USAID
FROM THE AMERICAN PEOPLE

A Situation Analysis of Care and Support for Rape Survivors at First Point of Contact in India and Bangladesh

Population Council
FRONTIERS
IN REPRODUCTIVE HEALTH

A Situation Analysis of Care and Support for Rape Survivors at First Point of Contact in India and Bangladesh

M.E. Khan
Aruna Bhattacharya
Ismat Bhuiya
Aditi Aeron

September 2008

This study was made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-98-00012-00 and In-house Project number 5800.53122. The contents are the responsibility of the FRONTIERS Program and do not necessarily reflect the views of USAID or the United States Government.

EXECUTIVE SUMMARY

Background

Rape survivors need timely medical attention and counseling. The first component of the comprehensive package of care and support that rape survivors need is the immediate counseling and services available at the primary place of contact—often the police station or the hospital. Currently, very little is known about the reproductive health (RH) services offered at these first points of contact. Rape is seen as a medico-legal case in many countries and therefore there are administrative and legal formalities associated with the visit of rape survivors the health facilities. Many times, paperwork and these administrative obligations delay rape survivors' access to some RH services, such as emergency contraception pills (ECP) or post exposure prophylaxis (PEP), because many of these services have small windows of time (72 hours) in which they can be administered effectively. Unless health service staff are aware and able, many of these women may miss their opportunity to obtain certain RH and HIV forms of care.

Study Objective

To evaluate the current environment, a situation analysis of post-rape care services available at the first point of contact was conducted. The aim of this investigation was to gather information that could be used in the development of a comprehensive care and support system for the rape survivor. Secondarily, the study field-tested sensitive and practical tools that could be used in the future for large-scale situation analyses of the rape survivor services. This study was carried out in three cities in India (Delhi, Lucknow, and Vadodara) and four cities in Bangladesh (Dhaka, Chittagong, Sylhet and Tangail).

Methodology

This study included a situation analysis of both police stations and health facilities, two of the most common points of first contact with service providers for rape survivors. The study tools were developed after reviewing existing instruments utilized by the following organizations: Sexual Violence Research Initiative; Liverpool VCT (a Kenyan NGO); the FRONTIERS Program; and a Population Council multi-country rape survival study in several African countries. After research and development of a study tool, it was pre-tested in Dhaka and Delhi, modified wherever where necessary and re-administered. Data were collected using the final version of the tool with medical practitioners and nurses from public hospitals, and police personnel from stations located near to health facilities.

Findings

The results demonstrated that there is no uniform service provision protocol to follow for managing rape survivors at health facilities in India or Bangladesh. A protocol was said to exist, yet no copy was available in any of the police stations included in the study, and many police officers interviewed were not even aware of its existence. In most places, the elected procedure for managing rape survivors was based on traditional practices at these stations.

In both countries, none of the police stations were providing RH services or information on ECP or PEP. According to police officers interviewed, their responsibility ends once the First Information Report (FIR) has been filed and the survivor has been taken to the hospital. Police personnel reported receiving little or no on-the job training on managing and/or counseling rape survivors.

A similar lack of services was observed in hospitals. Sexually transmitted infection (STI) management was not available in most health facilities, and when services were available they were not of any standard regimen. Referrals to VCT centers were rarely seen and PEP was an unfamiliar concept among health professionals. In most hospitals, neither PEP nor ECP was in stock. Skilled counselors were not regularly available in both India and Bangladesh and, similar to the situation in police stations, most doctors and nurses had no orientation on managing rape survivors.

It was clear that most police and medical providers were not sensitive to the needs and care of rape survivors. Interviewees many times reflected thoughts consistent with popular stereotypes towards rape survivors, blaming the survivor, emphasizing shame brought to the woman's family and a general lack of sympathy for rape survivors.

In Bangladesh, there were six dedicated centers for care and support for rape survivors—One Stop Crisis Centers (OCC)—that have been established to provide comprehensive services to rape survivors and survivors of other violent crimes. These OCCs should be studied further in detail as they may act as models for the provision of comprehensive care and support to rape survivors within the country and regionally.

It is important to note that these results should not be generalized because the sample sizes were small. Despite this limitation, the study findings are striking and provide a good lead for a full-scale situation analysis of the police stations and health facilities that may potentially provide services to these women in need.

The tools in this study were developed, revised and tested. In general, the tools were found to be efficient and may be applicable for use in a number of diverse settings. Unfortunately, because the situation analyzed in this setting was so dire, many questions were left unanswered as they were not applicable. To complement these findings, qualitative data should also be collected to get a fuller picture. As a comprehensive analysis, this information can lend to an overall understanding of types and quality of services provided to rape survivors.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
DTC	Diagnostic testing and counseling
EC	Emergency Contraception
ECP	Emergency Contraceptive Pills
FIR	First Information Report
FP	Family Planning
FRONTIERS	Frontiers in Reproductive Health Program
GA	General Anesthesia
HIV	Human Immune Deficiency virus
HOD	Head of the Department
HQ	Headquarters
ICRW	International Center for Research on Women
IO	Investigating Officer
IPC	Indian Penal Code
LPO	Lady Police Officer
MLC	Medico Legal Case
NCRB	National Crime Records Bureau
NGO	Non Governmental Organization
NFHS	National Family Health Survey
OCC	One Stop Crisis Center
OCP	Oral Contraceptive Pills
OTC	Over the Counter
PEP	Post Exposure Prophylaxis
PV	Per Vaginal
RH	Reproductive Health
SA	Situation Analysis
SHO	Station House Officer
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SV	Sexual Violence
SVRI	Sexual Violence Research Initiative
UPS	Unprotected Sex
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VAW	Violence against Women
WHO	World Health Organization

ACKNOWLEDGMENTS

This was a multi-country study undertaken by FRONTIERS Program of the Population Council.

We are thankful to the Police Commissioners of Delhi Police, and senior police officials of Lucknow in Uttar Pradesh and Vadodara in Gujarat for cooperating during data collection in India. We also thank the Medical Superintendents of Safdarjung Hospital, Delhi, Babu Jagjivan Ram Hospital, Jahangir Puri, Delhi, Deen Dayal Upadhaya Hospital, Hari Nagar, Delhi, Kings George Medical College and Hospital, Lucknow, Dafreen Hospital (Avanti Bai Mahila Chikitsalay), Lucknow and Sawai S G Hospital, Vadodara for allowing us to interview the HODs of the Department of Obstetrics and Gynecology and the Department of Forensic Science and the Medical Officers in-charge of casualty wards. The Medical Superintendents of the medical colleges and hospitals and Police Commissioners of the three cities where the study was carried out encouraged the study and made sure that the research protocol was fulfilled. Special mentions need to be made of the various doctors and paramedics who participated in the interview sessions and we acknowledge their valuable contribution.

We express our gratitude to the Principals of Dhaka Medical College Hospital (DMCH), Chittagong Medical College Hospital (CMCH), Sylhet Medical College Hospital (SMCH), and Civil Surgeon of Tangail District Hospital in Bangladesh for their extensive support to conduct the study. We are thankful to doctors working at the Department of Forensic Medicine (FM), Department of Gynae and Obstetrics, and Emergency Department, doctors working at One Stop Crisis Centre (OCC) and the Officers In-Charge (OC) in respective Thanas for providing relevant information. Thanks are due to Dr. Shimul Koli Hossain and Dr. Shahadat Hossain for helping us in collecting information.

We are thankful to United States Agency for International Development (USAID) for providing resources.

TABLE OF CONTENTS

List of Tables

BACKGROUND

Sexual violence is common and found in all parts of the world. These violent acts range from unwanted sexual advances to forced marriage, rape, forced abortion, and the denial of the right to use contraception (WHO 2002). Among these offenses, rape is perhaps the most traumatic—defined by WHO as *"physically forced or otherwise coerced penetration – even if slight – of the vulva or anus, using a penis, other body parts or objects"* (WHO 2002). However, the definition of rape differs greatly by cultural settings. For example, Box 1 provides a comparison of the definitions of rape provided by WHO and the Indian Penal Code.

Box 1: Definitions of Rape: No Uniformity

WHO defines rape as an act where the survivor has been sexually assaulted in any of the following form:

1. Sexually violated
2. Penetrated by force
3. Vaginal penetration, non-consensual
4. Anal penetration, non-consensual
5. Penetrated by an object.

According to WHO's definition, one or any combination of 1,2,3,4 and 5 are defined as rape.

According to the Indian Penal Code (IPC), only (3) is a rape case. (4) and (5) are cases of sodomy (unnatural sexual acts). (1) and (2) are neither rape cases nor cases of sodomy, but may be considered attempted rape or sexual harassment, depending on the details of the interaction.

Featured sections of the IPC directly addressing sexual assault include:

Section 354: Sexual harassment; attempt to outrage modesty of a woman.

Section 323: Simple assault

Section 377: Sodomy (sexual intercourse against the order of nature)

Section 375: Rape occurs when a man has sexual intercourse with a woman, against her will, without her consent, with her consent, when consent has been obtained by putting her or any person in whom she is interested in fear of death or hurt, with when she believes that he is her husband, with her consent, when consent was given due to unsoundness of mind or intoxication or administration of stupefying/unwholesome substance because of which she is unable to understand the nature and circumstances of her act, with or without consent when she is under 16 years of age. To constitute sexual intercourse, vaginal penetration is essential.

Sexual intercourse by a man with his wife under 15 years of age amounts to rape. Rape is an offense committed by a man upon a woman.

Section 376 / 511: Attempt to rape.

Incidence of Rape in India

Although the incidence of rape in India is very high, data are scarce. According to the Indian National Crime Records Bureau, in 2005 one crime was committed against a woman every 3 minutes, 1 molestation case was registered every 15 minutes, one sexual harassment case every 53 minutes, and one rape case was reported every 29 minutes (Times News Network 2006). Delhi, the capital city, was recently labeled the "rape capital" of South Asia, with more than 330 rape and molestation cases reported in the first four months of 2008 (Wax 2008). According to "Crime in India" (NCRB 2007) a total of 19,348 rape cases were reported during 2006, marking an increase of five percent from the previous year.

However, these numbers are a grossly underestimated picture of reality. These numbers only reflect rape cases that have been officially reported to the police. But women's groups say that less than two percent of sexually assaulted women actually report the crime to the police (Wax 2008)—resulting in a huge proportion of cases going uncounted. Rape goes unreported for a number of reasons: families may put pressure on the survivors to remain quiet because of honor (especially when the perpetrator is a member of the same family) (WHO 2002 & 2003), or there may be a lack of faith in law and the judicial system (WHO 2003). In 2006, 74,659 rape cases were due for trial in the Indian Courts; only five percent (3,806) resulted in a conviction. Another reason for vast underestimation is that forced sex or assault committed by a husband

on his wife is not considered rape in India. Studies on inter-partner violence in India (NFHS 2007, Koenig et al. 2006, Khan et al., 2003) have shown considerable incidence of rape and forced sex committed by husbands (10-60 percent). Yet these cases are not reported or acknowledged by the judicial system.

With these two considerations in mind, it is clear that the actual number of rape cases is astronomically higher than what has been officially recognized, exemplifying a most critical situation that warrants attention and intervention.

Incidence of Rape in Bangladesh

The present situation of rape in Bangladesh is similar to that of India. Data from an *Odhikar* press release on Violence Against Women in Bangladesh revealed that from January 2001 to February 2007, 5,816 women and children were reportedly raped across the country, of which 636 were killed (Coalition for the International Criminal Court 2007). As in India, Bangladeshi human rights monitors report the actual number of rape as being much higher than what is reported officially. Fear of social disgrace and lack of faith in the judicial system (U.S. Department of State 2005, Badruddoza 2002) are two reasons for this underestimate.

Additionally, a rape case must first be registered with the police before action can be taken, and many policemen demand bribes for proceedings with registration. Additionally, pursuing cases from lower to higher courts sometimes takes 2 to 3 years, and most women cannot bear the costs of these lengthy proceedings (Badruddoza 2002). Lastly, sexual violence conducted by husband is not considered an offense, is not counted in national statistics and does not warrant legal proceedings.

Consequences of Rape and Services for Survivors

The consequences of rape are both physical and emotional. Survivors of sexual assault suffer from mental stress and other psychological syndromes (NCRB 2006, Pitre 2006). These consequences are more damaging in cultural settings where men are expected to be sexually demanding and where women's sexuality is valued by its “purity” (i.e. avoiding sexual contact before marriage and remaining monogamous after marriage).

These social norms lead to “survivor blaming”, laying all burden on the woman, running down their self-esteem and level of empowerment. To appease this social norm, trauma counseling is an important treatment for rape survivors, and should be included in all therapy activities.

Potential ill-health consequences of rape include physical injuries, sexually transmitted infections, including HIV, and pregnancy. Pregnancies resulting from rape are generally unwanted and traumatic, and in countries where abortion is not legal, the effects of the rape may be even more traumatic and long-lasting than the incidence is alone. Timely emergency contraception (EC) to all female rape survivors, who are already not pregnant[1], could protect many from unwanted pregnancies. Other reproductive health needs of rape survivors include the prevention of HIV and other STIs with timely administering PEP (post-exposure prophylaxis) (Population Council 2007, WHO 2003, Christofides et al. 2005, Liverpool 2005).

[1]A pregnancy test is desirable to determine the status of eligible females. It is important to reassure clients that the EC pills will cause no harm to an existing fetus or to the course of the pregnancy (WHO 2004).

According to Amita Pitre (2006), an important reason for failure of securing convictions of rape offenders is that forensic evidence is not regularly collected or stored with requisite care. Review of sexual violence services in South Asia (Khan et al 2006) led to the identification of several limitations in the existing procedures. Recommendations were made to improve coordination between the police, medical and judicial systems to better elicit justice. Population Council's research on the comprehensive care for rape survivors (Keesbury, et al. 2006) recommends a comprehensive plan of action, with forensic examinations a key player in justice and medical requirements (see Box 2).

Box 2: A Comprehensive Model of Care for Rape Survivors

1. Medical Management of sexual violence at the point of first contact with the survivors (e.g. at the police station or medical facility)
   a. Treatment of physical injuries
   b. Pregnancy testing and emergency contraception (EC)
   c. STI prophylaxis
   d. HIV diagnostic testing and counselling (DTC) and Post-Exposure Prophylaxis (PEP)
2. Psychological Counselling of rape survivors
3. Collection of forensic evidence and its documentation that can be used during prosecution
4. Provision of referrals to the survivor in case she wants to initiate prosecution. This will require establishment of strong links between the police and health facility and NGOs so that incidents could be referred in either direction.

