Dilaasa

Crisis Intervention Department for Women

A Report

A joint initiative of

CEHAT

and

The Public Health Department

K.B. Bhabha Municipal Hospital

Cehat

Centre for Enquiry into Health and Allied Themes

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Cehat
Centre for Enquiry into
Health and Allied Themes

Dilaasa

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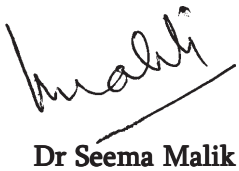
Preface

It gives me immense pleasure to present this report of Dilaasa. Dilaasa completes ten years of existence. The support that I have received from my seniors has allowed me to lead this project and replicate it in Mumbai as well as others cities. I congratulate the staff of both the hospitals for their tireless efforts in bringing in awareness about Violence against women (VAW) as a public health issue.

The work carried out by the two Dilaasa Departments and the Training cell has been recognised even by the World Health Organisation (WHO) as "good practice". This joint initiative with CEHAT has received recognition from the United Nations Development Program (UNDP) as one of the best practices in Gender Mainstreaming. The International Federation for Health and Human Rights Organisation (IFHHRO), Netherlands too has acknowledged it as one of the few good practices that demonstrated the role of the Health Professionals in responding to Human rights violations and advocating for "Right to health care.

I also hope that the Training cell will soon be institutionalised within the Municipal Corporation of Greater Mumbai (MCGM), and it will work earnestly towards improving the overall quality of care in hospitals and in addition to a sensitive response to Violence against women.



Dr Seema Malik
Project Director, Dilaasa.
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(Peripheral Hospitals), MCGM

I. Backdrop for establishing a hospital based crisis centre

Domestic violence is a difficult issue to address since it is seen as a very intimate problem. The violence faced by a woman on a regular basis is usually perpetrated by one or more close relatives of the woman. Women are often made to believe that they themselves are responsible for the violence they are subjected to. It is therefore rarely questioned. The beliefs associated with the issue of violence only make it more difficult for a woman to seek help. Some of these beliefs, when men are the perpetrators, include absurd things such as "men cannot control their anger" or it is a "woman's destiny", etc. Many women in our country have grown up not only seeing this, but they have been made to believe this to be true.

The challenge is thus making women believe that violence is not "normal", that it is unacceptable and something *can* be done to stop the abuse. Women with certain severity of abuse would inevitably approach the hospital or get admitted there. We as health care professionals (HCP) working as hospital staff are her first point of contact. However, although domestic violence as the cause of the injuries maybe obvious, there is no counselling or appropriate documentation (they end up having poor or no documentary evidence in the form of medical records). It is not considered to be a part of our prescribed duties and the workload in a public hospital is an added impediment. Moreover, as health professionals working at a hospital, we are not equipped to handle the non-physical needs of such patients. Let us remember that we are perceived as non-threatening by our patients and even looked up to. We can therefore play a crucial role in addressing the issue of domestic violence. Since we are an inevitable contact point, a setting such as our hospital can be just right for the purpose.

Dilaasa, which is a hospital based crisis centre, was set up in order to provide the much needed psychosocial support to women reporting domestic violence at our hospital. We have entered the ninth year of our existence. All of us associated with it have learnt a lot from our experiences. We now feel the need to disseminate the progress made by *Dilaasa* in the last eight years in the form of the present report.

Dilaasa was set up in the year 2001 at the K. B. Bhabha Hospital, Bandra as a collaboration between Municipal Corporation Greater Mumbai (MCGM) and Centre

for Enquiry into Health and Allied Themes (CEHAT). "*Dilaasa"* in Hindi means 'reassurance'. *It is India's first hospital based crisis centre for women facing domestic violence.* Our team at *Dilaasa* provides social, emotional, psychological and legal support. Eventually it has become a part of the integrated services of the hospital i.e., as a department and thus functions accordingly. Today, *Dilaasa* is seen as a success. It was recently recognized by the UNDP as one of the best practices in India in the public health sector. Subsequently, a second crisis centre has begun functioning with whole hearted cooperation of the MCGM since 2006 at the K. B. Bhabha Hospital, Kurla; and a third one in Indore, Madhya Pradesh at the MY hospital in 2008. The journey has been long and often, complex.

