WOMEN'S PERCEPTIONS ON INTIMATE EXAMINATION AND PATIENT RIGHTS

A Dissertation submitted to the University of Kerala in partial fulfillment of requirements for the Masters of Social Work Degree Examination

Subject Code: SW 2.4.5

University of Kerala

2021-2023

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

This research explores women's experiences and perceptions of intimate examinations in healthcare settings, with a focus on patient rights and quality of care. The study employs a mixed-method approach, utilizing qualitative interviews of 5 participants and quantitative surveys with 50 respondents. The qualitative data was collected through purposive sampling using an interview guide. The quantitative data was collected through convenience sampling using questionnaire.

The qualitative findings revealed diverse emotional responses, ranging from fear and discomfort to the desire for a supportive environment during intimate examinations. Themes related to privacy and dignity highlighted the importance of maintaining physical and emotional privacy during these procedures. Healthcare providers' attitudes and communication emerged as critical factors influencing patient experiences, underscoring the need for empathy, compassion, and effective information sharing. The quantitative data provided valuable insights into the feelings and attitudes of women undergoing intimate examinations. Respondents expressed anxiety and embarrassment during the process, emphasizing the need for healthcare providers to be sensitive to patients' emotional well-being. The preference for female healthcare providers indicates the significance of gender dynamics in shaping patient attitudes.

To ensure a positive patient experience during intimate examinations, healthcare institutions should adopt patient-centered practices, including comprehensive health education, respectful communication, and ensuring physical and emotional privacy. Integrating patient feedback and preferences into healthcare policies and practices will empower women, foster trust in healthcare providers, and ultimately contribute to the provision of high-quality healthcare services. By recognizing and addressing women's perceptions and rights during intimate examinations, healthcare systems can take significant strides towards delivering patient-centered care and meeting the unique needs of women in their healthcare journey.

CHAPTER 1: INTRODUCTION

CHAPTER 1: INTRODUCTION

Overview of the Chapter

The chapter provides a general introduction about the topic being presented in the study. The chapter includes statement of the problem, background of the study, relevance and significance of the study. It also includes chapterisation of the whole study.

1.1.Introduction

Intimate examinations, which entail the physical inspection of sensitive regions of a patient's body such as the breasts, genitalia, or rectum, are an important aspect of healthcare. These examinations are critical in identifying and managing numerous health issues, but they also pose fundamental ethical concerns about patient rights and dignity. In the realm of women's healthcare, intimate examinations are crucial, yet they are frequently disregarded in terms of patient experiences and rights. This study aims to close this gap by investigating how women perceive and navigate intimate examinations, with a focus on the consequences for patient rights. The study attempts to uncover areas where patient autonomy and dignity may be jeopardised by delving into women's viewpoints, developing more sensitivity and responsiveness from healthcare personnel during these sensitive procedures. Understanding women's perspectives and experiences during intimate examinations is critical for providing patient-centred care and protecting their rights.

The study aims to investigate a critical aspect of women's healthcare experiences, focusing on their perspectives and perceptions of intimate examinations performed by healthcare professionals. It sheds light on women's experiences, concerns, and preferences during intimate examinations, with the ultimate goal of improving the quality of care and advocating for patient rights.

1.2. Statement of the Problem

“Examinations that are generally described as intimate include breast, pelvic, genital, and rectal or anal. However, procedures such as urodynamic investigations and physiotherapy treatment can also prove intimate for many patients, as can undressing for any type of medical examination. Nearly every specialty within medicine and

surgery involves intimate examinations, particularly primary care, sexual health, gynecology and obstetrics, gastroenterology, emergency medicine, Genito-urinary medicine and dermatology" (Cream, 2019).

The patient may have a variety of reactions when goes in for an intimate examination. Individual differences in characteristics such as coping style, shame, humiliation, and fear are examples of this. Other factors include feelings of vulnerability, discomfort, shame, and suffering. These are more likely to be present if the patient has had a distressing experience during a previous intimate examination, has endured sexual abuse, or feels unable to communicate properly with clinicians (Stattin et al., 1991).

Many patients will find genital inspection quite humiliating. Success is dependent on the patient's cooperation and confidence, and it is preferable to postpone examination if the patient is uncomfortable and unable to relax. It's a good idea to offer a chaperone to both male and female patients if they want one. A sizable proportion of patients, both men and women, prefer to be examined by a doctor of their own gender. Patients have filed allegations of indecent assault even when their examining doctor was of the same gender. Cultural differences must also be taken into account. Many Muslim, Hindu, and Sikh women follow rigid sexual morals. Girls are raised to be shy and modest, and submitting to a vaginal examination may be frowned upon, even if it is a matter of life and death. Before beginning an examination, it is both sensible and kind to discuss these concerns with the patient (Dean, 1998).

Although respect for the patient is essential in all medical contexts, intimate operations necessitate extra attention in both interpersonal and environmental dimensions to ensure that patients retain as much dignity as possible. In many places, guidelines exist to guide intimate examination techniques. In the United Kingdom, for example, the Royal College of Obstetricians and Gynecologists (1997) recommends that a clinician never comment on the patient's body or functioning while performing the examination, while research on shame and dignity indicates that fears of how one's body appears to a doctor or nurse can contribute significantly to distress (Lazare, 1987).

Intimate examinations are an essential part of healthcare, particularly in gynecological and obstetric care. However, there is a growing concern regarding women's perceptions and experiences related to intimate examinations and their rights as patients. It is crucial

to investigate this issue to ensure that healthcare practices align with patients' needs, preferences, and rights. This study aims to explore women's perceptions of intimate examinations and examine the extent to which patient rights are upheld in healthcare settings.

1.3. Background of the Study

Intimate examinations include the examination of breasts, genitalia or rectum, (although other areas may also be classified as intimate by patients of diverse cultures) (Evans, 2003). Intimate examinations can vary depending on the gender and specific needs of the individual being examined. Examples of intimate examinations include breast examinations, genital examinations, pelvic examinations, rectal examinations etc. It may also include examination which involve direct contact such as abdominal examination.

A clinical breast exam (CBE) is a physical exam of the breasts done by a health care provider. It's often done during your yearly medical check-up. A CBE should be performed by a health care provider well-trained in the technique. This may be a doctor, nurse practitioner or other medical staff. Not all health care providers have this training. A trained health care provider should carefully feel your breasts, underarms and the area just below your clavicle (collar bone) for any changes or abnormalities, such as a lump. The provider should visually check your breasts while you are sitting up and physically examine your breasts while you are lying down (Komen, 2022)

A pelvic examination is the physical examination of the external and internal female pelvic organs. It is frequently used in gynaecology for the evaluation of symptoms affecting the female reproductive and urinary tract, such as pain, bleeding, discharge, urinary incontinence, or trauma (ACOG Practice Advisory on Annual Pelvic Examination Recommendations, 2014). A pelvic exam is a doctor's visual and physical examination of a woman's reproductive organs. During the exam, the doctor inspects the vagina, cervix, fallopian tubes, vulva, ovaries, and uterus.

Genital examination is the examination of the external female genitalia. The external female genitalia are a part of the female reproductive system, and include the: mons pubis, labia majora, labia minora, clitoris, vestibule, hymen, vestibular bulb and vestibular glands (Ferng, 2022).

Rectal examination or anal examination consists of visual inspection of the perianal skin, digital palpation of the rectum, and assessment of neuromuscular function of the perineum.

Intimate examinations are mostly linked with women because they focus on female reproductive and sexual health. These exams are critical for examining and monitoring different aspects of women's health, such as reproductive organs, finding anomalies or indicators of disease, and offering preventive care. Women are undergoing a greater number of intimate examinations compared to men because intimate examinations dealt with reproductive health, pregnancy and obstetrics, sexual health etc. The uterus, cervix, and ovaries are distinct reproductive organs in women that require frequent monitoring and evaluation. Intimate inspections aid in the assessment of these organs' health, discovering problems such as cervical cancer, uterine fibroids, ovarian cysts, or infections. The Papanicolaou method, or Pap test—is the study of normal and disease-altered, spontaneously exfoliated, or mechanically dislodged cells (surface micro biopsy) for the detection and diagnosis of various infections, abnormal hormonal activities, and precancerous or cancerous lesions (Walker et al., 1990) Cervical cancer is the fourth most common cancer among women globally, with an estimated 604 000 new cases and 342 000 deaths in 2020. About 90% of the new cases and deaths worldwide in 2020 occurred in low- and middle-income countries (Sung et al., 2021). Labour is usually monitored to ensure that it is progressing as expected, and that there are no signs of abnormal progress that might be harmful to mother or baby. The method most commonly used is routine vaginal examination (undertaken at regular time intervals), which provides information on how dilated the woman's cervix is and the position of the baby (Moncrieff et al., 2022). Intimate examinations are vital for evaluating a woman's sexual health, addressing concerns related to sexual activity, and managing issues like sexually transmitted infections (STIs).

As women are undergoing a greater number of intimate examinations, it is important to comprehend the experiences of women during such medical procedures. A study shows that intimate examinations, such as breast or vaginal examinations, can be stressful and embarrassing for many women. One solution was to favour female doctors for these tests, while having no preference when the medical issues were not sexual. Women who had previously had unfavourable encounters with doctors and/or were less calm with

intimate examinations were more likely to prefer a female doctor. These women are more susceptible and require "women-sensitive" practises, which women doctors may be more willing to deliver. This may be due to not only the perceived lower levels of sexual ambiguity when female doctors examine female patients, but also to the fact that female doctors may, on average, be better communicators. Personal comments and non-medical touches employed by general practitioners in a genuine wish to engage with female patients should be conscious that only a minority of women would respond positively, and some will be insulted, embarrassed, or confused. The rules of behaviour expected of most female patients in a medical examination differ from those that may contribute to good communication in a social situation. To determine patient levels of comfort with certain parts of medical style, such as the use of humour or touch for comfort, clear two-way communication is required. It is critical that general practitioners investigate and promote acceptable methods to improve the quality of communication and relationship between doctors and female patients (Moore et al., 2000). Some of the women participating in the study stated that Vaginal Examination (VE) performed at bedside, without protection of privacy, and in a crowded and noisy environment caused a negative VE experience m (Albers, 2007). Creating an examination environment that provides privacy and comfort for the women can contribute to a positive VE experience. Nearly half of the women participating stated that the doctor's expertise was more important for them. Interestingly, the other half focused more on the importance of the gender of the doctor performing vaginal examination. Vaginal examination may cause negative reactions such as embarrassment over genital exposure, which may in turn lead to feelings of helplessness and vulnerability, dehumanization, and a violation of privacy (Muliira et al., 2013).

Respecting patient rights is an important area to explore in healthcare setting. The preamble to the Charter of United Nations reaffirms faith in fundamental human rights, in the dignity and worth of human person, in the equal rights of men and women. The Tripartite International Bill of Human Rights, Universal Declaration of Human Rights (UDHR), The International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR) contained many principles and obligations that resembled norms of medical ethics. Provisions which overlap with medical ethics in these documents are right to life, liberty and dignity. Right not to be subjected to inhuman or degrading treatment and prohibition of

medical or scientific experimentation without free consent, equality and non-discrimination, privacy, right to information, medical care. The other components resembling medical ethics are right of everyone to the enjoyment of highest attainable standard of physician and mental health and also a right to share in scientific advancement and its benefits. Apart from the above important international instruments, certain provisions in Convention on the Elimination of All forms of Discrimination Against Women, Convention for the elimination of All forms of Racial Discrimination, Convention Against Torture and other Forms of Cruel, Inhuman, or Degrading treatment or punishment, convention on the Right of child, International Convention on the protection of the Rights of all Migrants workers and members of their families, convention on the right of persons with Disabilities, reflected principles of medical ethics.