Population Council, 2008

Providing ECP to rape survivors at the first point of contact can be an important entry point to strengthen other RH and related services available to these women. A study by Population Council in Zambia (Keesbury et al. 2006) demonstrated that the majority (91%) of sexual abuse survivors seek support from the police before seeking healthcare, and therefore some elements of a comprehensive package of care should be made available at these first centers of contact (such as ECP, counseling and information on PEP).

Population Council analyzed the care-seeking behaviors of rape survivors in a South Asian context, in efforts to build a base for a comprehensive package of care. Assessment tools for conducting rapid Situation Analysis (SA) were created and tested to evaluate the services offered at police stations and health facilities. The current report describes the process of development and improvement of these SA tools and some of the salient findings from this analysis.

STUDY OBJECTIVES

The ultimate aim of this study was to reduce the incidence of sexual violence and meet the reproductive health needs of survivors of sexual violence. The immediate objectives of the present study were:

1. To develop sensitive and practical situation analysis tool(s) for assessing the RH services available at first contact point for rape survivors in diverse settings.
2. To use the tools to conduct a rapid situation analysis of RH and other related services, available at health facility and police stations in three cities in India and four cities in Bangladesh.
3. Based on the experience of the pilot study in the two countries, to revise and finalize the SA tools to facilitate their use in diverse settings.

Research Questions

The key research questions investigated in this situational analysis include:

1. What happens when a rape survivor comes to a health care facility or the police station, reporting a rape incident?

2. Are standard protocols available to examine rape cases and survivors, and collect forensic evidence systematically?
3. Is it feasible to introduce specific reproductive health services in police stations and make them available to rape survivors?
4. What can be done to provide a comprehensive model of care and essential services to survivors of sexual assault?

METHODOLOGY

Location

A situation analysis was conducted in seven cities from two South Asian countries, three in India and four in Bangladesh, reflecting different cultural and administrative settings. The cities in the study were:

- Delhi, Lucknow, and Vadodara in India
- Dhaka, Chittagong, Sylhet and Tangail in Bangladesh.

Study Design

The study was exploratory in nature. It consisted of interviews with medical practitioners and nurses in public hospitals and police personnel in police stations adjacent to medical facilities. Interviewees were asked about the procedures followed and services provided to survivors of sexual assault when they reach the respective facilities. There were specific questions addressing the following: waiting time, counseling, provision of ECP, PEP services and medical and forensic examinations. The interview questionnaire also included sections on the providers' attitudes towards rape survivors and the extent and type of care they deemed necessary and appropriate for managing rape cases.

Implementation of the Study

Study implementation included four stages completed within six months:

1. Development of Situation Analysis (SA) tools
2. Health care providers and police personnel interviews
3. Situation analysis of care provided to rape survivors at police stations and in medical facilities
4. Modification of tools based on field experience and feedback.

Development of situation analysis (SA) tools: Development of the situation analysis tools comprised a literature review, question development, review of existing related tools, and an interview outline for personnel from the police and health services. The literature review included research on sexual assault in general, common RH requirements for rape-survivor services, and regional and international recommendations for rape-survivors at the first-point of contact[2]. Using this information, a list of questions was developed. Information from the Sexual Violence Research Initiative (SVRI 2007), Liverpool VCT (Liverpool 2005), and the Population Council was used to enhance the significance and applicability of the questions. The reference tools had several general themes in common, which were incorporated as far as possible into these tools. These themes/components were as follows:

[2]In some parts of the world, the first point of contact could also be the church or legal court (e.g. In Latin America) or village head (in Africa).

1. Procedures undertaken when the patient first reaches the facility and during the initial waiting time
2. Counseling of rape survivors
3. Provision of RH services (including ECP, PEP for STI/HIV)
4. Training of police and medical personnel on post-rape care
5. Availability of standard protocols and guidelines for managing rape cases
6. Information on medical and forensic tests available at the health facilities
7. Attitudes of police and medical personnel towards rape and rape survivors.

An interview outline was developed and then pre-tested in Delhi and Dhaka. Feedback from pre-tests was used to modify the interview outline, specifically in terms of accurately capturing the local context and applicability among police and health care personnel. The revised versions of the questionnaires were used to collect information for this pilot situational analysis and are presented below.

Interviews with health facility staff and police officers: As the topic of these interviews was very sensitive, many police officers and health providers were not interested in participating in the study. The interview required a large time commitment and several visits by the interviewer before interviews were even able to be initiated. Higher level officers (Medical Superintendents in the hospitals and Police Commissioners in police departments) gave permissions to interview participants. This permission was pertinent in retrieving information from police officers and health care providers at designated centers. For any large scale SA undertaken in future, considerable preparatory time and establishing close relationships with authorities involved is critical.

A total of 55 police personnel and 44 medical practitioners were interviewed. In Bangladesh, two providers were often interviewed from the same facility. In India however, only one person was interviewed from each facility; the interviewee was usually the head of the department/police station. Many times, upon seeking an interview from a second person within the same facility, efforts would be stopped. It would be explained that *"nothing new is going to come,"* or the potential second interviewees would be instructed not to participate.

Data collection many times was challenging. Interviews were conducted in the place of work, and many times interviews were left incomplete because of emergency situations. Finding time to complete all interviews was very difficult and sometimes issues were left unresolved.

Analysis of data and modification of tools: After data collection was complete, investigators in the two countries reviewed the questionnaires and further modified the content and layout of the tool. They used feedback from the interviews and personal field experience to guide modifications of the tool. The final modified tools are presented in the Appendices A and B. Data were coded, compiled, and then analyzed using SPSS. The salient findings are presented in the Key Findings section.

KEY FINDINGS

Situation Analysis of Police Stations

Rape as a medico-legal case: The First Information Report (FIR) records the details of a crime when reported at the police station after it occurs. In both India and Bangladesh, rape is classified as a medico-legal case, requiring the involvement of the police and an immediate FIR filing. However, rape survivors did

not always approach the police stations immediately after the rape incident (Table 1). According to protocol, a rape reported to a health facility is either referred to the police station or the police are called to the health facility before the patient is provided medical services.

Table 1: Percentage of rape cases first reported at the police station

	India (N = 17)	Bangladesh (N = 38)
75% or more	29	42
50%	24	26
25% or less	35	32
Do not know	12	0

Who attends a rape survivor: According to protocols available within police departments in India, a lady police officer (LPO) should be the investigating officer (IO) for all rape cases. However, only 5 of 17 police respondents (29 percent) said that rape cases were always registered by LPOs, and 2 reported that they themselves had responded to rape cases when the LPO was not there. Almost half of respondents reported that rape cases were attended by whoever is on duty, and not always by LPOs (Table 2).

In Bangladesh, there is no existing protocol dictating what gender the reporting police officer should be. Yet, 26 percent (10 out of 38) of the police personnel reported that rape cases were always attended by LPOs (Table 2).

Visits to the police stations in India revealed that all writers (a designation in the Police Department equivalent to Sub-Inspector rank) were males, and a number of police stations did not have LPOs. There was a shortage of female officers in the police force in both India and Bangladesh. To cope with this shortage, LPOs from adjacent stations were called to stations without LPOs to report and investigate rape cases (65 percent in India; 82 percent in Bangladesh). This referral system likely contributed to the extended wait time experience by rape survivors.

Table 2: Rape cases handled at police stations (percentage)

	India (N = 17)	Bangladesh (N = 38)
Rape survivor attended by LPO		
Always	29	26
Sometimes	6	45
Whosoever on duty	47	29
Lady Constable if LPO not there	12	0
Do not know	6	0
Waiting period before FIR is written		
15 minutes or less	23	5
20-30 minutes	59	74
45-50 minutes	0	8
1 hour or more	18	13
Interview with survivor in private room	77	12
Police personnel with NO formal training to manage rape cases	94	84
Police personnel showed willingness to attend training on post–rape care	47	82

Waiting time at police station: Rape cases are meant to be considered high priority cases. Unfortunately, interviews revealed that most rape survivors waited at police stations for the same length of time or even longer than other cases.

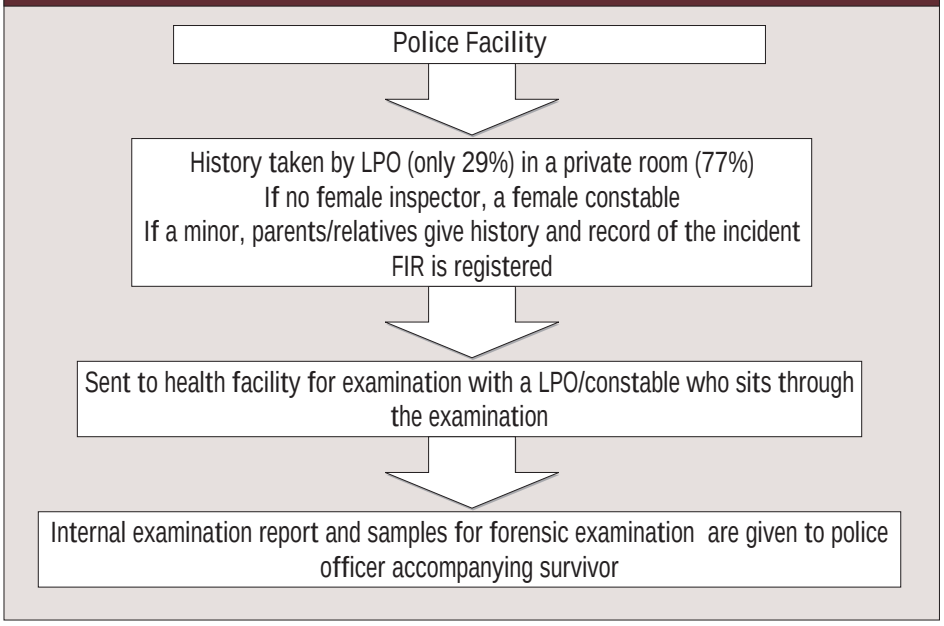
Women reporting rape cases wait before their cases are registered and also stay at the station throughout the proceedings. Only 23 percent of the police respondents in India and 5 percent in Bangladesh reported registering rape cases within 15 minutes of the survivor's arrival. Three-quarters of police personnel interviewed in Bangladesh and 59 percent in India reported a minimum waiting time of 20-30 minutes for FIR forms to be filled (Table 2). Waiting times for case registration were reported to frequently be over one hour (18 percent in India and 13 percent police in Bangladesh).

It was clear that waiting times were reflective of the presence of an LPO. Waiting times increased when an LPO was called from another police station to manage a rape case. At least 3 respondents from India and 17

from Bangladesh reported the LPO's arrival to take more than an hour at times.

In Bangladesh, a similar procedure is followed. The total duration from the time of arrival to the time when rape survivors are sent to medical facilities varies from one to 2.5 hours. Many times this variability depends on the availability of an LPO. The age of the rape survivor (whether she is an adult or a minor) may also affect the waiting and processing time.

Figure 1 - Flow chart of steps taken when rape survivor reports at police station



Training on care and support for rape survivors: All police personnel received general training before induction into the police force. For non-commissioned officers the training period is one month and for commissioned officers it is one year. Various areas of policing are addressed in these trainings, including the expected role of the police in the case of a rape reported.

During police officer interviews, questions about the existence or the potential for subsequent or more-detailed training were pursued. About 94 percent of the police respondents from India and 84 percent from Bangladesh reported receiving no additional training after joining. However, one police officer in India and six in Bangladesh (16 percent) reported receiving some additional formal training on care and services for rape survivors. In both countries, additional training included medical report documentation, counseling methods, managing juvenile rape cases and managing rape cases during pregnancy. In Bangladesh, however, this additional training was reported to be very general, with the range of topics including managing mentally and physically challenged cases of rape (11 percent), rape laws (11 percent), and forensic evidence collection (11 percent).

Many police officers vocalized interest in receiving additional training on management of rape survivors; 47 percent of the police personnel interviewed in India and 82 percent in Bangladesh demonstrated willingness to attend formal training for managing rape cases. Furthermore, 86 – 94 percent of all respondents believed that at least two officers/head constables in each police station should be specifically trained to manage rape cases.

Survivors counseling at the police station: Counseling may be provided to rape survivors and other survivors of violent crimes in order to assist them with coping strategies, treatment and their mental and physical recovery. Additional to the counseling that may be provided, police officers must interview rape survivors to gather information about the incident for criminal investigation. It is important to distinguish these two terms, counseling and interview, in the following sections.

a. Immediate counseling of the survivor on arrival at the police station: Forty percent of police officers interviewed in India reported that some counseling was provided to the rape survivor before paperwork was completed, in those cases when survivors arrived at the police station in an agitated condition. Forty-seven percent reported waiting until the survivor had calmed down before discussing the police proceedings and the rape incident. A few officers reported initiating interviews without providing any prior counseling or waiting for her to calm down before discussing the incident.

In Bangladesh, the situation appeared to be quite different, as it was reported that rape survivors were never interviewed when in an agitated state. According to 92 percent of the Bangladeshi police respondents, survivors were first provided with sedatives before discussion or interviews about the rape incident occurred. The remainder said that some counseling was given to the survivor before enquiring about the case (Table 3).

Table 3: Counseling offered to rape survivors at the police stations (percentage)

	India (N = 15)	Bangladesh (N = 37)
Counseling on arrival		
Survivors are given initial counseling	40	8
Survivors are given sedatives	0	92
Wait for survivors to calm down on their own	47	0
Interview the survivors in the state they came	7	0
Do not know	6	0
Counseling during/ after enquiry		
Yes, always	20	68
Yes, if needed	40	24
No	40	5

b. Counseling of survivor during or after enquiry: Six police respondents in India and two in Bangladesh reported that no counseling was provided to survivors once the woman had calmed down and legal questioning had begun. Other respondents reported providing some counseling to rape survivors during the registration process (Table 3). Counseling to rape survivors seems to be more common in Bangladesh than in India. Unfortunately, the majority of those providing counseling to survivors in both settings were neither trained in counseling nor necessarily LPOs assigned to conduct this type of counseling.