II. Dilaasa's journey in a nutshell (2001- 2008)

II. A. Needs assessment 2001

The commencement of the work of *Dilaasa* was a long drawn process. Due to the fact that it was the first such attempt in India to set up a hospital based crisis centre for women facing domestic violence, the team felt that it was crucial to understand the hospital system first. A needs assessment study was undertaken. This included components such as observations at the casualty, in-depth interviews of the hospital staff and study of the medico legal records. These studies revealed a very crucial aspect that we would have to deal with on a regular basis – i.e. HCPs saw domestic violence as a legal problem. They did not feel that it was their role to screen women and provide her with support services. The findings of the needs assessment prompted a need to develop a training module for the HCPs.

II. B. Developing a Training model (2001- 2005)

1. **Training of Trainers 2001 – 2003:**

This was peer to peer training for adult learning. It was thought that it would be more acceptable. Initially a mixed group was chosen. Once key trainers were trained, they were given the responsibility of taking initiative and training their own cadre of staff – doctor for doctors, nurses for nurses, and so on.

The training covered issues such as understanding of the concept of domestic violence as a health issue, its consequences on women's health, roots of domestic violence in

patriarchy, role of health systems screening methods, communication skills and eventually how to become trainers. The tools used for training included role plays, case studies, and discussion debates, etc. Only 12 members of our staff emerged as key trainers. This was a challenge in itself. However, they were very committed. They developed a module with the help of CEHAT and trained 833 other staff of the hospital. While there was enough enthusiasm amongst the staff, the referrals remained low. This led us to realise that one time training is not sufficient. It has to be a continuous process. Moreover, in order to get more referrals, we also needed to increase the visibility of *Dilaasa*. We therefore put up posters across the hospital. Both these strategies worked and very soon referrals of cases increased.

2. Expansion of the *Dilaasa* initiative in other MCGM Hospitals:

By 2004, *Dilaasa* had received a lot of attention from other public hospitals too. The then Municipal Commissioner wanted to replicate such centres across all the Mumbai hospitals. However, this was not a feasible idea. We felt that there was a need for capacity building of staff of other hospitals, who once trained could not only screen women for domestic violence but also provide referrals to centers close by. With this view, we proceeded to conduct yet another "Training of trainers" across 5 hospitals. This included a staff of 12 from each of the four hospitals - Rajawadi Hospital, Ghatkopar; MT Agarwal Hospital, Mulund (W); K. B. Bhabha Hospital, Kurla and Cooper Hospital, Vile Parle (W). By 2005, core groups of trained hospital staff across 5 hospitals had emerged; they had also started conducting orientation trainings/ poster exhibitions/ pamphlet distribution and film screenings in their respective hospitals.

It was around the same time that a group of committed HCP's came forward to set up the second *Dilaasa* crisis centre in Kurla Bhabha hospital. This centre is completely run by the hospital with its current personnel and infrastructure.

3. Establishing a Training Cell (2006- 2009):

Dilaasa was expanding and more HCPs were getting interested in the issue of domestic violence. However the current public health system lacked a formal mechanism to sustain the interest of the HCPs and formalise their roles. This led to the development of the "Training cell" (TC). It was formed to share resources and experiences of HCPs dealing with domestic violence, as well as provide them with formal roles of trainers with the aim of mainstreaming the training cell in the current health system. The cell began with a modest number of 25 HCPs and has now more than doubled (56).

The work of the training cell slowly expanded to issues concerning patients in general, whether it was about improving communication skills on the part of the hospital staff, getting together to put forth the problems that they were facing due to lack of basic facilities for the patients, or about demanding a salary revision. Some of the TC members have been invited in the capacity of experts to speak on the issues such as domestic violence and role of HCPs, patients' rights and the like. Slowly the cell is moving towards ensuring that the public health department recognise it and allocate yearly funds for its activities.

This year, Rajawadi hospital and Oshiwara Maternity Home have gone one step further. They are keen to respond to women reporting sexual violence as well and use a uniform protocol for examination and evidence collection in cases of sexual assault. It was with their enthusiasm and keenness that we implemented the SAFE kit (sexual assault and forensic evidence collection kit). Currently these hospitals are also ensuring that their staff gets trained in not just the use of the kit but also develop a perspective on the issue of sexual violence itself.