The Charter of Patient Rights is a document prepared by the National Human Rights Commission (NHRC) that enumerates 17 rights that patients should be entitled to. These rights are a compilation of rights that have been guaranteed by various statutes. The Universal Declaration of Human Rights (1948) emphasizes the fundamental dignity and equality of all human beings. Based on this concept, the notion of Patient Rights has been developed across the globe in the last few decades. There is a growing consensus at international level that all patients must enjoy certain basic rights. In other words, the patient is entitled to certain amount of protection to be ensured by physicians, healthcare providers and the State, which have been codified in various societies and countries in the form of Charters of Patient's Rights. In India, there are various legal provisions related to Patient's Rights which are scattered across different legal documents e.g. The Constitution of India, Article 21, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002; The Consumer Protection Act 1986; Drugs and Cosmetic Act 1940, Clinical Establishment Act 2010 and rules and standards framed therein; various judgments given by Hon'ble Supreme Court of India and decisions of the National Consumer Disputes Redressal Commission (NHRC, Charter of Patients' Rights, 2018).

Consent is defined as an agreement, cooperation, or approval granted voluntarily and without coercion. It is a communication process between a patient and a physician that leads in the patient's authorization or agreement to undergo a specific medical

intervention (Pillay, 2003). The Indian Contract Act defines consent as two or more people agreeing on the same thing in the same sense. It is regarded as a contract by the law. The requirement for permission in medicine is the legal manifestation of the ideals of self-determination and autonomy (Indian Contract Act, 1872).

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
    (i) the diagnosis (when known);
    (ii) the nature and purpose of recommended interventions;
    (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record. In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines (AMA Principles of Medical Ethics: I, II, V, VIII).

Even though, several rules and regulations regarding patient care are available, how far the patient rights are respected is a point of concern. Intimate examination experiences are examined in this research study, along with how they overlap with patient rights. The healthcare of women must include intimate examinations, such as pelvic and breast exams. However, in these situations, there is a chance for discomfort, unease, and patient rights violations. The purpose of this study is to comprehend the perceptions of women throughout intimate examination procedures and to highlight the need of safeguarding patient rights during such delicate medical encounters.

1.4. Relevance and Significance of the Study

Intimate examinations involve the physical examination of sensitive areas of a patient's body. Understanding women's perceptions and experiences in this regard is crucial to ensure ethical medical practice. The study helps identify potential areas where patient autonomy and dignity may be compromised during intimate examinations. Informed consent is a fundamental principle in healthcare, emphasizing that patients have the right to be fully informed about the nature and purpose of any medical procedure. The study explores women's perceptions of how informed consent is obtained during intimate examinations, contributing to the broader understanding of patient rights and the need for clear communication. The study highlights the importance of patient-centered care, emphasizing the need to prioritize the preferences, comfort, and emotional well-being of patients during intimate examinations. It provides insights into how healthcare providers can create a supportive and respectful environment for women undergoing such examinations, ultimately improving the overall quality of care. Intimate examination procedures can be sensitive and vulnerable experiences for women. Respecting their patient rights, including dignity, privacy, informed consent, and autonomy, is essential. By amplifying women's voices and experiences, the study can empower patients to become more aware of their rights and actively participate in their healthcare decision-making process. In India, the guidelines and rules related to patient rights, specifically informed consent are discussed in general in the existing guidelines. The absence of specific regulations for conducting intimate examinations in India highlights the need for the development and implementation of guidelines to ensure ethical standards, privacy and dignity during such examinations. The results of

this study can help with the creation of protocols, rules, and guidelines for intimate examination practices. It can serve as a catalyst for discussions on patient advocacy and encourage healthcare systems to implement policies and practices that prioritize patient autonomy and respect. The findings of the study can inform the development of educational programs and training initiatives for healthcare professionals. By better understanding women's perspectives, healthcare providers can improve their communication skills, empathy, and sensitivity when performing intimate examinations, leading to more positive patient experiences. The study's insights can influence healthcare policies and guidelines related to intimate examinations, ensuring that patient rights and preferences are upheld. It can prompt discussions and reforms aimed at standardizing procedures, enhancing privacy protections, and establishing clear protocols for obtaining informed consent.

1.5. Chapterisation of the Study

The whole study is divided into six parts and they are as follows,

- Chapter I Introduction: The chapter gives an overview about the background and significance of the study. It also elaborates on the statement of the problem.
- Chapter II Literature Review: The chapter summarizes the findings from different studies based on similar themes.
- Chapter III Methodology: The methodology followed in the present study is given in this chapter including the aim, objectives, universe and unit, details on data collection and analysis etc.
- Chapter IV Data Analysis and Interpretation: The results of analysed data are presented in this chapter. The qualitative data are analysed in the initial part and quantitative data are analysed as tables and figures. A mixed method data analysis is also shown.
- Chapter V Findings, Suggestions and Conclusions: The chapter summarizes major findings of the study. It also put forwards suggestions, implications and recommendations for further research. Conclusion of the whole research is also given.

CHAPTER 2: LITERATURE REVIEW

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

The analysis of prior and current studies that are relevant to the research at hand, as well as the identification of research gaps in those earlier studies, are two key tasks that has to be undertaken while conducting research. It aids in gaining a comprehensive understanding of the issue and raises the standard of empirical investigation. This chapter is written to establish the requirement of the current study by reviewing previous studies based on similar themes. Thematic analysis is used to conduct review of literature and different themes discussed under the review of literature include,

- Attitude of women
- Experiences of women
- Perceptions of women
- Patient Rights

2.2. Review of Literature

Attitude of Women

In a study conducted by Millstein et al. (1984), 84 female adolescents were examined in an adolescent clinic. The most common concerns about the examination were: fear of the discovery of pathology; fear of pain; and embarrassment about undressing and about personal cleanliness. Pre examination anxiety was measured in the adolescent prior to being seen by the healthcare provider. After the examination, subjects were queried about their sources of concern and affective responses to the pelvic examination. Post examination anxiety was measured at the conclusion of the survey. Reported anxiety during the pelvic examination varied as a function of subjects' sexual experience and history of previous pelvic examinations. Subjects with limited sexual experience reported significantly higher levels of anxiety during the examination than those who were more sexually experienced. Subjects who showed higher anxiety prior to the examination reported higher absolute levels of pain during the examination. Subjects who were most concerned that the examination would hurt did report more pain during the procedure than those who had less concern.

The aims of the study conducted by Yanikkerem et al. (2009) were: (1) to describe women's expectations of nurses and doctors during gynecological examination; (2) to identify if women have a preference for the doctor's gender; (3) to investigate women's feelings during gynecological examination; and (4) to determine why women consult the gynecological outpatient clinic. The study was a descriptive, cross-sectional study. A questionnaire, developed by the researchers and consisting of two parts, was used to collect data. This study found that 54.8% of women felt anxious or worried about their health situation during pelvic examination, and 41.8% of women were embarrassed about having to undress. Overall, 38.3% of respondents stated that fear of discovery of a pathological condition or fear of severe illness were their main concerns. One out of four women expressed worries about cleanliness or fear that the equipment used during the examination was unsterile. In total, 18% of women feared that they would experience pain during the examination.

A study by Baker et al. (2007) was to determine (i) the preferences of patients for the presence of a chaperone and (ii) the use of chaperones in primary care. The method of study was a bibliographic search for articles published up to March 2007 reporting quantitative or qualitative studies of patients' views on and professionals' use of chaperones in primary health care. There were five studies of patients' opinions found, but none were conducted in more than three general practises. In two trials, 75–90% of participants desired a chaperone, whereas in a third, just 35% of female participants and 10% of male participants desired a chaperone. In every study, patients' preferences for a chaperone's presence varied based on a number of variables, including the patient and doctor's ages and sexes. Ten research on the usage of chaperones were found, and it was shown that while female general practitioners frequently do not, male general practitioners routinely offer and use a chaperone for intimate examinations of female patients.

The review by O'Laughlin et al. (2021) aimed to analyze the anxiety and fear risk factors, pathophysiology, symptoms, screening and diagnosis while highlighting treatment considerations for women undergoing a pelvic examination. They considered all articles within the last 10 years to be relevant. Search terms included pain during pelvic examinations, anxiety with pelvic examinations, pain and anxiety with pelvic examinations and pelvic examinations. The review shows that regular pelvic exams are

crucial for sexually transmitted diseases and cancer early detection, as well as for treating immediate health concerns. The pelvic examination, however, frequently results in feelings of pain, discomfort, dread, shame, or worry. These circumstances may make people reluctant to finish pelvic examinations, which may lead to delays or avoidance and have a negative impact on their health. Women's anxiety about pelvic exams might be evaluated to help prevent postponing or avoiding exams. Identification of risk factors is a crucial aspect of this. Some cancers, like cervical cancer, are more likely to develop as a result of trauma exposure, particularly sexual trauma. Trauma survivors are also more likely to experience pain, worry, or panic during pelvic exams. This underlines the necessity of assessing exam-related anxiety in order to avoid screening delays. General anxiety assessments can help identify women who are anxious about pelvic exams in addition to taking into account risk factors. Particularly in women with high-risk factors or those identified by screening approaches as having anxiety, dread, or pain with tests, strategies to lessen these feelings should be routinely put into practise. As a result, early patient education and the application of techniques that lessen discomfort and psychological stress associated with pelvic examinations may be made possible, ultimately improving health outcomes. In summary, pelvic examination-related anxiety is a fairly prevalent problem that healthcare professionals should be aware of, screen for, and address in order to enhance patient outcomes.

Experiences of Women

A quantitative study by Moore et al. (1999) was to assess women patients' feelings about intimate examinations and their perceptions and experiences of sexually inappropriate medical practice. The survey was completed by 472 adult women, with an age range of 18 to 83 years (M= 36.9 years, sd= 12.9 years). The scope of the survey was limited to adult women from the western suburbs of Melbourne, Australia. Data collection points were spread across the region to obtain a diversity of responses. The findings show that the question about general preference for sex of doctor showed over half of the women had no preference in general, but that nearly two-thirds preferred women doctors for intimate examinations. Most women (67.9%) indicated that they found intimate examinations embarrassing, many classing them as more stressful than' other medical examinations (5 1.6%), but few believing them to be degrading (18.0%). One very strong finding from the survey was women expressed need to be informed

about what is happening to them. Most cases of perceived unnecessary intimate touching were perpetrated by male doctors, but some women had experienced such unwanted touching from female doctors as well.

The purpose of the study conducted by Bodden-Heidrich et al. (2000) was to analyze the association between anxiety and discomfort during the initial gynecological examination and how it was experienced. For the children who visited the special outpatient clinic, 169 completed questionnaires could be evaluated, whereas 210 completed questionnaires could be evaluated for the students. (1) Anxiety and pain had a statistically significant positive link, but the examiner's gender had no bearing on how the examination was felt. The people who were with the patients overstated their pain and understated their anxiousness before the assessment. (2) Loglinear models revealed no association between the type of school attended and the pain score, a significant association between the type of school and the anxiety (P.01), and a significant relationship between the anxiety and pain score regardless of the type of school attended. During the initial gynaecological examination, the investigations revealed a startlingly high frequency of discomfort, anxiety, and their association.

A study by Hilden et al. (2003) aims to evaluate how women experience the gynecologic examination and to assess possible factors associated with experiencing discomfort during the gynecologic examination. Consecutive patients visiting the Department of Obstetrics and Gynecology at Glostrup County Hospital, Denmark, were invited to participate in the study, and received a postal questionnaire that included questions about the index visit, obstetric and gynecologic history and sexual abuse history. From the study based on 1011 patients, discomfort during the gynecologic examination was strongly associated with a negative emotional contact with the examiner and young age. Additionally, dissatisfaction with present sexual life, a history of sexual abuse and mental health problems such as depression, anxiety and insomnia were significantly associated with discomfort. It is noteworthy that the experience of discomfort during the gynecologic examination was independent of the gender of the gynecologist.