Privacy is another important issue and is pertinent for the comfort and confidentiality of the rape survivor. When investigating the proportion of reports that were conducted in privacy, it was reported that in India interviews were mostly conducted in a private room (77 percent) and in Bangladesh interviews took place in public interrogation rooms most of the time (82 percent). This lack of privacy (especially in Bangladesh) may directly affect the number of rapes reported to the police and cases pursued legally, as confidentiality and privacy are intricate components of the reporting dynamic.

Reproductive health services at police facilities: Most rape survivors have urgent RH needs, including preventative measures that can be taken to prevent an unwanted pregnancy or a sexually transmitted infection. In order to understand what RH services were provided to rape survivors, police personnel in India and Bangladesh were asked about their knowledge of RH services and their availability. The study revealed that police stations in both countries have not taken any actions towards the provision of RH services.

a. STI management and HIV/AIDS prevention: Police officers in India did not provide any information about STIs and HIV infections to rape survivors, nor did they provide or recommend HIV testing for rape survivors. In Bangladesh, 55 percent of the police personnel interviewed reported discussing STIs and HIV with rape survivors, as well as the chances of contracting a disease from the rape incident (Table 4).

Two-thirds of Bangladeshi police officers reported recommending testing for rape survivors, yet none of them provided the tests themselves. When rape survivors enquired about HIV testing, 27 police respondents in Bangladesh but only one in India reported referring survivors to a hospital or VCT centre for possible counseling and testing.

Table 4: Information to rape survivors on danger of getting STI/HIV (percentage)

Informed danger of HIV	India (N = 17)	Bangladesh (N = 38)
Always	0	55
Sometimes/Rarely	0	21
Never	47	21
Don't Know	53	3

Almost all (95-100 percent) police personnel in India and Bangladesh were unfamiliar with the term and the components of post-exposure prophylaxis (PEP). This component of RH services should be further emphasized in provision of care to rape survivors.

b. Emergency contraception: All police personnel interviewed in India and 48 percent in Bangladesh admitted to never discussing the possibility of unwanted pregnancies with rape survivors (Table 5). Except for one officer in India, all police respondents were unfamiliar with EC pills (ECP) and their use in preventing unwanted pregnancy. None of the police stations had provisions for stocking ECPs, nor did the police stations have any informational handouts, such as leaflets or brochures, about ECP or reproductive health for rape survivors.

Table 5: Discussion of possibility of pregnancy (percentage)

Possibility of pregnancy discussed with survivor	India (N = 17)	Bangladesh (N = 38)
Always	0	26
Sometimes/Rarely	0	26
Never	100	48

Two police inspectors commented on the lack of RH services for rape survivors as follows:

> *"We take them (rape survivors) to hospitals anyway; all health facilities are available there. At police stations we don't have any health facilities, we are not doctors."*

> *"Taking (a rape survivor) to hospital is more important for us than to offer medical assistance or guidance."*

In general, there appeared to be a lack of interest among police officers to provide any RH information or services to rape survivors within the police station setting. According to police officers, their role was only to take the rape survivor to a health facility after pertinent information about the incident was collected at the station. A few police officers agreed that keeping informational brochures about EC and/or PEP in the police stations would be beneficial, yet none showed interested in pursuing a role as care providers.

Kits for managing rape cases: In both India and Bangladesh, standardized kits for managing rape cases were not available in police stations or familiar to police officers interviewed.

Protocol for managing rape survivors: About one-third of the police respondents in India (6 out of 17) and 89 percent in Bangladesh (27 out of 38) reported following some protocols / guidelines when managing rape survivors. Our research revealed that written guidelines on the management of rape cases do exist in booklet form, issued by police headquarters and are available for internal circulation. Yet official guidelines were not present in any of the police stations visited and most police respondents were unaware of their existence. Four police officers reported following unwritten guidelines that the station had abided by and one police officer reported working by the guidance of his own judgment only.

In Bangladesh, case management was similar. An official guideline on managing rape cases did exist, issued by the Police Headquarters and Ministry of Home Affairs. Yet upon probing police respondents, none of them had the protocol available in their station, and only seven of the 38 police respondents knew that guidelines had been issued. Among police officers who were unfamiliar with the guidelines, 28 believed that rape cases were managed through unwritten guidelines practiced in the police station, and others were unsure about guidelines in general.

Managing juvenile rape cases: In the case of juvenile rape survivors, all police formalities including interrogation and interviews were carried out in the presence of a parent or the survivor's guardian. Consent from the parent/guardian to interview the juvenile survivor was considered an important step by 76 percent (India) and 68 percent (Bangladesh) of the police respondents. In both countries, approximately two-thirds of police personnel reported seeking consent from the juvenile's parent before the interview.

One utensil recommended for the management of juvenile rape cases was pictorial depictions of the questions, to assist the children and youth in answering difficult questions associated with the incident. Unfortunately, over 10 percent of the police respondents in both India and Bangladesh reported never using any visual aids to help the child survivors to answer the questions, and many of them were unaware of these tools in general.

The presence of a parent/guardian during the child survivor's interview may be questionable in certain cases, as he/she may be a suspect. When asked about the presence of suspected parents/guardians during interview and examination, 93 percent of police personnel in India said they would not allow their presence. However in Bangladesh, 74 percent of police respondents felt that the parent/guardian could always be present during the child's interview.

Number of rape cases attended by police personnel: The documented number of rape cases registered in the police station during the last six months was considered confidential information and researchers were not permitted to view this information. However, some police officers did agree to discuss rape cases that they had registered during the last six months. Police officers were asked about the number of rape cases registered in the prior six months, of cases including adult survivors, adolescent survivors and child survivors.

a. Adult women: In India, three of the 11 police respondents indicated attending 2-3 rape cases involving adult women in the last 6 months and one police officer reported attending 7 rape cases in that period. In Bangladesh, of the 9 police respondents, 5 reported attending 1-3 adult rape cases and 3 reported attending 6-10 cases in the 6-month period. Over 90 percent of police respondents felt that the range was generally between 1 and 5 cases every month.

b. Adolescent girls and boys: Of the 12 police respondents in India sharing personal experience, four reported registering 1-2 adolescent rape cases during the last 6 months, and eight reported not registering any. However, one police officer reported registering 10 adolescent boy rape cases during this period. This information about rape of adolescent girls and boys was not sought in Bangladesh.

c. Children: Only one police officer in India reported registering a child rape case—he actually reported registering seven child rape cases in the last 6 months, all of them girls. 27 police respondents (of the total

38) in Bangladesh reported attending to child rape cases within the last 6 months; on average two boys and four girls within that period.

Attitude of police personnel towards rape survivors: Police personnel's attitude towards rape and rape survivors can have a significant bearing on how rape survivors are treated and how their cases are managed within the police system. In both countries, these attitudes were assessed.

As seen in Table 6, 63 and 74 percent of police personnel perceived rape as a serious medical problem, in India and Bangladesh respectively. Only Indian police personnel (69 percent) felt that rape survivors needed immediate medical attention, while three-fourths of Bangladeshi police felt that rape survivors did not require urgent attention and could wait at the hospital as with all other patients—that their injuries were not fatal.

As the number of rape cases reported increases, there are some suspicions that some reported rapes (and other harassment reports) are being fabricated in order to punish husbands and mothers-in-law who may be demanding dowry from their wife and wife's family (TOI 2008). Most police personnel in India (87 percent) and Bangladesh (68 percent) believed this to be true.

Most police respondents agreed that a husband can rape his wife (India: 94 percent and Bangladesh: 74 percent). Additionally many police officers believed that sex workers could not be raped (66 percent of Bangladeshi police officers and 31 percent in India). One police officer vocalized this impression by saying:

> *"Sex workers cannot be raped; who wants to rape them?"*

Consent for sex is another important issue to be considered when investigating rape cases. To establish rape, it is important to establish that intercourse had taken place without consent from the woman. It can become more complicated if the woman was found to be in inebriated during or after the incident. A majority of police personnel in India (63 percent) and Bangladesh (53 percent) felt that if a woman was drunk it was impossible to say whether or not she had agreed to the sex act.

Women who are raped may also be considered responsible for the attack, whether inebriated or not, if it is thought that they provoked the incident. For example, a common perception is that only "certain types" of women are raped; those women that "move around freely", unescorted and carelessly, women that wear provocative dresses and act in manners that are interpreted to encourage men to want to have sex with them. Bangladeshi police personnel were more likely to hold these views than their Indian counterparts (Table 6).

Additionally, the stigma of shame was associated with having been raped; 75 percent of officers in India and 60 percent in Bangladesh identified this. Surprisingly though, when asked about the stigma associated with rape and rape survivors, 75 and 47 percent of police personnel in India and Bangladesh respectively felt that society should not attach such "stigma" to rape survivors. This inconsistency between what is thought to be appropriate and what is actually practiced in reality is prominent in these potentially controversial situations.

To measure quantitatively the sensitivities of police respondents towards rape survivors, an index was developed using the statements in Table 6 with scores of 1 for responses indicating a lack of sensitivity and 3

Table 6: Attitude of police personnel towards rape survivors in India (N=16) and Bangladesh (N=38) (percentage)				
Statements	Country	Agree	No opinion	Disagree
A woman who is raped is a serious medical problem	India	63	6	31
	Bangladesh	74	21	5
A person rarely dies from injuries after rape so they should wait for their turn for care in hospital	India	31	0	69
	Bangladesh	76	13	11
Raped woman needs care and support for long time	India	88	0	12
	Bangladesh	68	19	13
Some women lie about rape to punish men	India	87	13	0
	Bangladesh	68	14	18
A husband can rape his wife	India	94	0	6
	Bangladesh	74	2	24
Sex workers cannot really be raped	India	31	6	63
	Bangladesh	66	21	13
If a woman is drunk, it is impossible to say she did not agree to sex	India	63	6	31
	Bangladesh	53	34	13
Rape happens because women move around unescorted and carelessly	India	25	6	69
	Bangladesh	53	15	32
Provocative dress and gestures of women are often the cause of rape	India	50	6	44
	Bangladesh	68	18	13
Only certain types of woman are raped	India	0	6	94
	Bangladesh	32	10	58
Attaching stigma towards rape survivors is also an offense	India	75	6	19
	Bangladesh	47	19	34
A woman who is raped brings shame on her family	India	75	0	25
	Bangladesh	60	24	16
Very delayed punishment or no punishment of perpetrators encourages rape	India	100	0	0
	Bangladesh	63	8	29
A boy can be sexually abused	India	81	0	19
	Bangladesh	71	5	24
Rape leaves obvious physical signs of injury	India	56	13	31
	Bangladesh	68	27	5

for those indicating sensitivity to give a maximum (most sensitive) score of 45 and a minimum (least sensitive) score of 15. The mean score of an Indian police officer was 34.68 and that of a Bangladeshi officer was 30.28. A T-test ($t=5.113$, $p< 0.0001$) confirmed that the police personnel in India held significantly more sensitive attitudes towards rape survivors than their counterparts in Bangladesh.

Health Facilities

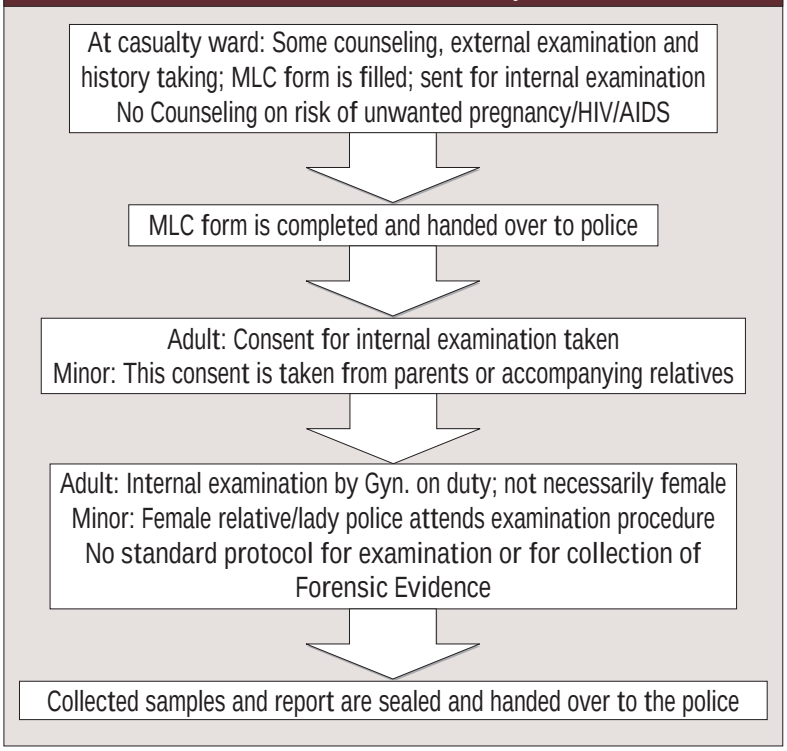
A medico-legal case: Health professionals interviewed in India felt that reporting a rape case to the police was a legal requirement; in Bangladesh, 63 percent acknowledged the importance of reporting the case to the police. Only 22 percent of Bangladeshi health personnel interviewed believed that this police report was a requirement, 16 percent did not recognize it to be a government requirement. In reality, the Bangladeshi legal system requires reporting of rape cases to the police first. In those cases when rape survivors come to the hospital before the police station, they are usually sent to the police station before receiving care.

Counseling and emergency treatment is often provided to rape survivors before they are sent to the police station. In India, 58 percent of health practitioners reported providing some counseling and emergency treatment to rape survivors before calling the police to register the rape case. However, 25 percent of the Indian providers and 69 percent of Bangladeshi providers sent rape survivors to the police immediately if the case was unreported, before providing any health services to the patient.

Additional to filing mandatory reports with the police, there are additional formalities to be completed within the health system. Medico-legal case (MLC) registration must be completed and patient consent must be obtained before the medical examination can take place. In Bangladesh, a requisition form must also be collected from police before patient examination can begin. Proof of a patient's identification and verification of a female attendant's availability for examination are two additional requirements that should be fulfilled before examination. It was estimated that these steps take approximately 30 minutes to complete, delaying medical examination while they are processed. Unfortunately, most health service providers were unaware of all of the process formalities—for example, obtaining consent from the survivor was only mentioned as a formality by 50 percent of Indian respondents and 41 percent in Bangladesh.