Achievements of the Training Cell 2008-2009

Hospital	No. of trainings	Attendance of participants
Kurla Bhabha	▪ 3 Trainings with Health Care Providers ▪ 1 Training with the police officials	▪ 60 HCPs ▪ 30 police officials
Cooper	▪ 2 Trainings on Domestic violence with HCPs ▪ 1 Training on Sexual Violence at Oshiwara Maternity Home with HCPs	▪ 40 HCPs ▪ 10 HCPs
Rajawadi	▪ 1 Training on Domestic violence with HCPs ▪ 2 on sexual violence with HCPs	▪ 18 HCPs ▪ 70 HCPs
M. T Agarwal	▪ 2 Trainings on Domestic violence with HCPs	▪ 44 HCPs
KEM	▪ 1 Training on Sexual Violence with Health Care Providers	▪ 70 HCPs
Sion Badlapur	▪ 3 Trainings of student nurses in 3 teaching hospitals	▪ 100 student nurses

III. Crisis counselling services at the centres with a feminist perspective

III.A. The process

III.A.1. Counselling:

In order to provide necessary help to women approaching the centre, we as counsellors at the crisis centre have been trained in women centric perspective and skills. Feminist counselling gives the counsellor a perspective through which women's experiences can be understood in view of their general oppression in society. Domestic violence is understood as a result of patriarchal structure and a tool to maintain status quo within a relationship.

Consent is sought for counselling and if women are not willing, their decision is respected._Once at *Dilaasa*, women are given emotional, psychological, legal and social support (see sections III.A.4 and III.A.5 below) as needed and desired by them. It was of utmost priority to make the women survivors feel that they themselves were not responsible for the violence that they had faced and to address their fears, anxieties and needs. We also do a safety assessment of the women along with a safety plan and necessary support in terms of referrals. While assessing the need for a safety plan a woman is asked a few questions pertaining to the history of violence. These include, whether there has been an escalation of abuse; if in earlier episodes of violence instruments had not been used, but in recent ones they have been; has there been a threat to life or children; any attempts to commit suicide; etc. In the event that the counsellor feels that the woman is in danger, she devises a safety plan. This plan can include helping the woman enhance her ability to cope (like seeking immediately the help of a reliable neighbour) or even a shelter.

III.A.2. Methodology of training / inducting new counsellors:

A new counsellor at *Dilaasa* undergoes training which is an intensive three month long process. They observe actual sessions of counselling. Issues are highlighted on a case to case basis. Over time, they undertake counselling sessions in the presence of senior counsellors. This is followed by a discussion on the session. Shortfalls on the part of the counsellor are identified and rectified. Thus it is a continuous learning and relearning process where each case is unique and poses challenges for counselling.

III.A.3. Training and orientation of staff for referrals:

In order that the staff at the hospital refer women facing domestic violence to the centre, it was necessary that we as part of *Dilaasa*, and the rest of our co-workers,

underwent a complete change in perspective and responsibilities. In order to achieve this, orientation and training of staff was essential. The training given to hospital staff enables us to screen cases of domestic violence refer them to the crisis centre. This can happen from the various wards or at out patient departments (OPD) of the hospital.

III.A.4. Linkages with shelters:

Depending on our analysis of the situation of a woman's need, our hospital provides temporary shelter as "admission" for upto 48 hours to women. If needed, there is also provision of temporary shelters at two shelter homes in Mumbai. Besides this, we have a strong network with organisations and community based organizations (CBO) in Mumbai for mutual support and referral.

III.A.5. Legal counselling:

Majlis has been providing legal counselling as well as litigation support to women at *Dilaasa*. A lawyer is available once a week at both the centres. They provide legal guidance as well as litigate cases. In the year 2007 – 2008 alone, legal counselling was sought by and provided for almost 50 women. Legal counselling for maintenance was given to 26 women, for divorce (16), streedhan and property matters (8), issues related to visitation rights and custody of child (9) (Litigation was pursued in case of five women for divorce as well as maintenance and restraining orders. One woman was able to get a restraining order due to the new act on domestic violence, i.e. The Protection of Women from Domestic violence Act (PWDA), 2005.

As a logical extension of legal counselling, we need to liaison with the police. We therefore had included them for awareness, sensitisation and training programmes.