A study by Lewin et al. (2005) was to investigate women’s perceptions of their experiences of vaginal examinations in labor using a prospective, analytic survey design using anonymized, self-completion, postal questionnaires. A multi-centre study

conducted in 2002 in three midwifery units in Cambridgeshire, England. A notional satisfaction index score of 74% was generated using a 20-item Likert scale. Based on 1435 ordinal data items, this indicates a positive level of satisfaction with the privacy, dignity, and the care, encouragement, and regularity with which vaginal exams during childbirth were managed. There was room for improvement, nevertheless, in areas including related discomfort, opportunity to decline exams, and more thorough information-giving. In relation to the frequency of vaginal examinations performed during delivery or the women's perceptions of the care they received from medical personnel, no statistically significant differences in women's perspectives could be proven in the three midwifery units.

The book written by Milne (2022) offers a thorough and in-depth investigation of the problems associated with unrestricted vaginal examinations of pregnant women. The selected collection includes a variety of chapters from all over the world that discuss the experiences of women, the harm caused, the legal status, and the shortcomings of the system and the law. The public's understanding and knowledge of medical professionals' nonconsensual vaginal inspections is expanding. The fact that the book does not question whether illegal vaginal inspections occur in the context of maternity care is one of its main advantages. In fact, the book's prologue states unequivocally that it does harms to women as a result of things that affect women worldwide. The variety of chapters in the book, as well as the authors' experience and knowledge, contribute to the book's second major strength. Brione's and Montgomery's first set of chapters describe the fundamental concerns facing women, including their experiences and the effects of those experiences. In terms of detailing what we know about unauthorized vaginal examinations of pregnant women and the risks involved, these chapters clearly establish the scenario. The three chapters that come after, offer critical insights into the theoretical protection pregnant women have from unwanted physical contact in the context of medical examination, as well as the cultural and social causes.

The aim of the study on Wendt et al. (2004) was to describe, in terms of critical incidences, women’s experiences concerning the personnel’s behavior in the situation of gynecologic examination. The informants were strategically chosen and consisted of 30 Swedish women between the ages of 18–82 years old. The data collection method was qualitative research interviews analysed by critical incident technique. The

investigation identified two key areas: confirmation and trust. When the staff emphasised the need of trust, chances for trust. The presence of women during the assessment circumstances inspired confidence and provided support. There was a lack of trust when this wasn't done. Confirmation was used to characterise situations in which staff members' actions verified or disproved the women's identity as individuals, depending on whether they were present or not. The major results of the study were (a) The staff's professional conduct during gynaecologic examination scenarios encouraged trust and gave the women confidence (b) Participation through information during the whole visit in gynaecologic examination situations was very important for the women, as information amounted to one fourth of the incidents in the material (c) The women were verified with a respectful and active demeanour, which facilitated a positive caring interaction and gave the women a good opportunity to advance their own health. Positive staff behavior fostered trust and validated the women's identities, but unfavorable staff behavior was decisive. There are many intricate patterns of nursing knowledge, participation based on knowledge that contributed to trust was significant and made up one-fourth of the material's events. An effective caring relationship was promoted by the women's confirmation of one another and their mutual respect. Through personnel behavior reflection and additional research on the experiences of women, the examination situation can be improved.

The article by de Klerk et al. (2018) aims to explore women’s experiences with vaginal examinations during labour in the Netherlands. They conducted an exploratory anonymous online survey with a mixture of fixed and open questions among women who underwent a trial of labour and gave birth to a living term child no longer than six months before completing the questionnaire. The women were approached via multiple channels, such as social media, client organizations and midwives throughout the Netherlands. It took approximately 10–15 min to complete this survey. 56 women (35.2%) out of the 159 women who met the inclusion requirements expressed dissatisfaction with the VE. More discomfort, shame, an inability to unwind, a lack of respect, and a lack of feeling like they could stop the examination were stated by these women. The likelihood of reporting unfavourable experiences rose when giving birth in a hospital, had an assisted delivery, increased examinations, examinations performed by more carers, and examinations conducted by carers who did not introduce themselves. About 41.7% of the female participants claimed that they had their health

checked more frequently (every two to four hours) than was recommended by national and international guidelines. The study concluded that since the vaginal examination can be experienced negatively by the labouring woman, the examination must only be performed when in the interest of the woman, after her consent and preferably performed by as few different caregivers as possible.

Perceptions of Women

The study by Tancman et al. (2021) involves a cross-sectional survey aimed to evaluate the subjective experiences of women during gynecologic examinations (levels of pain, embarrassment and trauma), the manner the examination was conducted, and women's suggestions for improving their experience. A number of areas of concern were revealed by the study, including those involving communication, privacy, and feelings of unease and worries about sexual harassment. Nearly half of survey participants said the examination is embarrassing, around one-third said it is painful or really unpleasant, and about one-fifth said it was traumatic or extremely traumatic. Nearly half of the individuals said they had used five or more gynecologists in their lives, and the most frequent justification for the switch was because they were unhappy with their previous doctor. The most reported concerns of women were all related to doctor-patient communication, including getting explanations, having time to ask questions, and being informed before unpleasant procedures. Additionally, these variables were discovered to be most substantially connected with examination-related feelings of discomfort, humiliation, and trauma to the patient's comprehension of the circumstance and feeling of control throughout the evaluation. Furthermore, clear explanation is essential for making wise selections. The survey respondents identified privacy-related issues as being crucial. An option for a companion was rated as important by 64% of the respondents. The findings emphasize the need for gynecologic examination recommendations to be developed using a patient-centered care methodology.

The study by Bal et al. (2022) aimed to identify the level of women's feeling of discomfort during the vaginal examination and associated factors. It was a cross-sectional research study performed with 386 women who had a vaginal examination at a public hospital in Malatya province of Turkey in August-November 2018. The Personal Information Form, the Visual Analog Scale (VAS), and the Impact of Event Scale were used in the collection of research data. The findings suggest that women had

negative feelings during the examination even if they felt different levels of discomfort. Another reason for women to feel different levels of discomfort during the examination may be the fact that the feeling of discomfort is a subjective experience and is measured by using different measurement tools in different communities. Moreover, the study found that women who received explanations from the doctor during a vaginal examination experienced less discomfort than those who received explanations from the midwife. Women put forward that the doctor conducting the gynaecological examination should be first of all well-informed and talented (63.8%) and should provide information (44.6%), and also, in the same study, 37.5% of women stated that they did not want anyone else, except the doctor, to be with them in the examination room during the gynaecological examination.

The study by Larsen et al. (1995) was to describe teenagers' expectations and knowledge of the pelvic examination (PE). The study was carried out as a cross-sectional postal questionnaire study. A total of 1500 women, aged 17 years, were selected at random from all Danish women of that age. The current study demonstrated that teens frequently have unfavourable expectations of physical education. The most common worries among individuals who had not experienced a PE were humiliation (67%), pain (48%) and fear of abnormal genitals (29%). Teenagers who had never had a PE believed that the examination would be painful in 48% of cases, and 29% of them feared that the doctor would find abnormal anatomy, 67% believed they would seem foolish by baring their genitalia, and 23% believed they would be ill for the remainder of the exam day. Only 17% of teens who had never taken a PE thought they knew enough about the test, compared to 68% of those who had ever taken one. Comparatively, 33% of those who had never had a PE knew what the doctor could look at during the practical portion of the test, as opposed to 55% of those who had. It is determined that a sizable part of teens have low expectations for physical education, and it may be advised to boost efforts to raise such expectations and expand understanding among teenagers about pelvic examination.

The article by Arasoo et al. (2021) sought to identify independent factors influencing women consenting to male medical students performing general and pelvic examinations under supervision. Most of the respondents (52.9%) were under 30 years old, were Malays (73.4%), were Muslims (75.3%), had at least a secondary education

(96.7%), were employed (58.4%), and were married (92.6%). Only 27.4% of respondents said they would be open to having their general health examined by male medical students, and only 18.9% said they would be open to having their pelvis examined. In the study, the univariate analysis revealed a significant relationship between ethnicity and male medical students' agreement to a general examination (p=0.011), "religion," and "employment status" (p=0.040). It's interesting to note that none of these demographic factors were linked to consent for a pelvic exam. Women's willingness to allow general and pelvic examinations by male medical students may be influenced by a number of factors, according to a univariate study. Male medical students' agreement to a general assessment was substantially correlated with grooming, politeness, and language use. The student being accompanied by a female chaperone, being introduced by a male specialist, being co-examined and treated by a senior doctor, and believing that male doctors needed to be skilled in women's health were all clinical scenarios that were associated with consent to general examination. Male medical students' agreement to pelvic exams was investigated in relation to its associations with race, religion, feeling pressured to consent if a senior doctor requested, being coexamined and treated by a senior doctor, and thinking that male students should not be subjected to such examinations. Only the notion that male doctors should possess the necessary abilities was substantially connected with a higher likelihood of women giving consent to pelvic exams among all of these potential factors. The patients' perspective is crucial since it informs what to concentrate on to enhance male students' learning experiences when performing pelvic examinations. The notion that men doctors should be able to examine women thoroughly, which calls for efforts to educate women about the value of having male doctors who can perform a pelvic examination and how they can support this.

In Maaita et al. (2017) study aimed to explore the feelings, opinions and knowledge of vaginal examination during normal labour in Jordanian women and to establish current practice of midwifery and obstetric staff regarding intimate examination to assess progress in labour. Cross-sectional correlational design was employed in this investigation. 150 postpartum mothers participated in interviews using a semi-structured questionnaire. Three certified midwives conducted the study during the postpartum period. The completed survey and all information were used (SPSS) version 19 for analysis. The topic of vaginal inspection during childbirth was discussed by

women. All comments were coded into one of four groups: useful, VEs performed, when necessary, a lack of regard for privacy and human dignity. Approximately 56.7% of women said VEs were helpful, 25.3% said there weren't enough privacy protections, 16% said VEs should be performed when necessary, and only 2% said there was no regard for human dignity or humanity during VE. Women were asked open-ended, qualitative questions on how they felt about being examined vaginally while giving birth on their own words. The substance of women's statements or reactions was divided into four categories: reassuring, uncomfortable, painful, and embarrassing. Only 2% of women claimed that VEs were reassuring, while 59% of women (n=89) said that VEs were unpleasant, 23% expressed embarrassment, 15% reported discomfort, and only 2% reported discomfort. Two thirds of the women were knowledgeable about VEs, including how to assess cervical dilatation, monitor labour progress, and look up foetal descent. On the other side, about 32% of women are misinformed about vaginal examinations; some believe that VEs hasten dilatation, while others believe that VEs checks for birth problems. Only 1.3% of women reported not knowing anything about VEs. Regarding permission statement, responses from women were gathered and classified into three groups, including giving instructions and requesting VEs, requesting VEs without instruction and answer to a complaint. Approximately 61.3% of women said that doctors asked their consent before performing an exam without giving them any instructions, and 32.7% of women said that doctors performed exams too frequently without explaining the results. Only 6% of women claimed to have received instructions and information about the exam, as well as requests for permission to conduct the examination from medical professionals. Understanding what women experience during VEs is crucial for health care professionals in order to increase women's expectations for the care given to them during childbirth. A minimum number of examinations with a minimum number of providers are part of evidence-based midwifery practises. The study's conclusions suggest that the hospital's physicians and midwives should enhance their methods for attending to labouring women and adopt evidence-based procedures for vaginal inspections. This will raise the standard of care we provide for our patients.

Rights of the patients

A study by Kalyani (2016) emphasize the need for uniform nationwide guidelines which must strictly force the State Governments to stop the practice of two finger test for forensic examination and mere two finger test will not declare the women history of sexual life and such kind tests are against the Article 21 that is Right To Privacy of Indian Constitution and must respect the survivors health, dignity, consent and there is a urgent need to change the laws and forensic procedures related to sexual assault. Based on the study, rape is heinous inhuman act which condemns the purity of Indian society and a Test like Two Finger Test is another inhuman and unscientific process attacking the right to privacy and it is a severe blow to her mental, physical and ethical status and such tests should be condemned, strictly prohibited by enacting amended laws which are uniformly applied over the country.