Medical examinations: The medical examination includes a gynecological examination and collection of samples for forensic tests. The study revealed that both in India and Bangladesh (83 and 94 percent respectively) "all" rape survivors are subjected to the full medico-legal examinations (gynecologic and samples for forensics) irrespective of whether they choose to pursue a case against the perpetrator. Discussions with the doctors revealed the following details about the medico-legal examinations.

Figure 2 - Sequence of steps taken when a rape survivor arrives at health facility



a. Waiting time before the examination: While waiting for the examination, a rape survivor in India generally waits in the corridor or outside the examination room. In Bangladesh, rape survivors wait in a private room most of the time. During the wait, the rape survivor is counseled, provided an explanation of the upcoming procedure and asked to give consent for the examination. In the case of minors and juveniles, consent was obtained from accompanying relative or parents before the examination takes place.

b. Examining doctor: Rape survivors are generally examined in the gynecology department or by a gynecologist in the emergency/casualty ward. When the patient is a juvenile, a pediatrician is also called in to examine the case. The examining doctor is not necessarily always a female, as some doctors interviewed reported:

"There is no such mandate to have a female doctor to examine a rape survivor. If there is a male gynecologist on duty, he does the examination (of the rape survivor)." HOD of Obstetrics and Gynecology Department.

"There are male gynecologists in our department and they do the examination when such cases come and if at that time they are on duty" - A female gynecologist.

c. Accompanying person: During the examination of adult rape survivors in India, female family members were allowed to be present in the examination room if desired by the patient. In Bangladesh, others were not allowed to accompany the patient, except in the case of minors. The majority of the doctors interviewed in India (83 percent) and Bangladesh (46 percent) reported allowing a family member into the room during examination.

d. Examination procedures: All rape cases were required to undergo an internal examination. Yet, there are a number of differences in procedures for adult and minor rape cases. The doctors interviewed reported conducting per vaginal (PV) examinations on married women, to identify possible cuts or bruises signifying forced penetration. In the case of virgins and juveniles, PV examinations were not conducted and only exterior wounds (such as bleeding, wounds and bruises) were examined. In fact, doctors from both study countries mentioned the difficulties of conducting internal examinations on survivors less than 10 years old, the potential need for anesthesia and the multiple surgeries that may have been needed for full recovery. Below is an account of how one doctor manages these cases:

"When in doubt as to what to do in such cases, we consult our seniors. This often happens during night shifts, when the senior doctors are not around. Sometimes they also have to come to supervise and guide us".

e. Collection of forensic evidence: In both countries, survivors undress for medical examination, mostly on their own. 83 percent of the health practitioners interviewed in India reported that the general practice was to collect survivor's clothes. Other biological samples for forensic examinations were also collected during the medical examination. Table 7 describes the various items that are routinely collected during examination of rape survivors and which are then sent for forensic tests.

Table 7: Samples collected during examination of rape survivors for forensic tests (percentage)

Materials collected during medical examination	India (N=12)				Bangladesh (N=32)		
	Always/ mostly	Some times	Rarely/ never	Do not know	Always/ mostly	Some times	Rarely/ never
Panties	67	8	0	25	0	22	78
Sanitary napkins	15	15	17	33	3	6	91
External anal swab	17	15	33	25	0	53	47
Tampons	33	17	25	25	0	6	94
External genital swab	75	0	0	25	53	41	6
Deep vaginal swab	83	0	0	17	97	0	3
Cervical swab	42	0	33	25	0	38	62

As the table shows, there was a wide variation in materials collected for forensic examinations. In India, panties, sanitary napkins, external genital swab, and deep genital swab were reported to be collected more than 50 percent of the time. Very few doctors in India reported the collection or observation of other potential items of evidence such as bloodstains, semen stains, and hair and nail clipping. In Bangladesh, doctors reported the collection of only three material evidences—external genital swab, deep vaginal swab and

cervical swab on a regular basis—and all others were only sometimes, rarely or never collected.

After their collection, samples were handled in a number of ways—either handed over to the police, taken to designated forensic laboratories or left in custody of facility manager. Methods varied by country and health care facility.

Concerns raised by survivors of sexual assault: When asking doctors about patients' concerns and worries associated with the rape incident, it was clear that very little information was sought by rape survivors. 50 percent of doctors reported that patients asked questions about pregnancy, and 75 percent said that patients enquired about STI or HIV/AIDS. Only a few doctors reported providing unprompted information about either HIV or STIs. Many survivors may be under shock and/or too uncomfortable to ask for information about these topics and so if doctors are not providing information or services on their own volition, many of these patients proceed without it.

> *"They don't ask for many of the services which you are asking (meaning ECP and PEP). We don't have all these services also. At that time they are so much traumatized to even think of anything else".*

A percentage of Bangladeshi doctors reported that rape survivors often enquired about the possibility of pregnancy (44 percent), possible internal injuries (59 percent) and the social stigma associated with rape (59 percent).

Reproductive health facilities for rape survivors: The provision of RH services to rape survivors is still not a well-developed concept in India and Bangladesh. There is no uniform code of conduct or protocol for managing the health and safety of rape cases in public health facilities. This disparity is well reflected in some of the queries investigated during data collection and analyzed below, and is also displayed in Figure 2 above.

a. Sexually transmitted diseases: Survivors of sexual violence are usually considered at increased risk of acquiring STIs, making STI prophylaxis services pertinent components of the services available to rape survivors. Health personnel interviewed had a good frame of knowledge about WHO's STI treatment regimen. Additionally, 58 percent of the providers in India and 50 percent in Bangladesh believed that every survivor of sexual violence should receive STI treatment. Unfortunately, when evaluating the STI treatment provided to the rape survivors, the picture is different. Table 8 describes the physician's impressions of STI treatment provision. In Bangladesh, 94 percent of the doctors believed that most rape survivors do not receive any STI protection services.

Table 8: STI prevention for rape survivors at health facilities (percentage)

Is STI treatment given to rape survivors?	India (N = 12)	Bangladesh (N = 32)
Yes, to all	42	6
Mostly not given	33	94
Don't Know	25	0

b. Anti-emetics (anti-nausea medications): The majority of health personnel in India (67 percent) and Bangladesh (94 percent) did not offer anti-emetics to rape survivors at their facilities. When these medications were administered, Perinorm was commonly prescribed in India, and Stemetil and Domiperidone in Bangladesh.

c. HIV prophylaxis: Nine questions were formulated to assess HIV prevention (including prophylaxis, VCT and referrals) services available to rape survivors.

PEP (post exposure prophylaxis) is an important drug regimen for the prevention of HIV transmission. The HIV preventative services offered to rape survivors are presented in Table 9. Twenty seven percent of doctors in India said that they advise rape survivors to take PEP if the timing is appropriate. However, only nine percent of doctors demonstrated correct knowledge about the PEP regime, questioning the validity of their provision. About 55 percent of doctors reported that HIV testing and voluntary counseling and testing (VCT) was available to rape survivors—27 percent of doctors reported offering VCT services; 55 percent reported referring patients to VCT center.

Table 9: HIV prevention services offered at the health facility (percentage)

	India (N=11)	Bangladesh (N=32)
Advice about PEP (if patient brought within 72 hours)	27	0
Correct answer for PEP regimen	9	19
HIV testing carried out for rape survivors	55	6
Offer VCT for Rape survivors	27	3
Referral for VCT	55	0

In Bangladesh HIV preventative services for rape survivors was practically non–existent. Although 19 percent of the doctors had correct knowledge of use of the PEP regime for infection prevention, none of the doctors were offering or advising PEP to rape survivors. Only six percent were carrying out HIV tests in their clinics and 3 percent were referring patients to VCT clinics.

d. Emergency contraception (EC): Two-thirds of doctors in India and 16 percent in Bangladesh reported offering EC to rape survivors (Table 10). Most facilities, however, did not have ECP available in stock. In most cases, when a survivor is advised to receive ECPs or asked about ECPs, they were sent to purchase it on their own from the market.

Table 10: Provision of emergency contraception to rape survivors (percentage)

	India (N=12)	Bangladesh (N=32)
Rape survivors offered emergency contraception	67	16
Stock ECP at facility	25	10
Pregnancy test conducted for rape survivors		
1. Always/mostly	33	3
2. Sometimes/rarely	25	6
3. Never	17	88
4. Do not know	25	3

Counseling for rape survivors: Counseling services for rape survivors were not well established in India and Bangladesh. Only 8 percent of the facilities reviewed in India and 22 percent in Bangladesh had trained counselors who were providing counseling services to rape survivors. In facilities without trained counselors, the nurses or doctors offered the counseling, although they may have actually been untrained in counseling. Doctors and nurses reported also referring rape survivors to other facilities for counseling (Table 11).

A senior doctor at a Delhi hospital explained his facility's counseling situation with the following quote:

> *"We don't have a counselor here at this facility; if need arises we refer the case to psychiatric department. But there is no follow-up, there is no second visit. They only come once for internal examination".*

In Bangladesh, counseling is mostly provided by One Stop Crisis Centre (OCC), an organization established to provide specialized care and support to rape survivors. However, there are only a few of these facilities throughout the country, attached to medical hospitals in major cities (see Box 3).

Table 11: Counseling services for rape survivors as reported by doctors (percentage)

	India (N=12)	Bangladesh (N=32)
Counseling offered to all survivors	17	31
Counseling facilities:		
Counselor at facility	8	22
Medical staff trained in counseling	8	3
Referral for counseling	42	72
No facility	42	3

Counseling sessions provided to rape survivors last between 10-30 minutes according to health practitioners in India; in Bangladesh sessions were reported to be between 1 and 2 hours. Unfortunately, legal advice was not readily available to patients in health facilities (reported by 82% medical respondents in India and 69% in Bangladesh). However, the OCCs are available in Bangladesh, and many of these counseling opportunities are available within these service centers.

Box 3: Care and support for rape survivors: One stop crisis centers (OCC) in Bangladesh

One Stop Crisis Center (OCC) is a specialized 'one stop' facility in Bangladesh, where all required services for rape survivors are provided. This provides health care, police assistance, social services, legal assistance, psychological counseling & shelter services.

In Bangladesh, OCCs have been established in all six country divisions. OCCs were established in Dhaka and Rajshahi Medical College Hospitals, during the pilot phase of the project, and four new OCCs were put in place in Sylhet, Chittagong, Khulna and Barisal Medical College Hospitals, initiating in June 2006.

OCC activities: The One-Stop Crisis Centers accepts patients of a variety of conditions and situations. Sexual assault survivors, burn survivors, and those who've experienced physical assault (including domestic violence). The OCC provides medical treatment, security and counseling by police at the center, and also provides legal counseling and support from the BNWLA. Medico-legal examinations may be conducted at the OCC if deemed necessary and appropriate for the incident. Psychological counseling is available as well. The Department of Social Service Office provides social welfare services to patients, and temporary shelter is also available at a partner organization, the BNWLA. Additionally, the OCCs have hotline services for patients in need of counseling or information; this service also provides academic activities and research training for providers.

How it works: Survivors of sexual assault are admitted to OCC either through the emergency department or from other referrals. The most important feature of these centers is that all services are available on site, medical and legal care is brought to the center, and patients have access to any service that they may need associated with the management of their incident. Acute medical issues endangering the patient (i.e. injury, fracture, perineal tear) are treated before referral to OCC. The OCCs are equipped with 8 beds and care is provided by the same doctors that work within the medical facilities, utilizing referrals to specialized departments (i.e. gynecology, orthopedics, pediatrics) if necessary. The medico-legal examination is conducted by the Department of Forensic Medicine, legal assistance is also available at the OCCs, and police are posted at each centre to answer questions and/or pursue criminal investigation. Psychological counseling is available for those patients requiring mental health services, and social services (including shelter and rehabilitation) are also available within the centre.

OCC personnel: One Coordinator and three staff members are posted at OCC. OCCs are usually located adjacent to medical center emergency departments and function on a 24 hour schedule, all days of the week. Doctors posted to the OCC work 8am to 2am, and outside of these hours, the emergency officer admits and treats patients.

Post-rape kit: Post-rape kits that include products such as sanitation products, clean clothes and objects of comfort, were familiar to some interviewed doctors. However, no facilities in India and Bangladesh had any post-rape kits available to rape survivors.

Protocol/management guidelines: Standard protocols for service provision to rape survivors were not available in facilities reviewed in India or Bangladesh. All doctors interviewed reported conducting services

according to the patient's needs and not following any set guidelines or recommendations established by the facility. Additionally, some doctors did not feel a need for a standardized protocol:

> *"There is no protocol, we don't need any protocol. Where is the need? We are taught all these. So we know"* – A senior resident doctor.

One hospital in Delhi the Director of Gynecology was assisting in the drafting of guidelines for a standard protocol for post-rape patient management.

Training for provision of services to rape survivors: In general, the medical professionals interviewed had not received any training in providing specialized care to rape survivors, although many respondents were aware of specialized trainings. The majority, however, (58% in India and 88% in Bangladesh) showed interest in and willingness to receiving training in the management of rape survivors.

Attitudes towards rape survivors: Attitudes of doctors and other medical professionals towards rape and rape survivors were captured in a questionnaire and responses are represented in Table 12. The majority of medical staff in India (75 percent) and Bangladesh (91 percent) considered rape a serious medical problem and child rape as an emergency medical situation (100 percent in both countries). Yet, doctors in Bangladesh did not feel the need to provide priority or expedited care to rape cases, when compared to other medical conditions, and 66 percent of Bangladeshi doctors believed that rape survivors should wait, together with all

Table 12: Attitude of health care providers towards rape survivors in India and Bangladesh

Statements	Country	Agree	No opinion	Disagree
A woman who is raped is a serious medical problem	India	75	0	25
	Bangladesh	91	0	9
A child who has been raped is an emergency medical case	India	100	0	0
	Bangladesh	100	0	0
A person rarely dies from injuries after rape, so they should wait for their turn for care in hospital	India	25	0	75
	Bangladesh	66	0	34
Some women lie about rape to punish men	India	100	0	0
	Bangladesh	91	3	6
Rape is more serious for someone who is a virgin	India	58	0	42
	Bangladesh	75	0	25
Sex workers cannot really be raped	India	0	0	100
	Bangladesh	13	3	84
If a woman is drunk, it is impossible to say she did not agree to sex	India	42	16	42
	Bangladesh	63	13	25
Provocative dress and gestures of women are often the cause of rape	India	42	8	50
	Bangladesh	84	0	16
It is disgraceful for women to bring rape cases to the court	India	25	8	67
	Bangladesh	81	0	19
A woman who is raped brings shame on her family	India	25	8	67
	Bangladesh	81	0	19
Rape leaves obvious signs of injury	India	42	8	50
	Bangladesh	22	0	78
Only certain types of woman are raped	India	0	8	92
	Bangladesh	4	0	88

other patients, because their injuries are usually not fatal. In India, the majority believed rape survivors should be prioritized in care provision.