III.B. Counselling Services at K. B. Bhabha Hospital, Bandra

After years of hard work, the number of women that *Dilaasa* has managed to reach out to and help has increased manifold. 472 women approached Dilaasa department for counselling services since April 2007 to March 2009. Out of which 52 were referred from the casualty, 34 from the Out patient department (OPD), while a large number of women i.e. 81 women were screened from the wards especially from the Female Medical Ward (FMW) with the history of poison consumption. 87 women were referred from community. It was seen that posters and pamphlets continue to have a large impact on women where by 67 women came by seeing the IEC material. 38 clients were referred from other organisations. 947 women followed up for counselling sessions and 155 came

in for legal counselling. Amongst these, legal counselling was provided for maintenance (39), divorce (38), and property matters (11). 14 women were provided legal counselling under the PWDVA. In the year 2007 – 08 alone, more than 500 follow – up counselling sessions were conducted.

Moreover, it was realised through counselling that if women facing violence could meet each other on a regular basis, then they would be better cope with their situations and trauma if they were in a 'support group' sharing experiences. Thus began the monthly *support group meetings*. Topics such as women and mental health, education, menopause, how women view the support they receive from *Dilaasa*, portrayal of women in media and various issues impacting women's lives and health were taken. During the meetings story telling, role plays and games are used to communicate issues. The counsellors continue to hold weekly meetings with women coming for counselling.

III. C. Counselling Services at K. B. Bhabha Hospital, Kurla

The *Dilaasa* department located at K. B. Bhabha hospital, Kurla, provides counselling services twice a week. Eighty new women approached the crisis centre at Kurla Bhabha hospital in the year 2007 – 2008. A large number of these have been referred from the hospital itself where as 87 women followed up with the counselling centre. Twenty-nine women were referred from the casualty; where as nine women were referred from the OPD. Seventeen women came in contact with *Dilaasa* as they were admitted in the wards. Out of these, a majority of them were admitted for an attempt to suicide. 14 women were referred by staff of the hospital itself, while 6 women came from the community. Only 5 women came after reading the posters and pamphlets. This shows that a large number of women were actually referred by the hospital staff itself which indicates a good assimilation of the department in the hospital.

Women's narratives -

After 5 years of Dilaasa's work, a study was conducted to understand women's experiences of having accessed counselling services at Dilaasa. In-depth interviews were conducted with women who received services at the centre. The key findings of this study were presented to a group of 45 clients at a women's meeting. These findings brought to the fore women's perceptions regarding the counselling experience, what they felt they had gained out of the experience and what changes they had seen in their lives as a result of accessing Dilaasa. The quotes below illustrate some of these findings, pointing to what all a feminist counselling model can offer abused women.

Women found Dilaasa to be a safe space where they could speak out and express their feelings. For some, the counselling experience was the first time that they had confided in someone.
"I talked to the counselor openly. I told her things that I had not even told my mother. For one and a half years I had kept it to myself. When I told her about it, I felt so relieved. It was quite difficult to tell but the way she asked me, I told her everything."

Some women narrated that the counselling experience had changed the way that they understand violence. The experience took away blame from them and put the onus of abuse on the perpetrator.
"Earlier, I used to blame myself. Used to think, 'What did I do wrong?' That is why I used to pacify him and seek his forgiveness. Then I realized that I was not at fault at all."

Women also reported an improvement in health – both mental and physical – after accessing services at Dilaasa.
"With this mental peace I can eat something otherwise I used to be very anxious. I also had a strange feeling in my hands and legs which has lessened."

The location of the hospital was reported as being advantageous by several women, as it was viewed as a neutral space and hence increased accessibility.
"Because Dilaasa is in the hospital, I could come. I came here telling my family that I am going to the hospital. As my husband is very suspicious, he doesn't allow me to go here and there. But I can come under the pretext of the hospital."

These findings illustrate the myriad ways in which a department like Dilaasa can reach out to abused women. It also underscores the importance of locating such services in a hospital setting.

One social worker from the hospital has been deputed as a centre in-charge and two nurses were trained intensively to provide counselling services. The counselling component since the start of *Dilaasa* has been completely handled by our own MCGM hospital staff. An experienced counsellor goes there on the counselling days to oversee the counselling done. Our staff at *Dilaasa* is responsible for counselling with the training and monitoring inputs being given by the CEHAT counsellors. Legal counselling is provided once a week by the lawyer from Majlis.

By the end of 2008, more than 1800 women have accessed the services offered by *Dilaasa.*

III.D .Challenges to counselling

As mentioned earlier, women referred to the centre, can deny counselling or choose not to come for follow – up sessions or seek any other help as perceived necessary by the counsellors. This is frustrating, often emotionally taxing, for the counsellors themselves. Interacting with traumatised women leaves an impact on us too. As a result of this we also often risk burnouts. Therefore, we as counsellors too need to keep having appropriate outlets and refresher courses. Counsellors are constantly provided fora for venting their fears and concerns.