The article by Griffith (2005) considers the legal and professional obligations on district nurses in relation to intimate examinations and treatment. The findings are intimate examinations and treatments are a source of distress and discomfort to patients. In order to protect patients from inhuman or degrading treatment during these private and personal procedures the law requires that they are only carried out where their medical necessity has been convincingly shown to exist. An important safeguard against abuse during intimate procedures is the provision of a qualified chaperone to oversee the procedure.

An exploratory qualitative study by Hassan et al. (2012) was to explore women's feelings, opinions, knowledge and experiences of vaginal examinations (VE) during normal childbirth. One key finding indicated that about two thirds of women did not receive any information about VE, and other women said that providers did not speak with them at all prior to, during, or following the VE or the way their VE was administered in an uncaring manner. This suggests inadequate provider communication and raises numerous concerns about the application of fundamental medical practice ethics, informed consent, women's reproductive rights, and cultural sensitivity. Palestinian women accepted frequent VE with little to no communication, occasionally during contractions, coupled by an unforgivingly harsh approach and discomfort, and occasionally with a disregard for their privacy. There are numerous concerns regarding the degree to which ethical ideals, human rights, cultural norms, and evidence-based

practises are put into action. This makes it necessary for providers to follow the fundamental principles of practises and moral principles.

A study by Robinson (2001) focus on the complexities of consent in intimate examinations. The commonest causes of psychological harm reported by women stem from two causes — manipulated 'consent' or ignoring refusal. Also, the number of examinations mentioned in the notes may not be followed and incase of four examinations, eight are carried out for obtaining results. Some told that sexual relationship with their husband is badly affected after conducting of several intimate examinations. Only a small number of the women who would like to refuse actually try to do so. In other cases, abuse has taken place in the presence of the chaperone. Worst of all, in one case reported, the female 'chaperone' (possibly the doctor's wife) was apparently one of an abusing pair and seemed to enjoy watching what was going on.

In a multicentre study by Rees and Monrouxe (2011), they aimed to explore medical students' explanations of their behavior when instructed to observe or perform intimate examinations or procedures without valid patient consent. The study used a qualitative design employing individual and group interviews to elicit narratives of dilemmas associated with professionalism. Of 833 narratives collected, 112 involved dilemmas associated with intimate examinations. Of these, 63% (n = 71) described dilemmas which came about because students were instructed to observe or perform intimate examinations or procedures without valid consent. Medical students are simultaneously confronted with strong societal norms about what constitutes ethical practice in relation to intimate examinations of patients and a weak ethical climate within the clinical workplace in which they are instructed by organization leaders to observe or perform intimate examinations or procedures without valid patient consent.

An exploratory study by Coldicott et al. (2003) conducted in one English medical school to examine if guidelines on intimate examinations are being met. 452 medical students from one medical school were interviewed for understanding about various aspects of intimate examinations (both vaginal and rectal) among the anaesthetized patients who were the subjects of 702 such examinations. For the study, structured self-completion questionnaire was designed in consultation with academic staff and piloted on five students. The questionnaire asked students to recollect the number of intimate (rectal and vaginal) examinations they had done throughout their undergraduate career,

at what stage in their training these took place, the setting of each examination, the level of consent obtained, the degree of supervision, and the extent to which they felt uneasy about doing these procedures. The study concluded that up to a quarter of intimate examinations in anaesthetized or sedated patients seem not to have had adequate consent from patients. In some cases, consent may have been obtained by a doctor but simply not witnessed by the student. Only 24% of these examinations received written consent, while another 24% were conducted without either written or oral consent. There were even times when numerous students would "examine" the same patient at once. Without the patient's consent, vaginal and rectal examinations are performed, which is against the law and actually an assault. In order to develop clinical skills, students in the medical field occasionally need to practice on actual patients. Although medical students were uncomfortable performing these checks without getting agreement, they claimed that they were unable to defy their instructors the consultant who had given them the test-taking instructions. Some of the respondents may have been aware of the ethical and legal issues surrounding intimate examinations, and some of the comments can be seen as attempts to shift responsibility to supervising staff by implying a certain amount of coercion or helplessness. If nurses, like student doctors, are unable to confront consultants, they should at the very least inform their senior management about the occurrence. This will force the manager to make sure that an official policy is developed regarding intimate examinations and start changing the culture of theatres.

The purpose of the study by Armitage and Cahill (2018) was to understand the factors which increase the likelihood of a woman allowing a student to perform an intimate examination. Women receiving care at a tertiary gynecology institution were handed questionnaires. Women were questioned on several topics, including factors that would make them agree to have a student examine them. Any student who could see them in clinic should provide demographic information as well as information on their prior gynecological history and preferences. Women were prompted to indicate their readiness to consent to a vaginal exam (but not to participate in the exam). The results show age, parity, civil status, or the source of the request had no bearing on a person's willingness to undergo a vaginal exam. The hypothetical agreement of the woman was positively influenced by the student's gender (female) and age (preferring older students); positively influenced by a casual/relaxed style and sophisticated

presentation; and positively influenced by the woman's prior experience with gynecology clinics. There was a correlation between being open to the idea of being inspected and whether the student had interacted with the woman by asking about her presenting issue. Several student-related characteristics, some of which are controllable, have an impact on women's willingness to consent to vaginal examination.

In the article by Griffith (2015), according to the Mental Capacity Act of 2005 and human rights law, a competent adult patient has a right to respect for their autonomy, which includes protection of their physical integrity. Before performing an examination or receiving therapy on a patient, their consent must be obtained. The patients freely expressed wish to undergo the entire procedure must be supported by reasonable knowledge for the consent to be considered legitimate. The consent may be verbally communicated, in written, or implied by the patient's behavior. Each has equivalent legal effectiveness. The nurse has a defense to an assault allegation or a tort action for trespass to the person if they successfully get the patient's consent. The Courts view consent as much more than just a defense against unlawful touching when it comes to intimate and invasive tests and treatments. The patient's permission is "so crucial as to be essential to the propriety of treatment." The quality of consent must, according to the legislation, match the intimate procedure's sensitivity. When granting permission for such a procedure, patients have a right to expect that nurses are competent to perform any surgery.

In a study conducted by Mankuta (2016), he tried to understand medical student's attitudes towards intimate physical examination during clinical rotations. The study was performed at a university hospital setting during the years 2008-2009 and included 100 medical students. The students filled a questionnaire about their attitudes towards patients' pelvic examination by students. The study discovered that in university hospital context, it is nevertheless normal practice to conduct a private physical examination while under anesthesia without obtaining a particular agreement. A patient's consent was not required for around a third of the exams. 90% of medical students are against this practice. The students support a change because they are informed. While understanding the value of the intimate physical examination for their medical education, only 30% of them have talked about the emotional components of the problem. Ninety percent of female medical students' value patient contact on the

topic higher than 49% of male students ($p = 0.005$). About half of the students would decline being examined by medical students themselves if theoretically they were patients more if the examiner would be from the opposite gender. The clinical task of performing an intimate examination is not receiving the appropriate teaching. Patient's informed consent is not obtained in many cases and not obtained appropriately in other.

An article by Brown (2020) states that, although pelvic exams are a standard component of obstetrics or gynecology care, their efficacy and morality have come under scrutiny in recent years. Particularly, pelvic inspections carried out before surgery under anesthesia have come under intense criticism from patients, ethicists, and the larger medical community. As long as a patient is mentally competent to make decisions on their own behalf, patient autonomy often takes precedence over medical need. The patient ultimately decides whether to accept the prescribed treatment, even if the doctor may provide essential information and make recommendations. According to the American Medical Association, informed consent entails explaining a medical intervention to a patient, along with its risks and benefits, assuring that the patient has understood what has been said, asking the patient if they agree to the treatment, and documenting this process in the patient's medical file. Informed consent also informs patients of other options, such as whether a pelvic exam can be substituted.

The article by Friesen (2018) states that it is unfair to perform pelvic exams on women who are under anaesthesia and who have not given their consent since it infringes on their autonomy and bodily rights. It also threatens the patient-physician relationship's ability to trust one another. The author thought about whether this practise might be an exemption to the need for informed consent, either because it has utilitarian effects or because it is minor, and he came to the conclusion that it is not. Women should specifically consent to having pelvic examinations performed on them while under anaesthesia, preferably before they are in the preoperative holding room, and by a person other than the doctor, in order to respect their bodily rights and autonomy. The majority of women who are questioned are likely to provide their consent, and it is highly unlikely that they will feel violated while unconscious at the hospital, according to the evidence.

The study by Karim et al. (2019) was conducted to assess the informed consent practices during normal vaginal delivery (NVD) process and immediate postpartum

care in the tertiary-level hospitals of Bangladesh. In November 2015, a cross-sectional study was carried out at the Sir Salimullah Medical College & Mitford Hospital (SSMCH) and the Dhaka Medical College Hospital (DMCH). Mothers who recently gave birth via normal vaginal delivery and received postpartum care at the study sites made up the study population and respondents (N=190). Researchers used a systematic questionnaire to interview each substitute mother from the patient registry. The results of the study showed that there were no informed consent procedures used during NVD and postpartum care in Bangladesh's tertiary institutions. Before beginning the NVD process, 95% of the mothers were given their consent (not informed consent), as were 50-72% of the examinations (excluding breast examination, 0%), and 8-72% of the operations throughout postpartum care. In every instance, the moms had no choice or preference to undergo a different examination, method, or process. As one of the fundamental rights of women who are pregnant or nursing, informed consent is supported by the Respectful Maternity Care (RMC) Charter. The study sites' lack of informed consent procedures suggests a disregard for maternity care and a violation of this right. This right is not explicitly stated in Bangladesh's Standard Clinical Management Protocols. To address the preservation of this right, it is imperative that the current procedure be improved and that knowledge and practises are raised.

The article by Rogstad (2007) examines the difficulties surrounding the use of chaperones and proposes a chaperoning policy for sexual health clinics, while noting that it may not be appropriate or acceptable to all patients or medical staff, or for different parts of the world. A chaperone’s role covers several areas ranging from someone to help the patient undress or provider of emotional support, to a protector of patient or doctor. Many recent UK chaperoning policies appear to have been motivated by a few medico-legal incidents in which doctors or nurses acted inappropriately and sexually abused their patients. There are several reasons why patients might reject a chaperone. Since there is a higher chance that a woman will make an accusation against a man, the BASHH (The British Association for Sexual Health and HIV) guidance advises that a chaperone should always be present in these situations. If the woman refuses to allow a chaperone, she should be examined by a female doctor or given the option of another appointment when a female doctor is available. It is a sad fact that some doctors may mistreat their patients, and in a world where there is an increase in lawsuits, some patients may falsely accuse their doctor. Any policy must take into

account the rights and protections of both patients and doctors, as well as any cultural or religious preferences of the patients. The best course of action for sexual health care clinics is pragmatism. If a nurse or healthcare assistant won't be assisting in the exam room: 1) Female doctors ought to let everyone have a chaperone. The majority of the time, the patient will indicate that this is not required; 2) male doctors should encourage all males to bring a chaperone. Once more, the patient will typically declare that this is not required; however, 3) male doctors should have a chaperone with them when they examine female patients. If the patient opposes, the doctor should find out why and decide whether a female coworker should conduct the examination instead.

2.3. Theoretical Framework

WHO Strategic Communications Framework effective communications

World Health Organisation (2017) recognises that effective, integrated, and coordinated communication is critical to achieving WHO's aim of creating a better, healthier future for people worldwide. The goal of this Framework is to establish a strategic strategy for successfully delivering WHO information, advice, and guidance on a wide variety of health challenges, ranging from chronic diseases to emerging and novel dangers. WHO has invested significantly to meet the growing demand for information, advice, and guidance, ranging from increased capacity to improved integration of available communication channels such as media relations, social and online communications, branding, visual communications, and health and emergency risk communications. To achieve programme goals, WHO requires all employees to understand and effectively use communications. This strategic approach is offered as a set of principles for effective practise that may be applied to a wide range of communications functions. It is based on contributions and reviews from WHO communicators in WHO's country, regional, and headquarters offices.