Similar to police officers, many medical professionals believed that rape cases may be fabricated in efforts to punish husbands and/or mothers-in-law. But conversely to the police, doctors were not so biased against sex workers and supported care and services for all women. Doctors did agree with the police in feeling that the choice of clothing and/or a woman's "inappropriate conduct" may make her more vulnerable to sexual assault. Bangladeshi doctors also reported believing that rape brings "shame" to a woman's family and her pursuing action in court is further disgracing to her family.

Virginity is important in South Asian countries and rape of a virgin is considered to be a more serious incident than rape of a married woman. The health staff supported this attitude, yet many doctors vocalized the gravity of rape for all patients, independent of marital status.

As for police officers, a sensitivity index was developed to assess and compare their level of sensitivity towards rape and rape survivors using the responses to the 12 questions described in Table 12, giving a score between 12 and 36. On an average, Indian doctors scored 27.6 and Bangladeshi doctors scored 22.8; a T-test suggests that this difference is statistically significant ($t=4.521$ $p< 0.0001$).

Situation Analysis Tool Development

One objective of this study was to develop sensitive and practical tools that could be used to conduct large-scale situation analysis studies of the RH services available to rape survivors at their first point of contact in this region. Accordingly, two interview schedules were developed, one for police personnel and another for health care providers, to assess these individual situations in terms of managing rape survivors.

Initial pre-testing of tools took place in India and Bangladesh, and tools were then modified and improved. A selected number of police stations and health facilities were included in the situation analysis pilot study and as a result, a few changes were made to improve the flow and wording of questions, and additional questions were added.

The results of this pilot study in India and Bangladesh demonstrate that the RH services available to rape survivors at the first point of contact, particularly within police stations, are lacking. With this scarcity of services, many of the items remained unanswered. The final tools are presented in Appendices A and B. To get a better insight, particularly as a large number of questions remained "not applicable" and unanswered, a certain amount of in-depth probing would enhance the quality of data collected and so is recommended when training researchers in use of these tools.

LESSONS LEARNED AND RECOMMENDATIONS

This pilot study provided a broad picture of the reproductive health services available to rape survivors at their first point of contact. However, the study only included a small number of facilities and so cannot provide findings that can be considered descriptive of the overall situation in India or Bangladesh. However, the results do indicate directions that could help in the planning and undertaking of larger situation analyses of rape case management. The salient points emerging from this research are presented below.

Waiting Time for Services

Rape survivors have legal and health requirements that require timely assistance. For instance, PEP and ECP are most effective when given within 72 hours of the exposure and forensic tests yield best results when samples are collected within 24 hours of the assault. This urgency should motivate immediate attention and care; however the analysis revealed that various situations and medico-legal requirements delay medical examination and treatment of rape survivors. These delays may lead to significant RH risks and may also weaken the survivor's legal case.

Rape in India and Bangladesh is treated as a medico-legal case, requiring police involvement and legal registration of the case. Accordingly, legal registration and a police report must be collected before medical attention is provided, many times inducing additional delay, especially when rape survivors seek care from a health facility before reporting incident to the police. Waiting times are inevitably increased, as paper work and administrative duties are burdensome and patients must often wait for lady police officers (LPOs) to come to the police station. These delays compromise the physical and psychological health of rape survivors within this system.

Situation at Police Stations

Lack of standard protocol: Most police stations visited in India and Bangladesh have a standard protocol to attend to the formalities associated with a rape case. Yet, copies of guidelines were not available and police officers were unfamiliar with the procedures.

Training: Police personnel received some training on the appropriate management of rape cases within their pre-service curriculum when joining the police force. However, most of them did not receive any additional training on this subject and did not express much interest to do so.

Counseling skills: Police officers and LPOs in both Bangladesh and India did not participate in any training on counseling rape survivors. Despite this, some officers do provide counseling to rape survivors. In Bangladesh, a common practice is to provide sedatives to uncomfortable rape survivors before interviewing them.

RH information and services: RH services, such as the provision of ECP services, STI prophylaxis, HIV testing or PEP counseling, were non-existent in police stations. Most police officers were unfamiliar with these services and believed that their duties concerning the survivor's health ended with taking the survivor to medical facilities. Only a few police officers showed interest in learning more about ECP and PEP; a few were also interested in providing RH information to rape survivors at the police station.

Privacy: Privacy for rape survivors was compromised in India, with waiting areas only available in common areas. In Bangladesh, the level of privacy available to rape survivors was good, with private rooms available for survivors during waiting and interrogation periods.

Sensitiveness of the police officers: Police officers demonstrated excessive insensitivities towards rape survivors, with prejudices and stereotypes prevalent in their interpretations. These thoughts were significantly more prominent among police officers in Bangladesh than in India.

Situation at Health Facilities

Standardized protocol for managing rape survivors: No standard written protocols or guidelines exist for managing rape survivors in health facilities in either country. Moreover, some doctors do not feel there is a need for development of such protocols.

Standardized protocol for collecting forensic evidences: No standard protocol was available in any of the facility to collect forensic evidences. As a result, forensic evidences collected during examination varied widely from one facility to other. Fewer items of forensic evidences were collected in Bangladesh than in India.

Availability of post-rape care kits: Post-rape care kits were unfamiliar to interviewed professionals and unavailable in the respective facilities.

On the job training and counseling skills: Doctors did not receive special training on the management of rape survivors. Similarly very few health facilities had a trained counselor available to counsel rape survivors. Indian hospitals appeared relatively better equipped than Bangladeshi hospitals, although the One Crisis Centers available in Bangladesh showed significant promise in care provision for rape survivors.

Provision of EC information and services: EC was not available at medical facilities in Bangladesh. EC was available in India, yet distribution had not been institutionalized and only a few hospitals in both countries were actively stocking the contraception method.

Provision of STI information and services: Doctors in both countries had a good understanding of STI treatment, yet only a few health facilities were providing STI/HIV prevention in India and STI information provision was almost non-existent in Bangladesh.

Provision of PEP information and services: Most providers lacked knowledge of PEP and this area warrants significant improvements.

Sensitiveness of the doctors towards rape survivor: There were noteworthy levels of insensitiveness among the doctors towards rape survivors and rape incidents in both India and Bangladesh. Changes in this realm should be pursued.

Tools for the Situation Analysis

The two tools developed and pilot tested in this study are comprehensive and can be used in similar situation analyses of the first point of contact of rape survivors in other settings. However, as the facilities visited had not developed post-rape care services and the provision of services was so compromised, many questions went unanswered. Because of this, it is strongly recommended that in-depth probing is added to the questionnaire that could collect greater detail.

Study Limitations

Rape is a sensitive issue and any data collection on the subject demands considerable time and preparatory work. Arranging appointments and obtaining permission from supervisors to interview police officers and doctors added significant challenges and delays to the study.

The results from this pilot study should be interpreted with caution as the total number of police medical professionals interviewed is quite small. However, the experiences and findings are noteworthy and the pilot study findings provide important lead-ins for further full-scale situation analysis in this area of interest.

RECOMMENDATIONS

- Steps should be taken to reduce waiting times at police stations and health facilities by making rape cases a priority.
- Both police and doctors need on-the-job orientation on how to properly manage rape cases, including emphasis on their reproductive health needs, sensitivities and service requirements.
- Protocols for managing rape survivors and collecting forensic evidences should be standardized, available and strictly implemented in police and health facilities.
- Trained counselors and other professionals with counseling skills are lacking in both police and health facilities. Counseling should be emphasized in the care of rape survivors.
- As part of a comprehensive care and support strategy for rape survivors, police officers should become familiar with medical and RH needs of rape survivors. Care and services for some of these needs could be made available at police stations, such as EC information and provision.
- Before major changes are pursued within these two systems, a situational analysis covering a larger number of health facilities and police stations would provide more valid information to guide such development of a more comprehensive system of post-rape care.

DISSEMINATION

The key findings from this situation analysis, and the program recommendations and actions, were presented in a dissemination meeting organized by FRONTIERS on ***"Challenges in Reproductive Health: Lessons Learned from FRONTIERS Program"*** in Ahmedabad, India on May 15, 2008. The participants included key program managers, state level officials and representatives from national and international agencies. During the meeting, prevailing gaps in the health and police system and the need to develop a comprehensive care package for sexual violence survivors within the public system were two recommendations highlighted by the speaker and in the discussion.

REFERENCES

Badruddoza, A.S.M. 2002. "Plight of Women in Bangladesh" *PUCL Bulletin,* December 2002. http://www.pucl.org/Topics/International/2002/bangla-women.htm.

Christofides Nicola, D Muirhead, R K Jewkes, L Penn-Kekanna, D N Conco 2005. "Women's experiences of and preferences for services after rape in South Africa: interview study" *British Medical Journal,* doi:10.1136/bmj.38664.482060.55 (published 5 December 2005).

Coalition for the International Criminal Court 2007. Odhikar Press Release on Violence against Women in Bangladesh on the Occasion of International Women's Day 2007, Dated: 08, March 2007.

International Institute of Population Sciences (IIPS) and Macro International 2007. *National Family Health Surveys (NFHS-3), 2005-2006: India,* Mumbai IIPS.

Keesbury, J., Skibiak, J. & M. Zama. 2006. "Reducing unwanted pregnancy among survivors of sexual assault: New windows of opportunity for Emergency Contraception. Draft paper: Population Council.

Khan, M.E. and Aditi Aeron 2006. "Prevalence, Nature and Determinants of Violence against Women in Bangladesh", *The Journal of Family Welfare,* F.P.A India, Vol. 52, Special Issue 2006.

Khan, M.E. and Aditi Aeron. 2006. "Situation of GBV in Asia" Oral presentation at SGBV workshop in Zambia. 16-19 October.

Khan, M.E., John W. Townsend, Ranjana Sinha and Seema Lakhanpal 2003. "Sexual Violence Within Marriage: A case study of rural Uttar Pradesh, India, International Quarterly of Community Health Education. Volume 21, Number 2.

Koenig, Michael A., Rob Stephenson, Saifuddin Ahmed, Shireen J. Jejeebhoy, and Jacquelyn Campbell 2006. "Individual and Contextual Determinants of Domestic Violence in North India", *American Journal of Public Health,* 2006 January; 96(1): 132–138.

Liverpool VCT & Care Kenya 2005. "Comprehensive Post-Rape care Services in Resource-poor Settings: Lessons learnt from Kenya", Policy Brings for Health Sector Reform, LVCT, Number 6 September 2005.

National Crime Record Bureau. 2006. "Crime in India – 2005". NCRB, Ministry of Home Affairs, GOI, New Delhi.

National Crime Record Bureau. 2007. "Crime in India – 2006". NCRB, Ministry of Home Affairs, GOI, New Delhi.

National Rural Health Mission (NRHM) 2006. Implementation Guide on RCH II Adolescent Reproductive Sexual Health: For state and district program managers. IEC Division, Ministry of Health and Family Welfare, Government of India.

Pitre, Amita. 2005. “Ethical Considerations regarding Medico-legal services in cases of Sexual Assault”. Paper presented at the 1st national Bioethics Conference, 25th to 27th November 2005.

Pitre, Amita. 2006. “Care for Survivors of Sexual Assault”. *Indian Journal of Medical Ethics.* Volume III, No. 3 July-September 2006.

Population Council 2007. Draft copy, Review of Literature. FRONTIERS/Population Council.

Population Council 2008. Sexual and Gender Based Violence in Africa: Key Issuesfor Programming. Population Council Inc.

Martin S.L., S. Young, D.L Billings 2007. Assessment Instruments Used To Study Healthcare-Based Interventions for Women Who Have Experienced Sexual Violence, IPAS, Sexual Violence Research Initiative (SVRI).

Times News Network 2006. “Women seek safety against cops”. Times News Network. 9 March 2006.

Times of India 2008. “Government to Review Anti-Dowry Law”. Times of India, Delhi. 2 September 2008.

U.S. Department of State 2005. “Bangladesh Country Reports on Human Rights Practices 2005”, released by the Bureau of Democracy, Human Rights, and Labor, March 8, 2006.

Wax, Emily 2008. “In India, New Opportunities for Women Draw Anger and Abuse from Men”, Washington Post Foreign Service, Monday, August 21, 2008; ALL; New Delhi.

World Health Organization (WHO) 2002. Adolescent Friendly Health Services: An Agenda for Change. WHO, Geneva.

World Health Organization. 2002. *World Report in Violence and Health.* Chapter 6. WHO, Geneva.

World Health Organization. 2003. “Guidelines for Medico-legal Care for Sexual Violence Survivors” WHO, Geneva.

World Health Organization 2004. “Preventing Violence: A guide to implementing the recommendations of the *World report on violence and health”*, WHO, Geneva.

World Health Organization. 2005. “Sexually Transmitted and other Reproductive Tract Infections: A guide to essential practice”. WHO/Geneva.

World Health Organization 2005. WHO Multi-country Study on Women's Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women's responses. WHO, Geneva.

