there needs to be a female employee besides him.
4. The evidence of the sexual violence needs to be gathered as soon as possible after the incident. But if the female or male victims of the sexual violence or the police informs the hospital within 96 hours of the incident, then the medical evidence of the examination can be gathered in this case also.
5. It is necessary for the doctor to write a clear and precise Provisional opinion about why is the medical evidence gathered and what further information is required from the FSL.
6. It is necessary for every hospital to have a committee, which can gather consent from the victims of the sexual violence who are homeless, abandoned, psychologically-ill, ones who are very disturbed and ones who have consumed narcotic substances. If such a committee doesn't exist, then its needs to be situated. From this panel, any person can give the consent on behalf of any female victim of sexual violence or for a minor. In this committee, there needs to be Medical officers from the Forensic division, Medical examiner, Gynaecologist, Paediatrician and Casualty. The presence of any two of the above professionals is enough for giving such consent.
7. In every case of sexual violence, it is binding on the doctor examining it, to write his temporary conclusions. The examining doctor cannot leave any column empty on the form of examination.

All the officers of the Zilla Health department, Zilla forensic department, Medical superintendents, Medical officers (health) should examine the victims of sexual violence to the best of their ability and follow every guideline mentioned with care, as is the order given by the Government of Maharashtra.

(As signed by)

Dr. Archana Patil
Additional Director
State Family Welfare department, Pune,
Government of Maharashtra.

Annexure- 9 Knowledge Questions with Reference to Law and Ministry Guidelines

List of statements on various aspects of medico-legal care for survivors of sexual violence and the corresponding sources (CLA 2013 and Guidelines) of these statements		
Sr no	**Statements based on various provisions in CLA 2013 and Ministry Guidelines**	**Sources of Legal provision**
1.	Medical examination of the survivor of sexual violence does not require police requisition. It is up to the survivor if she would like to move forward with reporting to police towards initiating police investigation.	◦ Sup court case verdict (yr 2000: State of Karnataka Vs Manjanna) ◦ Sec 27 POCSO Act 2012 ◦ Rule 5 POCSO Act 2012 ◦ Sec 357 C CrPC 2013
2.	It is mandatory for health care facility both private and public to provide treatment to survivors free of cost. [Comprehensive care including rehabilitation and follow up care is mandatory. These include care for injuries STD, HIV, pregnancy testing, emergency contraception, psychological counseling]	◦ Sec 357 C CrPC 2013 Section-23 ◦ Rule 5 POCSO 2012 Act ◦ Sec 166 B IPC (prescribes punishment for non reporting by providers) – to check if this is non-reporting or non-treatment
3.	Not providing comprehensive free care to survivors and non-compliance can attract imprisonment of one year and/or fine	◦
4.	It is unlawful to do any part of examination without survivor's consent	◦ Sec 164 A CrPC
5.	It is mandatory for doctors /hospitals to inform police about a woman examined for sexual violence	◦ Sec 19 POCSO Act 2012 (Reporting by providers is mandatory) ◦ Sec 21 POSCO Act 2012 (prescribes punishment for non reporting by providers)
6.	It is no longer essential to arrange for a female gynecologist for examination of the survivor	◦ The amendment of 2005 in Criminal Law Amendment Act in Sec 164 A CrPC – removed the insistence for female doctor to attend to survivors of sexual violence
7.	For child survivors less than 18 years it is mandatory to arrange for a female doctor to examine	◦ Sect 27 POCSO Act 2012 insists for such an arrangement
8.	Presence of injuries to the survivor is no longer necessary to arrive at an opinion that a woman has been sexually violated/raped.	◦ Explanation 2, Sec 357 CrPC clearly articulates that no sign of resistance can be construed as consent by the survivor to the act of sexual activity alleged to be sexual violence
9.	Documentation of sexual activities prior to sexual violence are not required as part of medico-legal evidence any longer	◦ Sec 146 Indian Evidence Act prohibits debate on previous sexual experience or past sexual practice in the witness box
10.	Medical age estimation in case of clear evidence/documentation of proof of age is not warranted and should not undertaken by examining doctors as part of medico-legal evidence collection	◦ Supreme Court order in case of Ashwini Kumar Saxena V State of MP opined against undertaking age estimation exercise in cases of availability of clear evidence of age. ◦ Contradiction arises since Sec 164 A CrPC and Sec 15 (15A) Immoral Traffic Prevention Act 1956 insists on medical age estimation from doctors
11.	It is important to document the details of WHEN examination is done	◦ No specific legal provision to enforce it. ◦ Being encouraged in the interest of the fact that examination and evidence collection is time sensitive due to high risk of losing significant evidence with delays.