The Framework is not intended to be a communications plan for specific diseases, health observances, or geographic locations. Instead, the ideas and techniques can be used as resources to construct specific plans that include more actionable, accessible, relevant, timely, intelligible, and trustworthy communications. It is a resource and reference intended for ongoing updating, as recommended by all WHO staff involved in communications.

2.4. Research Gap Analysis

While there have been several international studies exploring women's perceptions of intimate examination and patient rights, there remains a significant research gap in the Indian context, particularly within the state of Kerala. Despite the importance of understanding women's experiences and perspectives during intimate examinations, limited research has been conducted in India, and no studies have specifically focused on Kerala. This research gap presents a unique opportunity to fill the void in the literature and contribute to the understanding of women's perceptions, preferences, and concerns regarding intimate examinations and the protection of their rights within the local healthcare system. By conducting a study in Kerala, it aims to address this research gap and shed light on the experiences of women in the region. It is crucial to explore the cultural, social, and healthcare context specific to Kerala, as these factors may influence women's perceptions of intimate examinations and their awareness of patient rights. The findings from this study will not only contribute to the limited body of knowledge in the Indian context but will also provide valuable insights for healthcare providers, policymakers, and patient advocacy groups in Kerala, informing the development of patient-centered care strategies and policies that align with the unique needs and expectations of women in the region. Overall, this study aims to bridge the research gap by conducting an empirical investigation into women's perceptions of intimate examination and patient rights within the specific context of Kerala, India, thereby providing a foundation for further research and contributing to the advancement of women's healthcare practices and policies in the region.

CHAPTER 3: METHODOLOGY

CHAPTER 3: METHODOLOGY

Overview of the Chapter

A well-defined research methodology is an essential and most important component of a research study. This chapter describes on the methodology used for the present study. It gives details about the sample for the study, the research design, method and tools used for data collection and the statistical techniques used for data analysis.

3.1. Title of the Study

Women's Perceptions on Intimate Examination and Patient Rights

3.2. Objectives

3.2.1. General Objective

To understand women's perceptions of their intimate examination experience and how far their rights are respected.

3.2.2. Specific Objectives

1. To understand the experiences of women undergoing intimate examination procedures.
2. To understand the attitudes of women towards intimate examination
3. To investigate women's feelings during intimate examination
4. To investigate women's perceptions of their intimate examination experience

3.3. Definition of Concepts

Intimate Examinations

Conceptual Definition: Examinations that are generally described as intimate include breast, pelvic, genital, and rectal or anal. Nearly every specialty within medicine and surgery involves intimate examinations, particularly primary care, sexual health, gynecology and obstetrics, gastroenterology, emergency medicine, Genito-urinary medicine and dermatology (Cream, 2019)

Operational Definition: In this study, intimate examinations are physical examinations for medical purposes that includes examination of the breasts, genitalia, or rectum of a woman.

Perception

Conceptual definition: The process of organizing and interpreting sensory information, enabling us to recognize meaningful objects and events (Goldstein, 2019).

Operational definition: Perception refers to the subjective understanding, interpretation, and evaluation that women have regarding their experiences with intimate examinations during medical encounters. It encompasses their cognitive, emotional, and attitudinal responses to the process of undergoing intimate examinations, as well as their beliefs and expectations regarding their rights as patients.

Experiences

Conceptual definition: According to Daniel Kahneman, a Nobel laureate and renowned psychologist, experiences can be defined as "moments of consciousness, characterized by their quality, intensity, and duration." (Kahneman, 2011)

Operational definition: Experiences refer to the subjective encounters and interactions that women have during intimate examinations within the healthcare setting. Experiences can include a wide range of elements, such as the level of comfort or discomfort felt during the examination, the quality of communication and information provided by healthcare professionals, the degree of respect and empathy received, the perceived level of privacy and dignity maintained, and the overall atmosphere and environment of the healthcare facility.

Women

Conceptual definition: According to Judith Lorber, a sociologist and gender theorist, "Women are individuals who are assigned female at birth and who identify and live as women within the context of their own societies." This definition recognizes that gender identity and lived experiences of being a woman are influenced by both biology and social factors (Lorber, 1994).

Operational definition: In this study, women are individuals who are between the age group 20-50, who have undergone any kind of intimate examination.

Patient Rights

Conceptual definition: Patient rights encompass legal and ethical issues in the provider-patient relationship, including a person's right to privacy, the right to quality medical care without prejudices, the right to make informed decisions about care and treatment options, and to right to refuse treatment (National Centre for Farmer Health, 2014).

Operational definition: Patient rights refer to the specific entitlements and protections that women have as patients during intimate examinations within the healthcare setting. These rights ensure that women receive respectful, dignified, and patient-centered care throughout the process.

Attitude

Conceptual Definition: Attitude refers to a psychological construct that represents an individual's overall evaluation, feelings, or opinions about people, objects, events, or ideas (Baron & Byrne, 2003)

Operational Definition: In the study "attitude" refers to a woman’s overall evaluation, feelings, or opinions about undergoing medical examinations that involve intimate or sensitive areas of her body. This encompasses her emotional and cognitive responses, as well as her behavioural tendencies, with regards to these types of examinations. The woman's attitude may include specific desires, inclinations, or hopes regarding how intimate examinations are conducted. This could encompass factors such as the gender of the healthcare provider, the presence of a chaperone, the level of privacy provided, the use of informed consent, the communication style of the healthcare provider, and other elements that may impact her comfort, dignity, and overall experience during the examination.

3.4. Pilot Study

A pilot study was conducted in a Veliyam village in Kottarakkara Taluk to explore women's perceptions of intimate examination and patient rights. Data collection involved qualitative (interviews) and quantitative (survey) methods. This preliminary

investigation aimed to inform the research design and ensure the feasibility of the data collection procedures for the main study.

3.5. Research Design

The research design for this study on "Women's Perceptions on Intimate Examination and Patient Rights" utilizes an exploratory sequential mixed-method approach. This approach involves conducting the qualitative phase first, followed by the quantitative phase, enabling a deeper exploration and understanding of the topic.

Qualitative Phase:

The qualitative phase serves as the initial exploratory stage of the research design. It involves conducting in-depth interview to gather qualitative data from a selected sample of women. This qualitative data collection method allows for open-ended questioning and encourages participants to share their experiences, perspectives, and concerns related to intimate examinations and patient rights. The qualitative data obtained during this phase will be analysed using thematic analysis or content analysis, enabling the identification of common themes, patterns, and key insights that emerge from the participants' narratives.

Quantitative Phase:

Following the qualitative phase, the study progresses to the sequential quantitative phase. This phase involves identifying a structured questionnaire suitable for the study from past studies which is based on the themes and key insights derived from the qualitative analysis. The quantitative phase aims to further explore and measure the prevalence and significance of the identified themes and insights among a larger sample of women. The quantitative data collected will be subjected to statistical analysis, such as descriptive statistics and inferential analysis, to generate numerical findings and validate or expand upon the qualitative insights obtained in the previous phase.

Integration of Qualitative and Quantitative Findings:

The final stage of the research design involves integrating the qualitative and quantitative findings. This integration can occur through a process of triangulation, where the qualitative insights serve as a foundation for the design of the quantitative

survey instrument, and the quantitative data validate and complement the qualitative findings. By combining the strengths of both qualitative and quantitative methods, this mixed-method research design provides a more comprehensive and nuanced understanding of women's perceptions on intimate examination and patient rights.

3.6. Universe and Unit of Study

Universe: Women between the age category 20-50 who have underwent any kind of intimate examination is the universe of the study.

Unit: A woman between the age category 20-50 and underwent any kind of intimate examination is the unit of study

3.7. Sampling Design

Sample: Women between the age category 20-50 in the Kottarakkara Taluk in Kollam District, Kerala.

Sample size

- Qualitative phase of the study: 5 women between the age category 20-50 from Kollam district.
- Quantitative phase of the study: 50 women between the age category 20-50 from Kollam district.

Sampling Method

Study used non-probability sampling for the research in which samples were collected through convenience sampling.

3.8. Data Collection

The data was collected from the respondents through quantitative and qualitative methods. An interview guide was used to collect data in the qualitative phase of the study. Self-prepared questionnaire and a 20-item Likert scale was used to collect data in the quantitative phase of the study and data was collected manually via interview and through google forms.

3.9. Pre-test

Researcher conducted a pre-test to test the effectiveness of the tool. After conducting pre-test, researcher made some changes in the tool. In this study pre-test was conducted among 5 respondents.

3.10. Data Analysis

The qualitative data was analysed first and derived quantitative areas for study. The quantitative data was analyzed using descriptive statistics to find out the frequencies. The data analysis carried out using Statistical Package of Social Sciences (SPSS) 22 version.

3.11. Ethical Considerations

- The data is collected after obtaining informed consent from the participants.
- The participants were informed about their right to withdraw from the study.
- The confidentiality of information and the participant details to be maintained by the researcher.
- The researcher has not resorted to any unlawful means/ plagiarism to present data.
- The data collected will be used for only academic purposes.

3.12. Assumptions, Limitations and Scope

Assumptions

- Researcher assumes that the respondents would have genuinely responded to the questionnaire.
- Researcher assumes that the data will be correct since the questionnaire and tools were given in local language also.
- The researcher assumes that since the data was collected on anonymous basis the respondents would have given genuine response.

Limitations

- The research was conducted in a small period of time.
- Limited number of participants was available for the study.

- The findings of the study may have limited generalizability beyond the specific taluk in Kerala.
- The sample size and geographical scope of the study restrict the ability to draw conclusions that can be applied to a broader population.
- The unique characteristics, cultural context, and healthcare practices within the selected taluk may not be representative of the entire state or country.
- Given the sensitive nature of the topic, participants may be hesitant to share their true perceptions or negative experiences during intimate examinations, leading to social desirability bias.

Scope

- The study seeks to validate and expand upon the qualitative findings by conducting a quantitative survey among a larger sample of women in the selected taluk.
- It aims to generate knowledge that can inform local healthcare practices, policies, and patient-centered care strategies within the selected taluk in Kerala.
- Research can be conducted to understand the experiences of men during intimate examinations by considering patient rights.
- The research contributes to the limited body of knowledge on women's perceptions on intimate examination and patient rights in the specific geographic area, potentially serving as a basis for future studies in other regions of Kerala or India.

Summary of the Chapter

The methodology chapter described about the way in which the research is conducted. It included the aim of the study and objectives of the study. It also explained the objectives framed for conducting the study. It also described the method and design followed in the study. The way in which data was collected and analyzed and the tools and functions used to collect and analyses data was also mentioned in the chapter. The chapter also included scope, assumptions and limitations with regard to the study undertaken.

CHAPTER 4: DATA ANALYSIS AND INTERPRETATION

Chapter 4: Data Analysis and Interpretation

4.1. Introduction

The chapter will be divided into two sections, starting with the qualitative analysis followed by the quantitative analysis. This approach allows for a comprehensive exploration of participants' experiences and perspectives through qualitative data, followed by the quantification and statistical examination of the larger sample in the quantitative phase.

The qualitative analysis section will begin with an overview of the research questions and objectives, serving as a reminder of the study's purpose and guiding the subsequent analysis. The analysis will be conducted on the data gathered from five participants who were selected through purposeful sampling, ensuring a diverse range of perspectives. Using thematic analysis, the researcher will carefully examine the transcripts or field notes to identify patterns, themes, and recurring ideas related to women's perceptions of intimate examination and patient rights. The findings will be presented in a narrative format, allowing for a rich description and interpretation of the participants' viewpoints.