Appendix A: Situation Analysis of First Point of Contact for Survivors of Sexual Assault

Health Providers

Facility Identification

Q. No.	Questions and Filters	Coding Categories	Codes
1	Schedule Serial Number		☐☐☐☐
2	Country	India 1 Bangladesh 2	
3	City	Delhi 1 Vadodara 2 Lucknow 3 Bangalore 4 Dhaka 5 Chittagong 6 Khulna 7 Tangail 8	
4	Name of the facility **INS: Give name**	_____	☐
5	Date of interview	___/___/_____ DD/MM/YYYY	
6	Name of the Interviewer	…… …… …… ……	☐
7	Interview completed in	1 visit 1 2 visits 2	

Section 1: Characteristics of the service provider

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
101	What is your position at the health facility?	Psychiatrist 01 Gynecologist 02 Resident Medical Officer 03 Pediatrician 04 Trained staff for rape case 05 Counselor 06 Nurse 10 Forensic Doctor 11 Other (specify)_____ 77	
102	Sex of the Respondent? (observe)	Male 1 Female 2	
103	Current age of the respondent in completed years?	_____ Years	☐☐
104	What is your highest professional qualification?	MS/MD 1 MBBS 2 M.Sc/M.A 3 Specialization in Psychology 4 Nursing 5 Other 7	
105	How long have you been in service at this facility?	_____ Months	☐☐
106	How long have you been in Medical profession in total?	_____ Months	☐☐

Section 2: Service Provision

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
201	Who are the key service providers when the rape survivor is an adult? **INS: Multiple responses possible. Take up to TWO answers**	Psychiatrist 01 Gynecologist 02 Resident Medical Officer 03 Pediatrician 04 Trained staff for rape case 05 Counselor 06 Nurse 07 Forensic Doctor 08 Other (specify)_____ 77	☐☐ ☐☐
202	Who is the key service provider when the rape survivor is a minor? **INS: Multiple responses possible. Take up to TWO answers**	Psychiatrist 01 Gynecologist 02 Resident Medical Officer 03 Pediatrician 04 Trained staff for rape case 05 Counselor 06 Nurse 07 Forensic Doctor 08 Other (specify)_____ 77	☐☐ ☐☐
203	What are the working hours of the facility	Morning_____ To Evening_____	
204	The providers who usually conduct medico-legal examination of adult/minor rape survivors at the facility work full- time, part time or both?	Adult / Minor Full time 1 / 1 Part-time 2 / 2 Both 3 / 3	
205	Do the providers who usually conduct medico-legal examinations of adult/minor rape survivors at this facility are available only on call or mostly available at the facility during working hours?	Adult / Minor Called from other facilities 1 / 1 Mostly available at the facility 2 / 2 Refer to other department of the facility 3 / 3	
206	Generally, how much time after rape do survivors come to the facilities for examination and treatment?	Within 3 hours 01 Between 3-6 hours 02 Between 7-12 hours 03 Between 13-18 hours 04 Between 19-24 hours 05 Second day 06 Third day 07 After more than 3 days 08 Don't Know 88	

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
207	If the rape survivors come to the health facility first, are they sent to police station or police post before any physical examination at the facility or they are provided some services before referring the case to police	Sent to police before performing any service 01 Counseling is done and then sent to police for reporting 02 All required services are provided and then survivor is sent to police 03 All required services provided and then information is sent to police 04 Services provided, not reported to Police 05 Don't know 88	
208	Informing to police is legally mandatory or a rule of the facility?	A legal requirement 1 It is a protocol at the facility 2 No binding but for legal convenience 3 Don't Know 8	
209	What legal formalities are to be completed by the survivor at your facility before she is examined? **INS: Give in same sequence as actions are taken.**	First..... Second..... Next..... Next..... Next.....	☐ ☐ ☐ ☐ ☐
210	Generally how much time is taken to complete these formalities **before examination** starts	.....min	☐☐☐
211	In case the rape victim had contacted the police station first, who is she accompanied by when presented at the health facility? **INS: Multiple answers possible. Take up to TWO answers.**	Lady Police Officer 1 Any police officer 2 Head Constable 3 Constable 4 None accompanying her the hospital 5 but given a copy of FIR 6 Other (specify)_____ 7	☐ ☐
212	During last SIX months have you personally attended any rape survivor?	Yes 1 No 2	=>Skip 214
213	How many rape victims have you seen personally over the last SIX months aged: a) Survivors below 10 years of age b) Survivors 10-16 years of age c) Survivors above 16 years of age	_____ _____ _____	☐☐ ☐☐ ☐☐

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
214	How long does an examination (including management of the patient and documentation) of a rape survivor take on an average? a) Survivors below 10 years of age b) Survivors 10-16 years of age c) Survivors above 16 years of age	_____minutes _____minutes _____minutes	☐☐ ☐☐ ☐☐
215	What is the difference in procedure in examination of adult and minor (less than 16 years of age) rape survivors? **INS: Multiple answers possible. Take up to THREE answers.**	_____ _____ _____ _____	☐ ☐ ☐
216	(a) Is it allowed to have accompanying person in examination room if the survivor is an adult? (b) Is it allowed to have accompanying person in examination room if the survivor is a minor?	Adult / Minor Always 1 1 Most of the time 2 2 Sometimes 3 3 Rarely 4 4 Never 5 5 Don't know 8 8	
217	(a) Apart from examiners and assisting nurse(s), who else are present in the examination room if the survivor is an adult? **INS: Multiple answers possible. Code up to TWO answers.**	None 1 Other doctors 2 Other nurses 3 Lady police officer 4 Female family member 5 Male family member 6 Others (Specify)_____ 7 Don't know 8	☐ ☐
	(b) Apart from examiners and assisting nurse(s), who else are present in the examination room if the survivor is a minor? **INS: Multiple answers possible. Code up to TWO answers.**	None 1 Other doctors 2 Other nurses 3 Lady police officer 4 Female family member 5 Male family member 6 Others (Specify)_____ 7 Don't know 8	☐ ☐
218	Where do rape survivors usually wait before they are examined? **(INS: Observe and note)**	In a private room 1 In examination room 2 In a public waiting room 3 In the corridor/outside examination room 4 Other (specify)_____ 7	
219	Is the examiner always a female?	Yes, always 1 Yes, mostly 2 Not necessary 3 Don't know 8	

Q. No.	Questions and Filters	Coding Categories				Skip To/ Codes
220	What concerns do rape victims express if any? **INS: Allow respondents to give full answers before probing** **Probe: Do they express any other concerns particularly related to health?**	Mentioned yes		No	Not responded	
		Spontaneous	On probe			
	Internal injuries	1	2	3	9	☐
	HIV/AIDS	1	2	3	9	☐
	STIs	1	2	3	9	☐
	Pregnancy	1	2	3	9	☐
	Fear of examination	1	2	3	9	☐
	Stigmatization by the society	1	2	3	9	☐
	Other (specify)	1	2	3	9	☐
221	How do you assess injuries?	Description 1 Measurements 2 Both 3 Don't know 8				

Section 3: STI Prevention

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
301	Do rape survivors get STI treatment?	Yes, all rape survivors 1 Yes, some of the rape survivors 2 STI treatment is mostly not given 3 No 4 Don't know 8	 => Skip to 306 => Skip to 309
302	What STI treatment would you give to a patient who has presented after rape? **INS: Note spontaneous answers first and then probe**	Mentioned yes: Spontaneous / On probe; No; Don't know Give prophylactic treatment: 1 / 2 / 3 / 8 Refer to STD clinic: 1 / 2 / 3 / 8 Send swab to lab to test for STIs: 1 / 2 / 3 / 8	☐ ☐ ☐
303	Who are eligible to receive STI prevention?	Everyone 1 All adult women 2 All non-pregnant adult women 3 All non-pregnant adults and children 4 All children 5 Other (specify)_____ 7 Don't know 8	
304	Do rape survivors get STI treatment?	All gets as routine STI treatment 1 Some get and some do not get treatment 2 All non-pregnant adult women 3 All non-pregnant adults and children 4 All children 5 STI treatment is mostly not given 6 Other (specify)_____ 7	
305a	What regimen for STI prevention is used when a rape survivor is an <u>adult and non-pregnant woman</u>? **INS: Multiple responses possible. Take up to TWO answers** **<u>Correct answer</u>** • One dose each of Ciprofloxacin 500 mg **and** Metronidazole 2G • **PLUS** Doxycycline 100 mg 12 hourly for 7 days	Ciprofloxacin 500 mg one dose one time 1 Metronidazole 2G one dose one time 2 One dose each of Ciprofloxacin 500 mg and Metronidazole 2G 3 Doxycycline 100 mg (no mention of no of days and interval) 4 Doxycycline 100 mg for 7 days (interval not mentioned) 5 Doxycycline 100 mg for 7 days, at 12 hours interval 6 Other answers (note down) 7 _____ _____ _____ Don't know 8	☐ ☐

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
305b	What regimen for STI prevention is used when a rape survivor is <u>adult and pregnant</u>? **INS: Multiple answers is possible** **<u>Correct answer</u>** • One dose of Ceftriaxone 125 mg IM **and** Metronidazole 2G • **PLUS** Erythromycin 500 mg at 6 hourly for 7 days	Ciprofloxacin 125 mg one dose one time 1 Metronidazole 2G one dose one time 2 One dose each of Ciprofloxacin 125 mg and Metronidazole 2G 3 Erythromycin 500 mg (no mention of no of days and interval) 4 Erythromycin 500 mg for 7days (interval not mentioned) 5 Erythromycin 500 mg for 7 days, at 6 hours interval 6 Other answers (note down) 7 _____ _____ _____ Don't know 8	☐☐
306	Are anti-emetics given to rape survivors?	Yes 1 No 2	=>Skip 401 =>Skip 401

Section 4: HIV Prevention

Q. No.	Questions and Filters	Coding Categories				Skip To/ Codes
401	What HIV/AIDS focused services, if any do you offer the survivor after rape?	Mentioned yes: Spontaneous	Mentioned yes: On probe	No	Don't know	
	(a) Offer VCT	1	2	3	8	☐
	(b) Referral for VCT	1	2	3	8	☐
	(c) HIV Test carried out	1	2	3	8	☐
	(d) Give advice /prescription about anti-retroviral(PEP) if the patient is brought within 72 hours of the assault and not otherwise	1	2	3	8	☐
	(e) Provide anti-retroviral(PEP)	1	2	3	8	☐
	(f) If the patient is brought within 72 hours of the assault and not otherwise					
	(g) Others (specify)	1				
INS: If VCT is offered to rape survivors ask 402-403. If not, skip to 404.						
402	How often VCT is given to rape survivors?	Always 1 Most of the time 2 Sometimes 3 Rarely 4 Never 5				
403	When VCT is performed?	On the same day at same department 1 On the same day in other department 2 Date is given within same department 3 Referred to some other facility 4 Don't know 8				
INS: If HIV testing is done for rape survivors ask 405-406. If not, skip to 407.						
405	What HIV test is done?	Rapid HIV test 1 Lab based ELIZA 2 Both if required 3 Don't know 8				
406	When do they get the results of the HIV test?	Immediately 1 On return visit 2 Don't know 8				
INS: If PEP advice/provision mentioned then ask 407-409. If not, skip to 501.						
407	Who are eligible to receive PEP? **INS: Multiple responses possible. Take up to TWO answers**	If reporting within 72 hours of assault 1 Any time after the assault 2 She is not HIV positive 3 Other (specify)_____ 7 Don't Know 8				☐ ☐

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
408	What PEP regimen is used when rape survivor is an adult? **<u>Correct answer</u>** • AZT 300mg PO Q 12 hourly • 3TC 150 mg PO Q 12 hourly	AZT 300mg + 3TC 150gm twice a day at 12hr interval **(correct)** 1 AZT300mg + 3TC 150 gm (either dose or interval or both was not mentioned correctly 2 Other wrong answers (e.g: only one medicine mentioned) 3 Other (note down) 7 Don't know 8	
409	Is the full PEP regimen given at once?	Yes, given 28-day regimen 1 No, medicines only for a few days 2 No medicine is given, only prescribed 3 Don't know 8	

Section 5: Emergency Contraception

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
501	Do rape survivors receive pregnancy test?	Always 1 Most of the time 2 Sometimes 3 Rarely 4 Never 5	
502	Are rape survivors offered emergency contraceptive?	Yes 1 No 2	=>Skip 601
503	Which women get emergency contraception?	Everyone 1 All non pregnant adult women 2 All non-pregnant adult women who are not on a reliable method of contraception 3 If raped during danger period 4 Other (Specify)_____ 7	
504	How long after the assault ECP could be given or ECP is effective?	12 hrs 1 24 hrs 2 Within 48 hrs 3 Within 72 hrs 4 Up to five days 5 Don't know 8	
505	Do you stock emergency contraceptive for rape survivors?	Yes 1 No, only prescribe 2 Do not advice ECP 3 Don't know 8	

Section 6: Counseling

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
601	Does the facility offer counseling service to all the rape survivor cases?	Yes 1 No 2	
602	Does this facility have a counselor?	Yes 1 No 2	
603	Does the facility have trained staff to carry out counseling?	Yes 1 No 2	=>Skip 606
604	Do you refer the case elsewhere for counseling and support?	Yes 1 No 2	 =>Skip 606
605	Where? **INS: Multiple responses possible. Take up to TWO answers.**	One stop crisis center 1 Psychiatric department at the Facility 2 Psychiatric department of other facility 3 NGO 4 Other 7	☐ ☐
606	How often do you offer rape victims for trauma/psychological counseling?	Always 1 Sometime 2 Rarely 3 Never 4	
607	How counseling session/s are carried out?	Only on the day rape survivor comes for examination 1 Later on 2 Don't know 8	
608	How many sessions usually use for counseling?	_____Sessions	
609	Usually how long is the counseling session?	_____Minutes	☐☐☐
610	How often do you offer rape victims for legal advice / support?	Always 1 Sometimes 2 Rarely 3 Never 4	

Section 7: Medico-legal Examination

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
701	Who undresses the patient before the examination?	Patients themselves 1 Nurse 2 Examining provider 3	
702	Is the patient undressed on a sheet of paper?	Yes 1 No 2	
703	What procedures are followed before the medical examination? **INS: Multiple responses possible. Take up to THREE answers.**	Counseling 1 Full explanation of the medico-legal examination and what procedures it will involve 2 Patient's consent 3 Others (Specify)_____ 7	☐ ☐ ☐
704	Are the medical and forensic examinations done together or separately?	Together 1 Separately 2	

705a What different things do you collect when examining a rape survivor?
Spontaneous answer: **(Record answer in column 2 table below)**

705b Probe: Do you collect anything else? Here are some other things one may collect during examination. Tell me whether you collect any of these? **(Record answer in column 3 table below)**

INS: Now ask each item individually whether answered spontaneously or on probe.