		• It is expected that cases of sexual violence when presented to health care facilities are treated at par with medical emergencies and therefore prioritized by doctors and hospitals
12.	It is encouraged that examining doctors provide provisional opinion about the case without having to wait for the report from forensic science labs (FSL)	
13.	It is legally binding for examining doctors to provide final opinion with adequate reasoning to support the stated opinion. It is advisable to issue it before getting into the witness box	• Sec 164A CrPC prescribes that negative evidence or lack of evidence such as absence of semen needs to be explained as part of reasoning
14.	Medical opinion in the current context of various legal reforms is relevant but it is NOT the ONLY evidence	• This is because of the significant shifts taken place in the notion of rape and sexual violence
15.	In case of children, it is mandatory that child's parents are present during the medical examination or guardian or any other person whom she trusts	• Sec 2 POCSO Act 2012 • In case such a person is not available, it then is the duty of the hospital to provide such a person
16.	Special tests are advised to be used with caution	• Special tests such as colposcopy (to detect micro-injuries), toluidine dye test (micro-injuries detection) have limitations in detecting such injuries of only sexual violence; Wood's Lamp examination (for detecting semen) which has limitation of false positive test
17.	DNA examination in SV violence is relevant and considered crucial comparable evidence	Despite its importance, challenges needs to be acknowledged: • Needs to be collected and profiled properly • Limitations in the Indian context include accused might not be caught immediately; Sec 164 A crPC Sec 53 A CrPC insists for DNA evidence collection; however due to limited resources and FSLs it tends exert immense pressure on the system and delays in readying reports in timely manner; and lastly India doesn't have database of population or at least of those with criminal records
18.	Reasonable pressure is allowed for medical examination in case or rape accused	• Sec 53A CrPC although mentions this lacks clarity about what is reasonable force • This section necessitates collection of blood, semen, saliva, hair, body fluids etc • Documentation of informed refusal is necessary • It is also mandatory that what is involved in medical examination needs to be given to the accused before medical examination is initiated
19.	Potency test of the accused is not relevant and not necessary	• Sec 375 IPC has widened the scope of definition of rape. • Medically one cannot definitively opine on person's potency.

Annexure – 10: Government of Maharashtra, Circular dated 7th August 2015 circulating the Ministry of Health & Family Welfare Guidelines

(English Tranlation)

Govt. of Maharashtra
Public Health Department
Govt circular no. 2014/No. 270/Health-3,
10th Floor Building Complex,
G.T. Hospital, Mumbai- 400001
Date: 7 August 2015

Guidelines for medical examination of the victims, survivors of Sexual abuse/violence.

Reference: Government Regulation, Public health department, dated- 10th May 2013

Government Regulation:

According to application filed in the honourable High court, Mumbai division, Nagpur, numbering 46/2010, by Dr. Ranjana Pardhi vs State of Maharashtra regarding bringing about regulation and uniformity in the medical examination of the women who are survivors of sexual violence/abuse which was ordered by the High Court and a government circular that was released, the following guidelines have been created. These guidelines have been sent to all the medical examiners who are authorised to conduct such check-ups.

1. After the Supreme Court directed the government, the Centre has sent guidelines which have to be followed uniformly in all states. Therefore, the guidelines and circular sent by the state government on 10th May 2013 stands cancelled.

2. Along with the directive which has been sent out, a detailed booklet with rules/directions has also been attached which has to be brought into attention of all the currently practicing medical practitioners and practitioners who provide medico-legal assistance. They have to be instructed that these guidelines have to be strictly followed.

The document/booklet is available on the government's website- www.maharashtra.gov.in and the guideline can also be found by the number- 201507131248455617. This is a digitally-signed directive.

By order of the Governor of Maharashtra.

Shekhar Vasantrao Dhawale.

To,

Personal secretary of the Health Minister
Personal secretary of Minister of State for Health

Secretary, Department of Medical Education and Pharmacy, Mantralaya, Mumbia

Chief Secretary, City Development department, Mantralaya, Mumbai

Secretary, (Law and order) Department of Home affairs, Mantralaya.

Secretary, Women and Child Development department, Mantralaya.

Director, Department of Crime and Investigation, Pune.

Director, Health Care, Mumbai

Director, Division of Medical Education, Mumbai

Director, Forensic Laboratory.

Principal and department head, Medico-legal science, Grant Medical college.

Principal and department head, Gynaecology, Grant Medical college.

Co-ordinator, CEHAT, Mumbai.

Co-ordinator, UNFPA, Mumbai.

All Sub-Directors, Health Care (Aarogya Seva)

All Co-Directors, Health Care (Aarogya Seva)

All Zilla Forensic Examiners,

All Zilla Health Officers,

Public Health department (All employees)

Nivadnasti (Health- 3)

ISBN : 978-81-955347-0-8 (E-book)

ISBN : 978-81-955347-1-5 (Book)