Following the qualitative analysis, the chapter will shift focus to the quantitative analysis. The section will start with a summary of the research questions and objectives pertaining to the quantitative phase. The analysis will involve the data collected from the 50 respondents who participated in the survey portion of the study. The data will be analyzed using appropriate statistical methods, such as descriptive statistics, inferential statistics, or both, depending on the nature of the research questions and the data collected. This analysis will enable the researchers to derive meaningful insights and draw conclusions based on the numerical data obtained.

Finally, the chapter will conclude with a synthesis of the qualitative and quantitative findings, highlighting key similarities, differences, and overarching themes that emerged from both parts of the study. This synthesis will provide a comprehensive understanding of women's perceptions on intimate examination and patient rights, utilizing the strengths of both qualitative and quantitative approaches.

Overall, this chapter will serve as a crucial component of the research study, offering a detailed and nuanced analysis of the data collected. The qualitative and quantitative analyses will complement each other, providing a comprehensive understanding of women's perceptions and shedding light on important factors related to intimate examination and patient rights.

4.2. Qualitative Data Analysis

This section presents the results of analysis done using the qualitative data collected from participants. The data was analysed on a thematic basis.

The section is divided into following sub-sections,

- Sociodemographic profile of respondents
- Details of Intimate Examination of Respondents
- Themes Identified
    a) Attitude towards the Examination
    b) Privacy and Dignity
    c) Healthcare provider's approach
    d) Consent taken prior to examination
    e) Communication
    f) Feelings during the examination
    g) Factors contributing to make intimate examination a negative or positive experience.
    h) Effects of experience
    i) Improvements or changes needed

Table 4.2.1: Sociodemographic Profile

Characteristic	Participant A	Participant B	Participant C	Participant D	Participant E
Age	29	28	30	23	26

Level of Education	Post-graduation	Post-graduation	Post-graduation and above	Post-graduation and above	Post-graduation and above
Income Status	Income is higher than outgoings	Income is higher than outgoings	Income is equal to outgoings	Income is lower than outgoings	Income is equal to outgoings
Marital Status	Married	Unmarried	Married	Unmarried	Married
Occupation	Homemaker	Student	Student	Student	Employed-full time
Previous Pregnancy	Yes	No	Yes	No	No
Number of children	1	Not applicable	2	Not applicable	Nil

Table 4.2.2: Details of Intimate Examination Underwent

Characteristic	**Participant A**	**Participant B**	**Participant C**	**Participant D**	**Participant E**
Reason for visiting Hospital	Pregnancy-related	Breast-related	Pregnancy related	Allergy	Breast-related

Kind of examination underwent	Pelvic	Breast	Pelvic	Genital	Breast
Number of examinations underwent	14	4	4 or above	1	1
Gender of the doctor examined	Male and Female	Male and Female	Male and Female	Female	Male
Type of hospital	Government	Private	Private	Government	Private

4.2.3. Themes Identified

a) Attitude towards the examination

Participant A has fear and discomfort prior to the examination. Participant B was not feared of the examination, but have fear whether a pathological medical condition will be diagnosed.

Participant C: *"I felt very anxious and my legs are shivering because of fear."*

Participant D was very nervous before the examination.

Participant E: "As I explained about the breast pain, the doctor said that he needs to examine the breasts. I expect a very supportive environment but I didn't get that. My partner is not allowed inside which adds up the tension."

Based on the responses of the participants, the responses indicate that women's experiences with intimate examinations can vary in terms of fear, discomfort, anxiety, and nervousness. The specific themes that emerged from the participants' responses are **fear and discomfort** (participant A expressed fear and discomfort prior to the

examination, suggesting that some women may experience anxiety or uneasiness about intimate examinations), **fear of diagnosis** (participant B mentioned fear not about the examination itself, but rather about the possibility of a pathological medical condition being diagnosed. This fear indicates concerns about potential health issues and the emotional impact of receiving such a diagnosis), **anxiety and physical symptoms** (participant C reported feeling very anxious, to the extent that their legs were shivering. This highlights the emotional and physiological effects that anxiety can have on women prior to intimate examinations), **nervousness** (participant D was described as being very nervous before the examination. This suggests that some women may experience heightened nervousness in anticipation of the examination, potentially due to concerns about the procedure or the potential outcomes) and **lack of supportive environment** (participant E's response highlighted the importance of a supportive environment during intimate examinations. They expressed disappointment that their expectations of a supportive environment were not met, particularly regarding the absence of their partner during the examination. This finding suggests that the presence or absence of support can significantly influence a woman's experience).

b) Privacy and dignity

In case of Participant A, privacy was not maintained. There were no curtains to separate the patient from the patient in the next bed. Participant B has a different experience. She was in a closed room but the presence of medical students led her to feel that the privacy was not properly maintained.

Participant C: "*The first examination failed to keep the dignity and privacy due to presence of a lot of medical professionals in the room whereas the second one was done with dignity and privacy as doctor was only present at that time.*"

Participant D*: "Even though curtains are there, it is possible for anyone to come inside the space when the examination was going on. So, I am always thinking whether someone will come inside."*

Participant E: *"When the examination was going on, other patients are being consulted by another doctor in the same room. A properly closed space was not there in the room."*

Based on the participants' responses regarding privacy and dignity during intimate examinations, it indicates that there are instances where privacy and dignity were not adequately maintained. The specific themes that emerged from the participants' replies are **lack of physical privacy** (participant A mentioned that privacy was not maintained due to the absence of curtains to separate patients in the same room. This lack of physical privacy can be distressing for women undergoing intimate examinations, as it exposes them to the presence and potentially intrusive observations of others), **presence of medical students** (participant B reported feeling that privacy was compromised due to the presence of medical students during the examination. This suggests that the inclusion of additional individuals in the examination room can create a sense of vulnerability and discomfort for women, even if the room itself provides physical privacy), **number of medical professionals** (participant C noted that the first examination failed to maintain dignity and privacy due to the presence of multiple medical professionals in the room. However, the second examination, which involved only the doctor, was described as being conducted with dignity and privacy. This finding suggests that the number of people present during the examination can impact a woman's perception of privacy and dignity), **concerns about unauthorized access** (participant D expressed concerns about someone potentially entering the space despite the presence of curtains. This apprehension indicates that even if physical privacy measures are in place, women may still experience anxiety or worry about the possibility of unauthorized individuals entering the examination area) and **shared spaces** (participant E mentioned that during the examination, other patients were being consulted by another doctor in the same room, indicating a lack of a properly closed space. This finding highlights the importance of providing women with dedicated and private examination areas to ensure their privacy and dignity).

c) Healthcare provider's approach

Participant A: *"While she was inserting the speculum and hands at the same time, I felt so much pain and I leaned backwards and due to the pain, a small sound came from my mouth, similar to a cry. At that instant, she angrily pulls out her hands and speculum in a hurry and stands beside me by holding her hands tight. Then she said that she will only do the examination if I lay still in an indignant way. I don't know what to say or do…(cries). I am very much upset because of her attitude towards me. After some time,*

I told her to examine me and I said I will tolerate the pain. Then she started examining me again with that angriness. I somehow managed to tolerate the pain while she was inserting the speculum."

Participant B said that they are giving information prior to the examination. But they are not explaining about the need for doing more than two examinations.

Participant C: *"The empathetic approach from the doctor makes me confident and comfortable during the examination and it helps me to cope with the situation."*

Participant D experienced an unsupportive attitude from the doctor. He was being silent throughout the examination. When the participant tries to ask him doubts, the doctor was only nodding the head and humming. He was not interested in communicating with the participant.

Participant E also felt the doctor is not providing relevant information regarding the procedure.

Based on the participants' responses regarding healthcare providers' approach during intimate examinations, the responses indicate a wide range of experiences, varying from empathetic and supportive approaches to instances of insensitive and unsatisfactory interactions. The specific themes that emerged from the participants' replies are **insensitive and indignant attitude** (participant A shared a distressing experience where the healthcare provider responded angrily and impatiently to their expression of pain during the examination. This unsympathetic approach created feelings of upset and distress for the participant, further highlighting the importance of a compassionate and understanding demeanor from healthcare providers), **lack of adequate information and communication** (participant B mentioned that healthcare providers provide information prior to the examination but fail to explain the need for conducting more than two examinations. This lack of clarity and communication can leave patients feeling uninformed and uncertain about the procedures being performed, which may lead to increased anxiety and discomfort, participant D experienced an unsupportive attitude from the doctor, who remained silent throughout the examination and showed no interest in communicating or addressing the participant's concerns. This lack of communication can lead to a sense

of disconnect and frustration, as patients may have questions or doubts that are left unanswered and participant E felt that the doctor did not provide relevant information about the procedure. Clear and comprehensive explanations about the examination process, including what to expect and any potential discomfort, are essential for women to feel informed and empowered during intimate examinations) and **empathetic approach** (participant C highlighted the positive impact of an empathetic approach from the doctor. This approach instilled confidence and comfort in the participant during the examination, helping them cope with the situation more effectively. Empathy and understanding from healthcare providers can significantly improve the overall experience for women undergoing intimate examinations).

d) Consent taken prior to examination

For participant A, consent was not taken prior to the examination nor when the medical student came for the examination.

"She told me to make my legs up and she started inserting a speculum into my vagina followed by inserting her fingers."

"Another male medical student again came to me to perform the pelvic examination. He didn't ask me for my consent and didn't even explain to me regarding the need for such an examination and didn't try to support me even for a second. He did the examination and went away."

Participant B: *"Consent was taken when the main doctor was examining, but when a group of medical students unexpectedly entered into the room, I was not informed prior or the consent was not taken."*

Participant C: *"A prior consent was taken for conducting the examination."*

A proper informed consent was not taken prior to the examination for Participant D and E.

Based on the participants' responses regarding consent prior to intimate examinations, the responses indicate that there were instances where informed consent was not properly obtained. The specific themes that emerged from the participants' replies are **lack of consent** (participant A, participant D and participant E mentioned that consent

was not taken prior to the examination or when medical students were involved. This lack of consent violates the principles of patient autonomy and informed decision-making. Participant A further noted that the medical student performed the examination without obtaining consent or providing any explanation), **unexpected entry of medical students** (participant B highlighted a situation where a group of medical students entered the room unexpectedly during the examination without prior notification or obtaining consent. This lack of communication and consent infringes upon the patient's right to privacy and informed involvement in their healthcare). Participant C reported that **proper consent** was obtained prior to the examination, indicating a positive experience where the healthcare provider respected the patient's autonomy and ensured informed decision-making.

e) Communication

Participant A: *"I know the importance of pelvic examination for a pregnant woman and there is nothing to replace the examination. But they are not even trying to understand our feelings. It is my first pelvic examination experience. If they try to provide me with some information like 'it will be painful' or 'it will be uncomfortable' might help me to get prepared for the examination."*

"When examinations are conducted by the medical students in the general ward, one of the female medical students explained to me before the examination, how it will be happening. She drew the picture in a book and explained it to me when I asked her doubts. In that examination, I didn't suffer much."

Participant C has a more supportive attitude from the doctor.

For participants B, D and E, a proper communication from the doctor is not received.

Based on the participants' responses regarding communication during intimate examinations, the data indicate a range of experiences, including both positive and negative interactions. The specific themes that emerged from the participants' replies are **importance of communication** (participant A highlighted the importance of effective communication during intimate examinations, particularly in providing patients with information and preparing them for the potential discomfort or pain involved. This participant expressed a desire for healthcare providers to understand and

acknowledge patients' feelings and to provide relevant information to help them cope with the examination), **positive communication experience** (participant A also mentioned a positive experience where a female medical student explained the examination process, answered their questions, and provided visual aids. This communication approach helped alleviate anxiety and resulted in a more comfortable examination), **supportive attitude** (participant C reported a more supportive attitude from the doctor, indicating that effective communication can create a supportive environment during intimate examinations. The participant likely felt more at ease and comfortable due to the doctor's communication style) and **lack of communication** (participants B, D and E mentioned a lack of proper communication from the doctor, indicating that they did not receive the necessary information or explanations about the examination. This lack of communication can contribute to increased anxiety, discomfort, and a sense of uncertainty for patients).

f) Feelings during the examination

Participant A: "*The same female doctor was examining another woman and told her that ' Don't you feel pain while lying with your husband?', 'you have to bear this'. After hearing all this, I felt very disappointed and feared whether there is another examination for me today."*

Participant B: *"When the doctor is conducting breast examination for more than two times without a proper explanation, I felt confused, whether this examination is necessary."*

Participant C felt more supportive because of the gentle behavior of doctor and nurse.