705c Would you say that you always, mostly, sometimes, rarely/never collect the following? Circle answers whichever applicable.

	Things collected during examination	Mentioned			705c				
		705a	705b						
		Spontaneously	Yes on probe	No	Always	Mostly (80% of the cases)	Some times (50%of the cases)	Less frequently	Rarely/ Never
a	Panties	1	2	3	1	2	3	4	5
b	Sanitary pad (if used)	1	2	3	1	2	3	4	5
c.	External anal swab	1	2	3	1	2	3	4	5
d	Tampon (if used)	1	2	3	1	2	3	4	5
e	External genital swab	1	2	3	1	2	3	4	5
f	Deep vaginal swab	1	2	3	1	2	3	4	5
g	Cervical swab	1	2	3	1	2	3	4	5
h.	Reference DNA sample	1	2	3	1	2	3	4	5
i.	Nail scraping	1	2	3	1	2	3	4	5
j.	Hair	1	2	3	1	2	3	4	5
k.	Pubic Hair	1	2	3	1	2	3	4	5
l.	Semen stain	1	2	3	1	2	3	4	5
m.	Blood stain	1	2	3	1	2	3	4	5

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
706	Do you use a **pre-packaged rape kit** when conducting a medico-legal / forensic examination?	Yes 1 No 2	=> Skip 710
707	What is the source of supply of these kits?	Police 1 Government Depot 2 Purchased from the market 3 Other 7	
708	Would you say that the pre-packaged rape kits are in pristine condition always, mostly, sometimes, seldom, never?	Always 1 Mostly 2 Sometimes 3 Seldom 4 Never 5 Don't know 8	
709	Is it available in your stock now?	Yes 1 No 2 Don't Know 8	
710	Where are the medico-legal/ forensic examination reports/kits kept after completion?	In the examination room 1 In the facility manager's office 2 Given to Police 3 Other (specify)_____ 7 Don't know 8	=>Skip 801
711	Are the reports/kits kept in a locked cupboard (after they are completed)?	Yes 1 No 2 Don't know 8	
712	Who keeps the key?	Nurse in-charge 1 Emergency Room/casualty chief 2 Medical officer 3 Facility superintendent 4 Matron 5 Other (specify)_____ 7	

Section 8: Protocols/Clinical Management Guidelines

Q. No.	Questions and Filters	Coding Categories		Skip To/ Codes
801	Are there protocols or guidelines for the management of rape survivors?	Yes No Don't know	1 2 8	 =>Skip to 901 =>Skip to 901
802	Where are they kept?	In the examination room Facility manager's office Other (specify)_____ Don't know	1 2 7 8	
803	Are they displayed or kept in a drawer?	Displayed In drawer Don't Know	1 2 8	
804	Are they available right now? (ASK TO SHOW)	Yes (showed) Yes, but could not show No	1 2 3	

Section 9: Training

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
901	Is there any special training for examining rape cases at the facility: (a) For Doctors (b) For Nurses	Yes 1 No 2 Yes 1 No 2	
902	Have you ever received any formal training on the management of rape?	Yes 1 No 2	 =>Skip to 907
903	How many different training courses have you attended in management of rape?	_____Give number	☐
904	In which year did you receive the last training of management of rape?	_____Year	☐☐☐☐
905	How long was your **last training**?	_____Days	☐☐
906	I am going to read various topics, kindly tell me whether any of these topics were covered during any of your training that you have attended on management of rape survivor cases.	Answers	
	a. Medical treatment excluding PEP	Yes 1 No 2	
	b. PEP	Yes 1 No 2	
	c. Using the evidence collection kit	Yes 1 No 2	
	d. Completing the medico-legal form	Yes 1 No 2	
	e. Law (covering rape and sexual offences)	Yes 1 No 2	
	f. Giving evidence in court	Yes 1 No 2	
	g. Referrals to other services	Yes 1 No 2	
	h. Psychological issues	Yes 1 No 2	
	i. Counseling	Yes 1 No 2	
	j. Gender issues	Yes 1 No 2	
	k. Training on male survivors of sexual violence	Yes 1 No 2	
	l. Child sexual assault	Yes 1 No 2	
	m. Collection of forensic evidence	Yes 1 No 2	
	n. Documentation of forensic evidence	Yes 1 No 2	
	o.Other (Specify)_____	Yes 1 No 2	
907	Would you like to receive (additional) training on rape?	Yes 1 No 2	
908	Have you ever provided training on the management of rape / sexual assault to other health care providers?	Yes 1 No 2	

Section 10: Attitudes

1001	I am going to read some statements about rape. I would like you to tell me whether you strongly agree, agree, disagree or strongly disagree with the statements	Strongly agree	Agree	No opinion	Disagree	Strongly disagree	Did not answer
a.	A boy can be sexually abused	1	2	3	4	5	8
b.	A husband can rape his wife	1	2	3	4	5	8
c.	Forced sex with sex workers cannot be called rape	1	2	3	4	5	8
d.	If a woman is drunk, it is impossible to say that she refused sex and got raped	1	2	3	4	5	8
e.	Some women lie about rape to punish men	1	2	3	4	5	8
f.	Rape happens because women move around unescorted and carelessly.	1	2	3	4	5	8
g.	Provocative dress and gestures of women are often, the cause of rape.	1	2	3	4	5	8
h.	Only certain types of women are raped	1	2	3	4	5	8
i.	A woman who is raped brings shame on her family	1	2	3	4	5	8
j.	It is disgraceful for women to bring rape cases to court	1	2	3	4	5	8
k.	A woman who has been raped could have a serious medical problem	1	2	3	4	5	8
l.	A child who has been raped is an emergency medical case	1	2	3	4	5	8
m.	A person rarely dies from injuries after rape and so they should wait for their turn for health care	1	2	3	4	5	8
n.	Rape is more serious for someone who is a virgin	1	2	3	4	5	8
o.	Rape leaves obvious signs of physical injury	1	2	3	4	5	8
p.	Very delayed punishment or non-punishment of perpetrators encourages rape.	1	2	3	4	5	8

Section 11: Multisectoral Linkages

Q. No.	Questions and Filters	Coding Categories	Skip To/ Codes
1101	How would you describe the relationship between this health care facility and police over rape cases	Participatory 1 Neutral 2 Passive 3 No relationship 4	
1102	Is there an established link of your facility with NGOs?	Yes 1 No 2	
1103	If yes, which ones? Give the names.	1._____ 2._____ 3._____	
1104	How would you describe the relationship between this healthcare facility and NGOs over rape cases?	Proactive 1 Cooperative 2 Non-cooperative 3	
1105	What referrals are provided to the survivor? **INS: Multiple answers possible**	None 1 Legal support – lawyer 2 NGOs 3 Counselors 4 One stop crisis centre 5 Other (Specify)_____ 7	☐ ☐ ☐
1106	How many times did you give evidence in the court in the past year?	_____Give number	☐

Thank you for your time and participation in the study!

Appendix B: Situation Analysis of First Point of Contact for Survivors of Sexual Assault

Police Facility

Facility Identification

Q. No.	Questions and Filters	Coding Categories	Codes
1	Schedule Serial Number		☐☐☐☐
2	Country	India 1 Bangladesh 2	
3	City	Delhi 1 Vadodara 2 Lucknow 3 Bangalore 4 Dhaka 5 Chittagong 6 Khulna 7 Tangail 8	
4	Name of the facility	Give name_____	
5	Date of interview	___/___/_____ DD/MM/YYYY	
6	Name of the Interviewer		
7	Interview completed in	1 visit 1 2 visits 2	

Section 1: Demographic characteristics

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
101	Gender (Observe)	Male 1 Female 2	
102	How old were you on your last birthday?	<35 years 1 35-39 years 2 40-49 years 3 50 and more years 4	
103	What is the highest level of education you have obtained?	Matriculate 1 Higher secondary 2 Under graduate 3 Graduate 4 Post graduate 5 Other (specify)_____ 7	
104	How long have you been working at this station/post?	_____Years	☐☐
105	In total, how long have you been in police department?	_____Years	☐☐
106	What is your rank? (Please write)	Constable 1 Head Constable 2 Sub Inspector 3 Inspector 4 D S P 5 S P 6 Other (specify)_____ 7	

Section 2: Training history

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
201	What are the different sexual acts which could be considered as 'sexual assault'? DO NOT READ THE ANSWER **INS: Multiple responses possible. Take all that apply**	Any of the following without consent: Vaginal penetration 01 Vaginal penetration by object (not penis) 02 Anal penetration 03 Attempted vaginal/anal penetration 04 Oral penetration 05 Unwanted kissing 06 Unwanted touching 07 Provocative verbal statements related to sexuality 08 Other (specify)_____ 77	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
202	Who can be sexually assaulted? **INS: Multiple responses possible. Take all that apply**	Women 1 Men 2 Children (less than 10 years) 3 Adolescents (10-16 years) 4 Anyone 5	☐ ☐ ☐ ☐ ☐
203	Have you received any formal training that has enabled you to manage survivors of sexual assault?	Yes 1 No 2	= Skip 207
204	How many training on <u>sexual assault</u> have you received?	(Write numbers)_____	☐
205	In what year was your most recent training on sexual assault given?	_____(write year)	☐☐
206	Thinking of all the trainings that you have received during last FIVE years on sexual assault, were any of the following topics covered?		
a	Emergency contraception	Yes 1 No 2	
b	Post exposure prophylaxis for HIV	Yes 1 No 2	
c	Completing the medical report form/ documenting evidence	Yes 1 No 2	
d	Counseling the survivor	Yes 1 No 2	
e	Special needs of children survivor	Yes 1 No 2	
f	Special needs for pregnant women survivor	Yes 1 No 2	
g	Special needs for the mentally and physically challenged survivor	Yes 1 No 2	
h	Rape laws	Yes 1 No 2	

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
i	Forensic evidence collection	Yes 1 No 2	
j	Giving evidence in court	Yes 1 No 2	
k	Role of professional counselors	Yes 1 No 2	
l	Role of police officers in rape survivor case	Yes 1 No 2	
207	Do you feel that you need more training in order to provide appropriate care to survivors of sexual assault?	Yes 1 No 2	

Section 3: Service provision

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
301	In your opinion, what proportion of sexual assault cases that occur in your area during last month are reported to the police?	All 1 Most 2 About half 3 Very few 4 None 5 Not sure 6	
302	In the last 6 months, about how many sexual assault survivors have you personally attended to?	Total children:___Boys___Girls____ Total adolescent ____Adolescent boys_____Adolescent girls_____ Total adult_____Adult men____ Adult women _____ None: 00	☐☐☐ ☐☐☐ ☐☐☐
303	Generally, how long after the assault, does a rape survivor reaches the police station	Within 3 hours 01 Between 3-6 hours 02 Between 7-12 hours 03 Between 13-18 hours 04 Between 19-24 hours 05 Second day 06 Third day 07 After more than 3 days 08 Don't Know 88	
304	Who handles a rape survivor when she/he comes to your police station?	Lady police officers, all the time 1 Lady police officer, sometimes 2 Whosoever is duty that time 3 Don't Know 8 Refused to answer 9	
305	If there is no lady police officer on duty at that time at police station or she is not posted at the police station then who attends the case?	Lady police officer is called from other office 1 Lady Constable 2 Whoever is on duty at that time 3 Other specify)_____ 7 Don't Know 8	 =>Skip 307 =>Skip 307
306	Generally, what is the time gap from the time lady officer is called to the time she actually reaches the facility?	_____Minutes	☐☐☐
307	In your police station, where do rape survivors usually wait before they are interviewed? **(OBSERVE)**	In the main waiting room 1 In a private room 2 In a public interrogation/reporting room 3 In the corridor 4 Other (specify)_____ 7	

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
308	On arrival at police station, on average, how long do sexual assault survivors wait before they are interviewed or FIR is written?	_____ (time in minutes)	☐☐☐
309	When a survivor reports to the police station, about how long do they spend with an officer discussing their case and writing FIR?	_____(minutes) Not sure_____888	☐☐☐ ☐☐☐
310	In your police station, where do interview with sexual assault survivors takes place?	In a private room 1 In a public interrogation/reporting room 2 Other_____ 7	
311	If an adult rape survivor presents in a highly agitated state or is continuously weeping, what do you do <u>first</u>?	Give sedatives 1 Attempt to calm through counseling 2 Have survivor wait for interview until he/she is calm 3 Interview survivor in current state 4 Other (specify)_____ 7	
312	Do adult rape survivors receive any type of counseling at police station?	Yes, always 1 Yes, if needed 2 No 3 Don't Know 8	=skip 316
313	If yes, who does it?	Lady police officer 1 One of our staff trained in counselling 2 Counsellor from linked NGO 3 Any one on duty 4 Other (specify)_____ 7	=skip 315 =skip 315
314	Is that person trained in counseling?	Yes 1 No 2 Don't know 8	
315	What topics are generally counseled or what all points are emphasized? **INS: DO NOT READ. Circle which all are applicable.**	Not your fault 01 Should not be ashamed 02 Look ahead in life positively 03 Pursue the case against perpetrator 04 Don't pursue the case against Perpetrator 05 Suppression of the matter is better 06 Take ECP immediately to prevent from unwanted pregnancy 07 Danger of STI/HIV/AIDS 08 Take PEP 09 Contact NGOs for further help 10 Other (specify)_____ 77 Don't know 88	☐☐ ☐☐ ☐☐ ☐☐

Section 4: STI/HIV Prevention

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
401	How often the rape survivor is informed about if danger of getting HIV or STI infection?	Always 1 Sometimes 2 Rarely 3 Never 4 Don't know 8	
402	What information or points are emphasized about HIV/AIDS to the rape survivors?	None 1 Go for VCTC 2 Information on PEP 3 Other (specify) _____ 7 Don't know 8	
403	When interviewing a survivor, have you suggested HIV testing?	Yes 1 No 2	
404	If a survivor expresses interest in HIV testing, what do you do?	Refer to hospital or health center for VCT 1 Refer to VCT center 2 Provide information on VCT and where it could be obtained 3 Provide information on PEP 4 Other (specify)_____ 7	
405	**See 316. If PEP is not mentioned then ask.** Have you ever heard of post-exposure prophylaxis (also known as PEP) for HIV?	Yes 1 No 2	=Skip 501
406	What does PEP do? **(Record Verbatim)**	_____ _____ _____ _____	☐ ☐
407	What is the time limit within which PEP must be taken after rape to be effective in preventing HIV?	Within 12 hours 1 Within 24 hours 2 Within 72 hours 3 Within 1 week 4 Don't know 9	
408	How long does the course of PEP last?	7 days 1 28 days 2 90 day (3 months) 3 Don't know 9	
409	Is PEP 100 percent effective in preventing HIV transmission?	Yes 1 No 2 Don't know 9	