Moreover, we felt that more advanced counselling skills are required for serious cases - such as a woman having consumed poison. Therefore capacity building of the team of counsellors is a constant ongoing activity. Moreover, in order to get a better perspective towards certain approaches to counselling in our Indian context, it was necessary to understand our own social determinants. Therefore we underwent perspective *training* on issues such as intersectionality of class, caste and its effect on women facing violence. Over and above all the specialised counselling training, a senior consultant comes to *Dilaasa* every quarter. The consultant observes, with the woman's permission, actual counselling sessions. Following this, the counsellor handling that session is given relevant feedback. Our team of counsellors also present issues that we need to discuss and issues that we were unable to resolve satisfactorily. The forum provides for ways to better resolve and handle such issues.

Training nurses as counsellors also proved to be a challenge. In 2005, nurses were officially deputed to the *Dilaasa* crisis intervention department as counsellors. However, after receiving intensive training in crisis counselling, some of the deputed staff withdrew, while some came intermittently. Each time a staff member withdraws,

another has to be trained. Considerable amount of our resources and energy is wasted. We were also concerned with maintaining of confidentiality of the histories women share during counselling. Therefore, a trainee leaving mid-way or immediately after the training, causes a certain amount of uneasiness. The source of the problem could be selection of staff, relief from other hospital duties, departmental pressure or staff shortage. This was an important key to enable replication of the centre at other hospitals. Eventually, by 2006, a significant development has been that of the deputed staff, the CDO has started counselling women independently and there are two nurses who are currently providing support to women under the guidance of a senior counsellor. Thus the counselling services are currently being handled by the BMC staff.

III. E. Outreach activities of Dilaasa

The women seeking services at *Dilaasa* had expressed need for support at the community level. In order to be able to meet such a need, we identified one community based organisation (CBO), Navjeet Community Centre. It is based in a slum in Bandra. In 2005-2006 a series of trainings were conducted in order to create a deeper understanding on the issue of domestic violence in the community setting. In the second phase of training, the community volunteers were trained in basic counselling skills. Case studies related to their daily lives were developed and we encouraged the participants to get into the role of a counsellor. Most of the principles, values and techniques related to counselling were woven around the case studies itself. A feminist counselling methodology was specially developed for grassroots workers. This had proved to be a challenge. Issues covered during the training included principles and techniques of feminist counselling, values of a counsellor, techniques/ skills in counselling and the like. The coordinator of the community centre has started a counselling centre. Working at the community level continues to be an important part of our activities.

Since the past 8 years, *Dilaasa* has been able to establish its name in the field of counselling. Various organisations are aware of our work. They approach us for training and inputs for their own staff and organisation. For example, Jagruti Kendra, a community based organisation approached us to design a counselling module for their workers who are already engaged in providing support to women facing domestic violence at the community level. A two day module was designed where in emphasis was given on principles and values of feminist counselling, ways of assessing safety of the woman as well as devising a safety plan and suicide prevention counselling.

IV. And Further…

Since *Dilaasa* was started in a hospital which obviously had an established system, any desirable change was an uphill task. Full cooperation of all the stakeholders right from the planning stages was needed. For this, involvement and participation of our hospital staff was indispensable. Accordingly, for example, for orientation and training of staff, the content was evolved through involvement and contribution of our co-workers across various cadres. Today since adequate time was spent in involving us, we have a sense of ownership towards *Dilaasa*. This encourages us to take initiatives to take it forward in the best possible manner. And for the same reason, our work is better understood, accepted and integrated within the hospital. *Today, the centres are being completely managed by the hospitals with technical inputs for training and counselling from CEHAT.*

Moreover, we see nurses as having huge potential and a lot to contribute. They are underutilised. Their formal training as nurses provides them with skills that can be used to the optimum, provided they are allowed to do so. This is not the case at present because our healthcare model is doctor centric. In Dilaasa, however, nurses and other staff contribute in a big way. Nurses, in fact, have been officially deputed to provide counselling services and they are doing very well.

There has been very little research and documentation in India on violence and related issues, particularly on issues such as health sector response. *The Dilaasa department has successfully created, and continues to be the resource for such work in India.* The research that has been undertaken will contribute in a big way in improving our responses to women facing domestic violence and our systems can be further improved and evolved.