Participant D felt nothing during the examination.

Participant E: *"Due to lack of privacy and informed consent, I was not able to be comfortable throughout the examination."*

Based on the participants' responses regarding their feelings during intimate examinations, the responses indicate a range of emotional experiences. The specific themes that emerged from the participants' replies are **disappointment and fear** (participant A expressed disappointment and fear after overhearing the doctor's

comments to another patient. This incident contributed to feelings of discomfort and concern about their own examination, indicating the impact of negative comments and insensitive remarks on patient emotions), **confusion** (participant B mentioned feeling confused when the doctor conducted breast examinations multiple times without providing a proper explanation. This confusion highlights the importance of clear communication from healthcare providers to help patients understand the necessity and purpose of the examinations), **supportive experience** (participant C had a more supportive experience due to the gentle behavior of the doctor and nurse. This positive experience demonstrates the impact of healthcare providers' demeanor and empathetic approach on patient comfort and emotional well-being), **neutral experience** (participant D reported feeling nothing during the examination, suggesting a lack of strong emotional response. It is important to note that individual experiences and emotional responses can vary) and **discomfort due to lack of privacy and informed consent** (participant E expressed discomfort throughout the examination due to the lack of privacy and informed consent. This highlights the negative impact of insufficient attention to privacy and communication on patient comfort and trust).

g) Factors contributing to make intimate examination a negative or positive experience.

Participant A: "*The labour room where I was admitted has the atmosphere of a jail. Not even my mother is allowed to speak to me. Mobile phones are also restricted. There is nobody near me even to share my difficulties. Nobody is allowed to visit me due the COVID protocols. I know it is because of the pandemic, but the whole day when I am lying in the labour room, I am crying inside for what happened to me."*

Participant B considers that a proper explanation regarding the examination by the doctor or nurse will contribute to a more positive experience.

Participant C said that the presence of so many medical students other than doctors and arrogant behavior from the doctor make the intimate examination a negative impact for the patients.

Participant D considers the attitude of doctors will be responsible for making the examination a negative or positive experience.

Participant E*: "The bystander being with the patient and the doctor being a female will create a more positive environment for me. Giving proper details regarding the reason behind the examination and the findings will also make the examination better."*

Based on the participants' responses regarding factors contributing to making intimate examinations a negative or positive experience, the responses indicate several key factors. The specific themes that emerged from the participants' replies are **restricted environment and lack of support** (participant A highlighted the negative impact of a restricted environment, such as being in a labour room without the ability to communicate with loved ones or share difficulties), **proper explanation and communication** (participant B emphasized the importance of healthcare providers providing a proper explanation of the examination. Clear communication about the purpose, process, and expected outcomes of the examination can contribute to a more positive experience for patients), **presence of medical students and attitude of doctors** (participant C mentioned that the presence of multiple medical students and an arrogant behavior from the doctor can contribute to a negative impact on patients during intimate examinations. The presence of additional individuals and a negative attitude from healthcare providers can lead to feelings of discomfort, vulnerability, and diminished trust and participant D highlighted the significance of the attitude of doctors in determining whether the intimate examination is a negative or positive experience. A caring, compassionate, and respectful attitude from healthcare providers can significantly influence patient comfort and overall experience) and **supportive environment and information sharing** (participant E mentioned that a supportive environment, including the presence of a bystander and a female doctor, can contribute to a more positive experience during intimate examinations. Additionally, providing patients with proper details regarding the examination's purpose and findings can enhance the overall experience).

h) Effects of experience

Participant A: "*After the delivery, due to all these experiences, I am always angry towards everyone. I cried every day and I am not in the mood to eat anything. One day I told my mother to give me some poison to end my life. I can't bear my angriness and I am very much distressed about everything. Even now, when I am remembering those*

instances, I have difficulty to share all those. I begin to cry every time I try to remember those experiences"

"As I mentioned earlier, I have a cyst in the ovary. I bought the test results from the hospital post-delivery after 8 months. Now it is time for another scan, but I am scared to do the scan fearing about the treatment process ahead."

Participant B overcame fear of such kind of examinations.

Participant C: The examination during pregnancy caused me pain and made more discomfort during the time of delivery.

Participant D become more nervous and she will not undergo this kind of examination in the future.

Participant E felt that health setting is not providing a safe space for patients. It makes her anxious to seek treatment in future.

Based on the participants' responses regarding the effects of their experiences during intimate examinations, the findings indicate several emotional and psychological impacts. The specific themes that emerged from the participants' replies are psychological distress and anger (participant A expressed significant psychological distress, including feelings of anger, sadness, loss of appetite, and even contemplating self-harm. They also mentioned ongoing distress when recalling those experiences. This highlights the profound emotional impact that negative experiences during intimate examinations can have on individuals, leading to long-lasting psychological distress), **fear and apprehension** (participant A also mentioned feeling fearful about future medical procedures, such as undergoing a scan for an ovarian cyst. Negative experiences during intimate examinations can create fear and apprehension regarding future medical care, making individuals hesitant or anxious about seeking further treatment), **overcoming fear** (participant B reported overcoming the fear associated with such examinations. This suggests that positive experiences or a change in perception can help individuals overcome initial fears and build resilience), **pain and discomfort** (participant C highlighted the experience of pain and increased discomfort during pregnancy and delivery due to previous examinations. Negative experiences during intimate examinations can contribute to physical discomfort and complications

during subsequent stages of medical care) and **anxiety and loss of trust** (participant E expressed anxiety and a loss of trust in healthcare settings. Negative experiences can lead to a lack of confidence in healthcare providers and settings, causing individuals to feel anxious or apprehensive about seeking future medical care).

i) Improvements or changes needed

Participant A: *"My experience during the examination procedure is very much distressing. The major reason which contributes to the distressing experience was the attitude of the doctor. She was not understanding, she was not supportive and she was very rude to me. Therefore, more than privacy, I felt the attitude of the doctor needs to be changed to a gentler behavior."*

Participant B: *"For me, I felt so much discomfort when the medical students enter into the examination room when I am undressed. There is no prior information from the doctor. If they took permission from me regarding the medical students' presence, I will be prepared and it will not cause me this much discomfort."*

Participant C: *"During some treatment or diagnosis intimate examinations are compulsory, so we cannot replace the examination, rather than the way of approach of the practitioner should be more empathetic, sharing and should clarify the concerns of the patient."*

Participant D: *"The medical professionals should obtain consent, should provide privacy and should make the patient feel safe."*

Participant E: *"Informed consent should become mandatory before the examination takes place."*

Based on the participants' responses regarding improvements in intimate examinations, the findings indicate several key areas for improvement. The specific themes that emerged from the participants' replies are **attitude of healthcare providers** (participant A emphasized the importance of improving the attitude of healthcare providers during intimate examinations. They highlighted the need for a gentler and more understanding behavior from doctors, as a negative attitude can contribute to distressing experiences for patients), **communication and consent** (participant B mentioned the importance of

prior information and obtaining permission from patients regarding the presence of medical students during examinations. Clear communication and obtaining consent can help patients feel more prepared and alleviate discomfort), **empathetic approach** (participant C highlighted the need for healthcare providers to approach intimate examinations with empathy, sharing information, and addressing patient concerns. An empathetic approach can contribute to a more positive and supportive experience for patients), **privacy and safety** (participant D emphasized the importance of providing privacy and creating a safe environment for patients during intimate examinations. Privacy, both physical and emotional, is crucial for patients to feel comfortable and respected) and **informed consent** (participant E stressed the importance of obtaining informed consent before conducting intimate examinations. Informed consent ensures that patients are fully aware of the procedure, potential risks, and alternatives, allowing them to make informed decisions about their healthcare).

4.3. Quantitative Data Analysis

This section presents the results of analysis done using the quantitative data collected from respondents. The data analysed using descriptive statistics for frequencies. The data thus derived is presented as diagrams and tables in this chapter.

The section is divided into following sub-sections,

- Sociodemographic profile of respondents
- Details of Intimate Examination of Respondents
- Women's feeling during intimate examination
- Attitude of women towards intimate examination
- Women's perceptions of their intimate examination experiences.

Personal Profile of Respondents

The demographic profile of the respondents includes age, sex, level of education, income status, marital status, occupation, previous pregnancy and number of children.

Fig. 1: Age of the Respondents

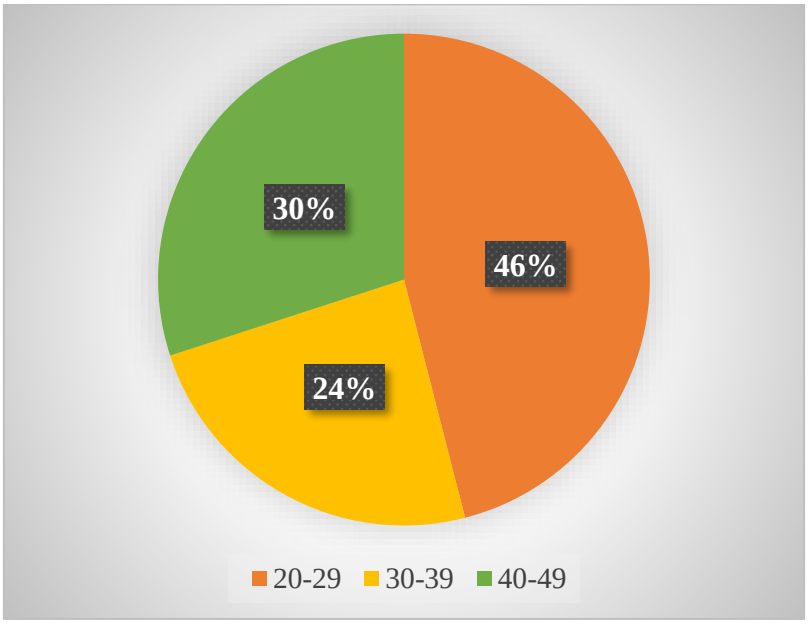

Fig. 1 shows the age of the respondents. Among the respondents 46% belonged to the age group of 20 and 29 years, 30% belonged to the age group of 40 and 49 years and 24% belonged to the age group of 30 and 39 years.

Fig. 2: Sex of the Respondents

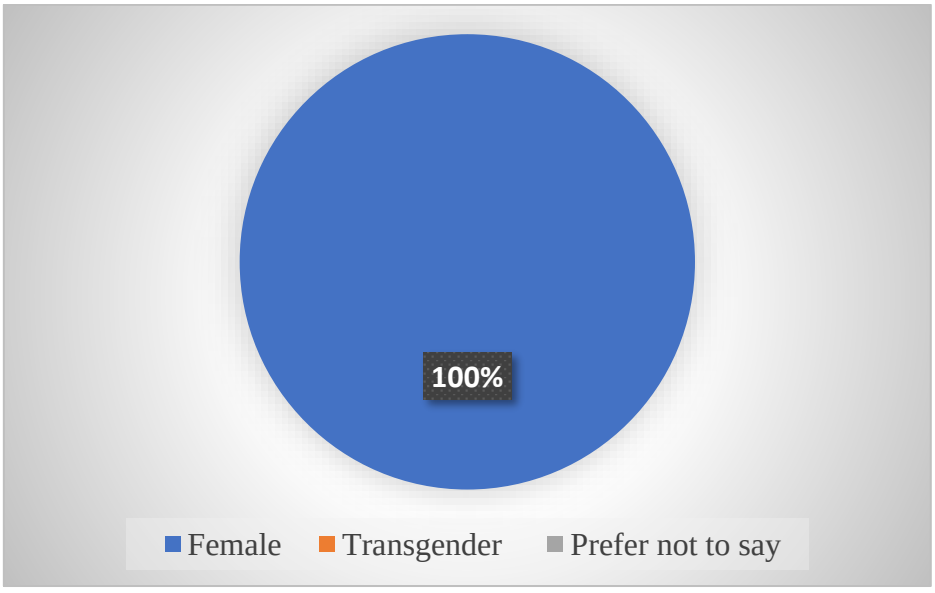

Fig. 2 shows the sex of the participants. As the study concentrated on women, all the respondents were females. No responses were there for the option transgender and prefer not to say.