Section 5: Pregnancy Prevention

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
501	How often do you personally discuss the possibility of unwanted pregnancy with rape survivors?	Always 1 Sometimes 2 Rarely 3 Never 4	
502	Have you ever heard of emergency contraception (EC) or the "morning after pill"/ I-pills /E-pills?	Yes 1 No 2	=Skip 601
503	If yes, what does emergency contraception (EC) do? **(Circle only ONE response)**	Induces abortion 1 Prevents pregnancy after unprotected sex 2 Prevents pregnancy before unprotected sex 3 Prevents disease transmission 4 Other_____ 7	
504	What is the minimum age to give emergency contraceptive pill (ECP)?	To all women who is menstruating 1 Any girl/woman above 10 years of age 2 Other answers (note) 7	
505	Does your police station stock ECP and offer it to rape survivors?	Stock ECP and always offer it 1 Stock ECP but offer sometimes only 2 Stock ECP but don't offer unless asked 3 Do not stock ECP 4 Don't Know 8	 =Skip 601 =Skip 601
506	Is any emergency contraception pill (ECP) in stock today (ask for a pack).	Yes, provide the pack 1 Yes, could not provide pack 2 No 3	
507	Have you ever given emergency contraceptive (EC) to a rape survivor?	Yes 1 No 2	
508	Is it necessary to conduct a pregnancy test prior to administering emergency contraceptive (EC) pills?	Yes 1 No 2 Don't Know 8	
509	What is the time limit within which emergency contraception pill (ECP) must be taken to be effective? **(INS: Circle only ONE response)**	24 hours 1 72 hours 2 120 hours 3 Don't know 8	
510	Where can emergency contraceptive (EC) be obtained? **(INS: Multiple Responses possible. Take up to TWO answers).**	Health center/clinic/hospital 1 Pharmacy 2 Police station 3 Don't know 4 Other Specify)_____ 7	☐ ☐
511	ECP and PEP should be stored at the police station to provide all rape survivors coming to the police station. Do you agree or disagree?	Yes 1 No 2	

Section 6: Child Survivors

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
601	In your experience who **most often** accompanies a minor rape survivor? **INS: Multiple responses possible. Take up to TWO answers**	Mother 1 Father 2 Both parents together 3 Other female relative 4 Other male relative 5 Friend/ neighbor 6 Other _____ 7	☐ ☐
602	Is it necessary to attempt to obtain consent from a child who is old enough to speak before interviewing or discussing with her?	Yes 1 No 2 No incident of child rape survivor 3 Don't know 8	
603	When a child is old enough to speak for her/himself, how often do parents participate in the interview?	Always 1 Sometime 2 Rarely 3 Never 4 No incident of child rape survivor 5 Don't know 8	 =>Skip 701
604	Do you use any visual aid when interviewing/interrogating a minor rape survivor?	Yes 1 No 2 Don't know 8	
605	What visual aids generally do you use? **(PROBE: any other thing do you use?)**	1_____ 2_____ 3_____ 4_____ 5_____	☐ ☐ ☐
606	"Children should NOT be interviewed in the presence of the suspected offender, irrespective of who he is (parent/guardian)"	Agree 1 Disagree 2	

Section 7: Forensic Evidence

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
701	What is meant by the term "forensic evidence?" **INS: Multiple responses possible. Take up to THREE answers**	Samples collected for legal purposes 1 Samples collected for use in treating the survivor 2 Collecting clothes/debris of rape survivor 3 Collecting any material which could provide evidence for assault 4 Other (write verbatim) _____ 7 Don't know 8	☐ ☐ ☐
702	In what situations should forensic evidence be collected?	In all cases 1 Only when survivor intends to prosecute 2 Only when the police order evidence collection 3 Only for child survivors 4 Don't know 8	
703	Do you go for collection of evidence after medical examination at hospital is done and rape is confirmed?	Yes 1 No 2	
704	If yes, what kind of evidence? **INS: Multiple responses possible. Take up to THREE answers**	_____ _____ _____ _____ _____	☐ ☐ ☐
705	Have you ever personally collected forensic evidence from a survivor?	Yes 1 No 2	=>Skip 708
706	If no, who collects forensic evidence? **INS: Multiple responses possible. Take up to TWO answers**	Officer, who makes the enquiry of the case 1 Lady police officer 2 Medical doctor at the hospital 3 Other (specify)_____ 7 Don't know 8	☐ ☐
707	What is the duration after a sexual assault evidences should be collected for accurate and effective forensic samples?	12 hours 1 24 hours 2 72 hours 3 1 week 4 Don't know 8	
708	What type of containers is used to collect clothing or debris of rape survivors?	A plastic bag 1 A paper bag 2 A covered basket 3 Other (specify)_____ 7 Don't know 9	

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
709	Do you have standard procedures for maintaining the 'all the evidences collected'?	Yes 1 No 2	 =>Skip 711
710	If yes, please describe these procedures. **INS: multiple responses possible. Take up to TWO answers.**	_____ _____ _____ _____ _____ _____	☐ ☐
711	Is there any protocol describing procedure for maintaining the evidences?	Yes 1 No 2 Don't know 8	
712	Is this presently available with you? **(ask to show)**	Yes, and showed 1 Yes, could not able to show 2 No 3	☐
713	What are the evidences collected before and after receiving medical management at the hospital once rape is established by the police? **INS: Multiple responses possible. Take up to THREE answers**	_____ _____ _____ _____	☐ ☐ ☐
714	Is there a different procedure for children? **INS: Multiple responses possible. Take up to THREE answers**	_____ _____ _____ _____	☐ ☐ ☐

Section 8: Referral and support services

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
801	About what percentage of survivors report about the assault to the police station **first**?	100% 1 75% 2 50% 3 25% or less 4 Don't know 8 Refused to answer 9	
802	Who is most likely to refer a sexual assault survivor to police station? **INS: Multiple answers possible. Code up to TWO answers.**	Family 01 Survivor herself 02 Friends/Neighbors 03 Community people 04 Hospital/clinic personnel (doctor, nurse, etc) 05 Police/ officer from field duty 06 NGOs 08 Other (specify)_____ 77 Don't know 88	☐☐
803	How often do lady police accompany survivors to a health facility?	Always 1 Often 2 Sometimes 3 Rarely 4 Never 5 Don't know 8	
804	If lady police officer is not available who accompanies the rape survivor? **INS: Multiple answers possible. Take up to TWO answers.**	In-charge of the police station 1 Officer who takes the FIR 2 Any other on duty 3 Head constable 4 Constable 5 Other (specify)_____ 7 Don't know 8	☐☐
805	If survivors do not report to police station first, where are they most likely to go for assistance? **INS: Multiple answers possible. Take up to TWO answers.**	Public Health facility 1 Private health facility 2 NGOs 3 Women's group 4 Community group 5 Other (specify)_____ 7 Don't know 8	☐☐
806	If the survivor presents first at the public health facility, how often are the police called by the health provider?	Always 1 Sometimes 2 Never 3 Don't know 8	

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
807	In your opinion, how well do police and health facility staff work together in rape cases?	Always work well together 1 Sometimes work well together 2 Depends whether the survivor wants to pursue the case 3 Never work well together 4 Don't know 8	
808	How often do you refer survivors for legal advice or support?	Always 1 Often 2 Rarely, only when asked 3 Never 4 Don't know 8	
809	Where do you refer survivors for legal advice or support? **INS: Multiple answers possible.**	NGOs 1 Some legal advisor 2 Women Commission 3 One stop crisis centre 4 Others (Specify)_____ 7 Don't know 8	☐ ☐
810	In your opinion why many rape survivors do not report to police? **INS: Multiple answers possible.**	_____ _____ _____ _____	☐ ☐
811	What could be done to increase reporting of rape survivors to police? **INS: Multiple answers possible.**	_____ _____ _____ _____	☐ ☐
812	Is posting a woman officer to each police station or for a group of police stations (say 2-3 police stations) could increase reporting?	Yes 1 No 2 Other (specify)_____ 7 Don't know 8	
813	Will you support training of at least 2 officers/head constables in each police station in managing rape survivors?	Yes 1 No 2 Other (specify)_____ 7 Don't know 8	

Section 9: Laws and procedures

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
901	In this police station, do staffs follow any guidelines or protocols for managing sexual assault survivors?	Yes 1 No 2 Don't know 8	 =>Skip 904 =>Skip 904
902	If yes, what form are these protocols? **(Ask to show a copy, if available)**	Written 1 Unwritten 2 Personal judgement 3 Don't know 8	☐
903	Who issued these guidelines or protocols? **INS: Multiple answers possible. Code up to TWO answers.**	Ministry of health 1 Ministry of women and child 2 Ministry of home affairs 3 Police head quarter 4 Other (specify)_____ 7 Don't know 8 Refused to answer 9	☐ ☐
904	Generally how much time (months) is taken from date of offence to decision on the case: a) Lower courts b) High courts	_____ Months Don't Know 88 _____ Months Don't Know 88	☐☐ ☐☐
905	In your opinion, what proportion of sexual assault cases go to trial?	All (more than 90%) 1 Most (55-75%) 2 About half (40-55%) 3 Very few(less than 40%) 4 None 5	
906	In your opinion, what are the **THREE most common** reasons that sexual assault cases are not pursued in court **INS: Multiple answers possible. Code up to THREE answers.**	Not enough evidence 01 Survivor/parent settles out of court 02 Accused is family member 03 Corruption 04 People want to suppress spread of information 05 Court cases takes long to give decision 06 Court cases expensive 07 Fear of physical harm from the perpetrator 08 Pressure from perpetrator/senior /influential people in support of perpetrator 09 Other 77	☐☐ ☐☐ ☐☐
907	In your opinion in what percentage of cases the perpetrator are convicted?	_____percent Don't know 88	

Q. No.	Questions and Filters	Coding Categories		Skip To / Codes
908	Can a rape survivor get medical attention without opening a case for prosecution if the survivor wants so?	Yes No Don't know Refused to answer	1 2 8 9	

Section 10: Attitudes and perceptions

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
1001	How common do you think rape is in your community?	Very common 1 Fairly common 2 Rare 3 Don't know 8 Refused to answer 9	
1002	How does the community treat cases of rape survivors?	Treated worse 1 Treated the same 2 Treated better 3 Don't know 8 Refused to answer 9	
1003	What follows is a list of statements. There is no right or wrong answers. We would like you to tell us whether you generally agree or disagree with each statement.		

		Agree	Neutral/DK	Disagree	Not answered
a	A boy can be sexually abused	1	2	3	9
b	A husband can rape his wife	1	2	3	9
c	Forced sex with sex workers cannot be called rape	1	2	3	9
d	If a woman is drunk, it is impossible to say that she refused sex and got raped	1	2	3	9
e	Some women lie about rape to punish men	1	2	3	9
f	Rape happens because women move around unescorted and carelessly	1	2	3	9
g	Provocative dress and gestures of women are often, the cause of rape	1	2	3	9
h	Only certain types of women are raped	1	2	3	9
i	A woman who is raped brings shame on her family	1	2	3	9
j	It is disgraceful for women to bring rape cases to court				
k	A woman who has been raped could have a serious medical problem	1	2	3	9
l	A child who has been raped is an emergency medical case				
m	A person rarely dies from injuries after rape and so they should wait for their turn for health care	1	2	3	9
n	Rape is more serious for someone who is a virgin				
o	Rape leaves obvious signs of physical injury	1	2	3	9
p	Very delayed punishment or non-punishment of perpetrators encourages rape.	1	2	3	9

Section 11: Domestic Violence

Q. No.	Questions and Filters	Coding Categories	Skip To / Codes
1101	How often do women present with complaints of violence from husbands/ partners?	Rarely 1 Sometimes 2 Never 3	
1102	What types of violence are reported? **INS: Multiple responses possible. Take up to THREE answers.**	Dowry related 1 Torture 2 Beating 3 Forced sex 4 Threatening to remarry 5 Other (specify)_____ 7	☐ ☐ ☐
1103	During the last 5 years has the reporting by wives against husbands/partners increased or remained the same or has declined?	Increased 1 Remained the same 2 Declined 3	
1104	Do all of the reported cases turn out to be correct?	Yes, mostly (90%) 1 Yes, majority (50-75%) 2 Some (about half) 3 Less than half 4	
1105	What percentage of cases goes to prosecution?	_____percent	
1106	What percentage of cases is prosecuted?	_____percent	

Thank you for your time and participation in the study!

Population Council

The Population Council conducts research worldwide to improve policies, programs, and products in three areas: HIV and AIDS; poverty, gender, and youth; and reproductive health.

FRONTIERS
IN REPRODUCTIVE HEALTH

FRONTIERS is funded by the Office of Population of the United States Agency for International Development (USAID) under the terms of Cooperative Agreement Number HRN-A-00-98-00012-00.

ASIA AND NEAR EAST REGION

BANGLADESH
Population Council
Frontiers in Reproductive Health Program
House CES (B) 21,
Road 118, Gulshan, Dhaka
Tel: 880 2 882 1227/6657
Fax: 880 2 882 3127
E-mail: frontiers@pcdhaka.org

EGYPT
Population Council
Frontiers in Reproductive Health Program
59 Misr-Helwan Agricultural Road,
Maadi, Cairo
Tel: 2 02 525 5965/7/8
Fax: 2 02 525 5962
E-mail: frontiers@pccairo.org

INDIA
Population Council
Frontiers in Reproductive Health Program
Zone 5A, Ground Floor, India Habitat Centre
Lodi Road, New Delhi 110003
Tel: 91-11-2464 2901/2
Fax: 91-11-2464 2903
E-mail:frontiers-india@popcouncil.org

FRONTIERS Website: http://www.popcouncil.org/frontiers/