The experience of this crisis centre further reiterates the earlier findings and leaves no doubt that a hospital based department increases access to services for survivors of domestic violence. Thus, *hospitals with appropriate support through capacity building and with constant improvisation through research, can have crisis centres as an integral part of their services without any additional burden on resources – both human resources and financial. And with a cultivated sense of ownership, the intervention is also sustainable.*

Through our years of work at *Dilaasa* we have learnt a lot. Earlier we saw domestic violence as an issue that was rather left *officially* unspoken. We had never perceived that we could ever contribute in helping women facing violence. Today, through *Dilaasa*, we believe it to be a serious health issue. We realized that we have a significant role to play and we see an opportunity for bringing about a change.

While a lot has been achieved, we still have a long way to go. The present report is the first of its kind from *Dilaasa*. We hope to continue bringing out reports about our work. Towards this we hope to receive your feedback and suggestions towards the same.

Acknowledgment: This report has been prepared by Tejal Barai Jaitly based on the annual reports prepared by CEHAT and the other process documents, with inputs from Sangeeta Rege.

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In the press:
Indian Express, 18 February, 2008

A Toolkit for Justice

Jinal Shah

This plain white cardboard package could change the way Mumbai's hospitals deal with victims of sexual assault, from their medical examination and collection of evidence to their after-care and rehabilitation. Better still, while this little white box ensures that victims are treated in a systemic, effective and sensitive manner, it also helps medical professionals give accurate testimony in court.

Conceptualised and developed by non-governmental organisation Center for Enquiry into Health and Allied Themes (CEHAT), the magic box is actually a first-of-its-kind Sexual Assault Care and Evidence kit called SAFE, making its public healthcare debut in two civic hospitals this week. Thanks to the kit, the R N Cooper Hospital in Vile Parle and the Rajawadi Hospital in Ghatkopar will now be able to deal sensitively and effectively with victims of abuse.

"The need for such a SAFE kit was felt as there is no particular timing for sexual assault cases to land in hospitals and the doctors who generally collect evidence are MBBS students who have theoretical knowledge but are not trained practically. The manual attached to the kit is a step-by-step guide in conducting the procedure," said Dr Nikhil Datar, honorary gynaecologist at Cooper Hospital.

The SAFE kit is actually a simple compilation of various materials used for collection of evidence in such cases, otherwise used haphazardly, and also includes a complete manual on how to go about examining the victim. Colour-coded patient consent forms to be submitted

to the hospital and to the police, with details of the patient's examination. "The kit is very simple to use - like it provides a large sheet of plain white paper on which the victim is made to stand so that any grass or hair or any tiny foreign object falls on it and can be collected," said Padma Deosthali of CEHAT.

The SAFE kit was first prepared in the late Nineties when trustees and researchers of CEHAT were involved in investigating a case of sexual assault of a hearing-impaired girl in an observation home in Mumbai, who had been assaulted by a cook within the premises. Panelists found gross inadequacies in the process of eliciting medical history of the patient, medical examination and collection of forensic evidence. "The investigation highlighted the need for a uniform, standardised and meticulous protocol accompanied by guidelines and a training manual to care for and document evidence in such cases," said Deosthali.

It was then that Dr Lalitha D'Souza, a paediatrician working with CEHAT, developed the SAFE kit. The kit was first adapted from a kit used by the Ontario Police, Canada, in 1998. "In India, the kit has gone through several rounds of review and feedback by forensic doctors, gynaecologists and obstetricians as well as human rights and women's rights activists from Mumbai and other parts of India to suit the needs and requirements in the Indian context," added Deosthali. Used with appropriate perspective and training, this could be one step to generate better quality evidence and better testimony in court. "Also, the doctors will be trained to use the kit," Deosthali said.

Cooper Hospital has received three such kits. "On an average, Cooper Hospital gets two cases of sexual assault on a woman or child every month. This kit will help us as we will not fall short of swabs due to administrative problems like non availability of swabs on nights when the pathology laboratory is closed," said Dr Datar. "Using this kit will just increase the chances of getting good and accurate amount of evidence," he added.

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Hindustan Times, 5 October, 2009

This kit may hold the key to nailing rapists

MEDICAL GEAR can help doctors collect evidence from sexual assault victims

Neha Srayyam

WHAT'S IN THE KIT

IMPORTANCE OF EVIDENCE

The contents of the kit.