Fig. 3: Level of Education of the Respondents

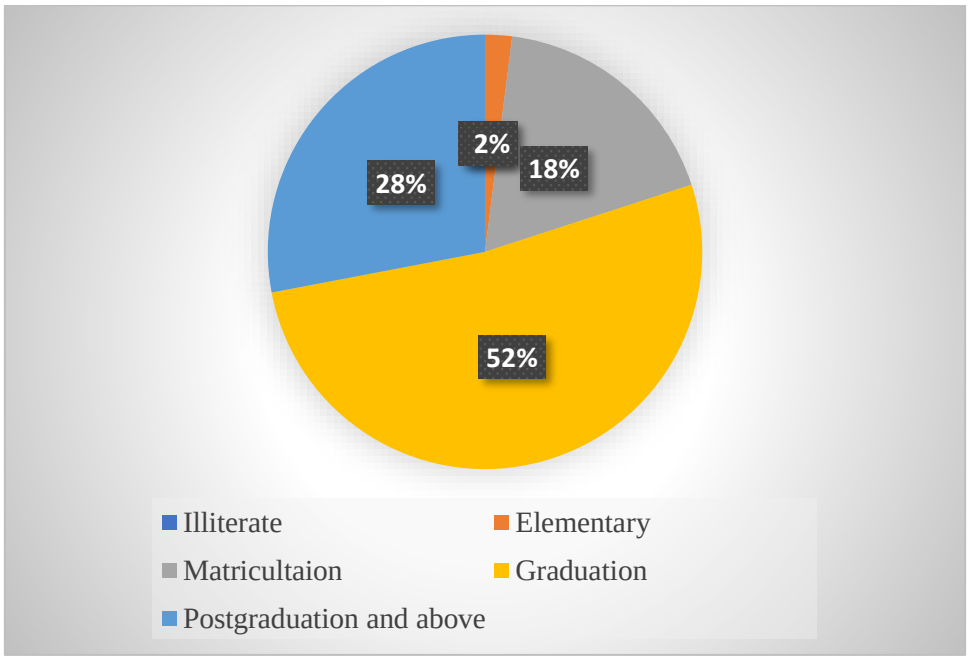

Fig. 3 shows the level of education of the respondents. In this study 52% holding graduation, 28% holding post-graduation and above, 18% holding higher secondary and 2% holding matriculation as their level of education. No responses were there from women with level of education illiterate and elementary.

Fig. 4: Income Status of the Respondents

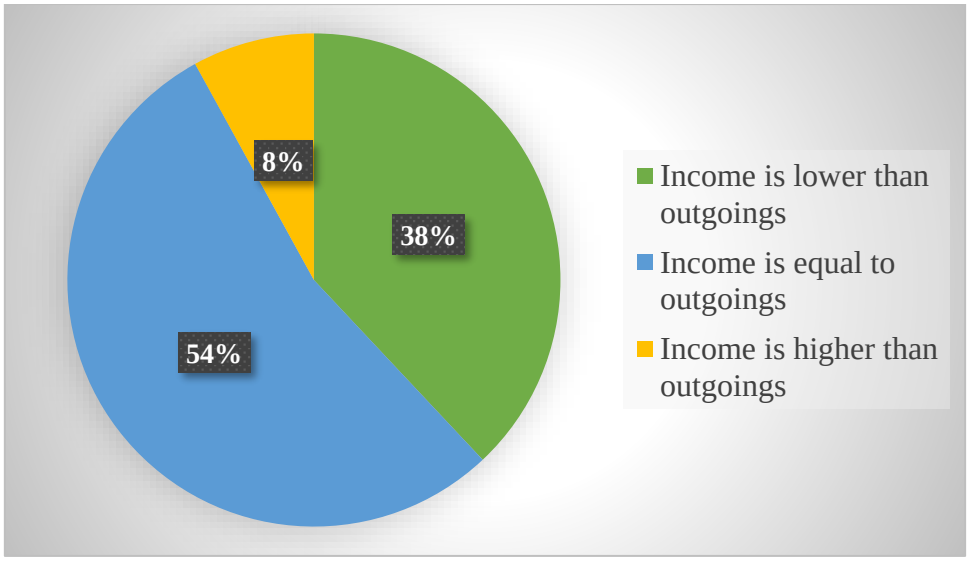

Fig. 4 shows the income status of the respondents. About 54% respondents have income equal to outgoings, 38% have income lower than outgoings and 8% have income higher than outgoings.

Fig. 5: Marital Status of the Respondents

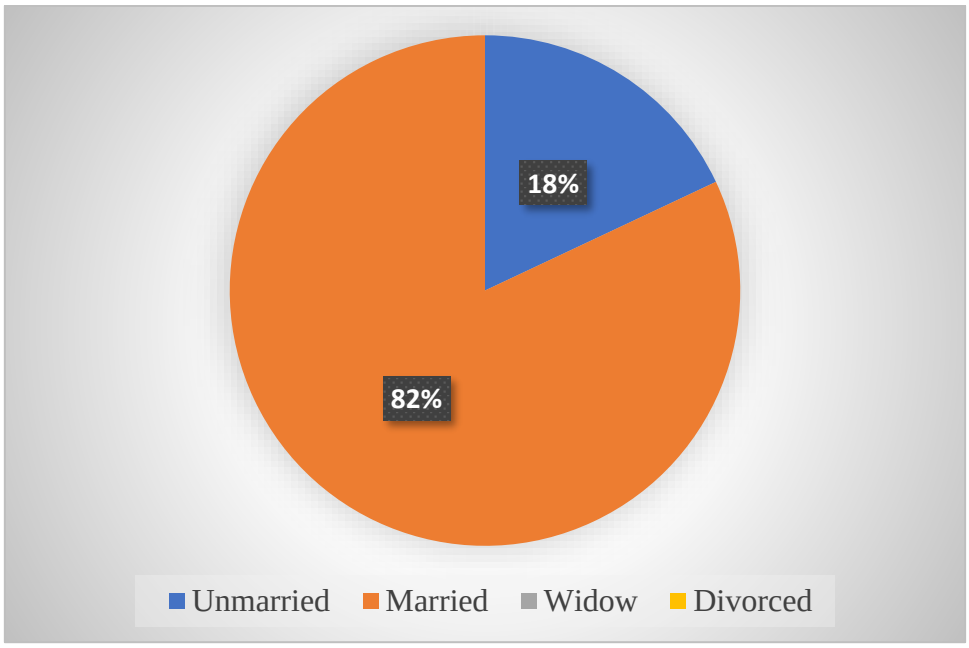

Fig. 5 shows the marital status of the respondents. Of the total respondents, 82% are married and 18% are unmarried. No responses from the category widow and divorced.

Fig. 6: Occupation of the Respondents

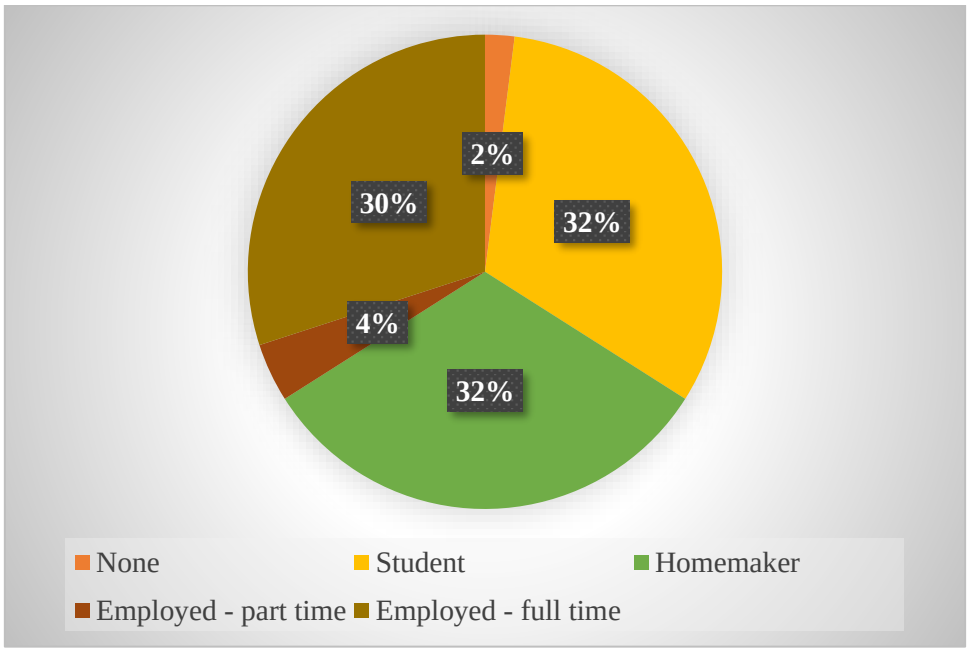

Fig. 6 shows the occupation of the respondents. In this study, 32% are homemakers, another 32% are students, 30% are employed full – time, 4% employed part-time and 2% are unemployed.

Fig. 7: Previous Pregnancy

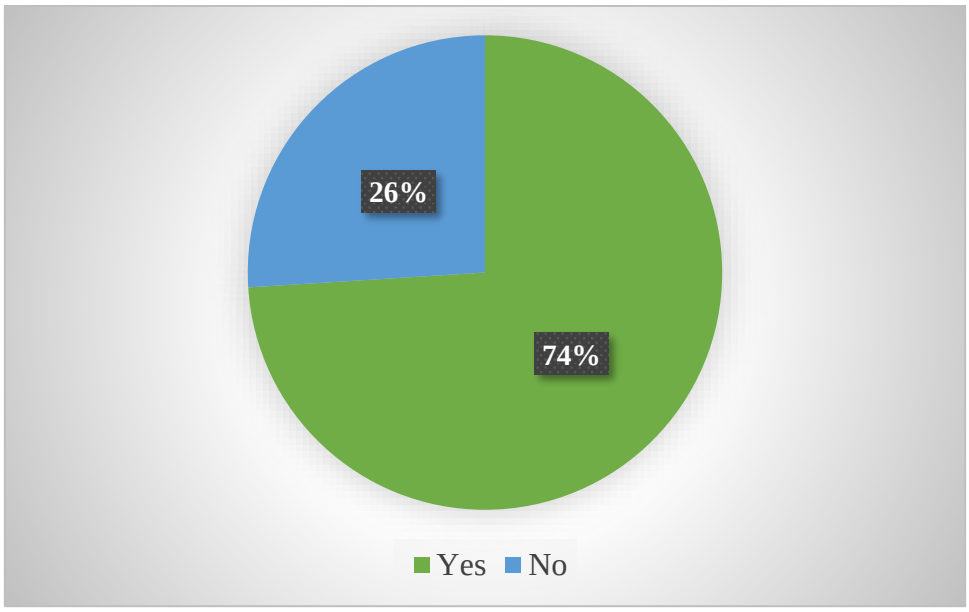

Fig. 7 shows the previous pregnancy status of the respondents. Of the total respondents, 74% had previous pregnancy and 26% didn't have previous pregnancy.

Fig. 8: Number of Children of the Respondents (if any)

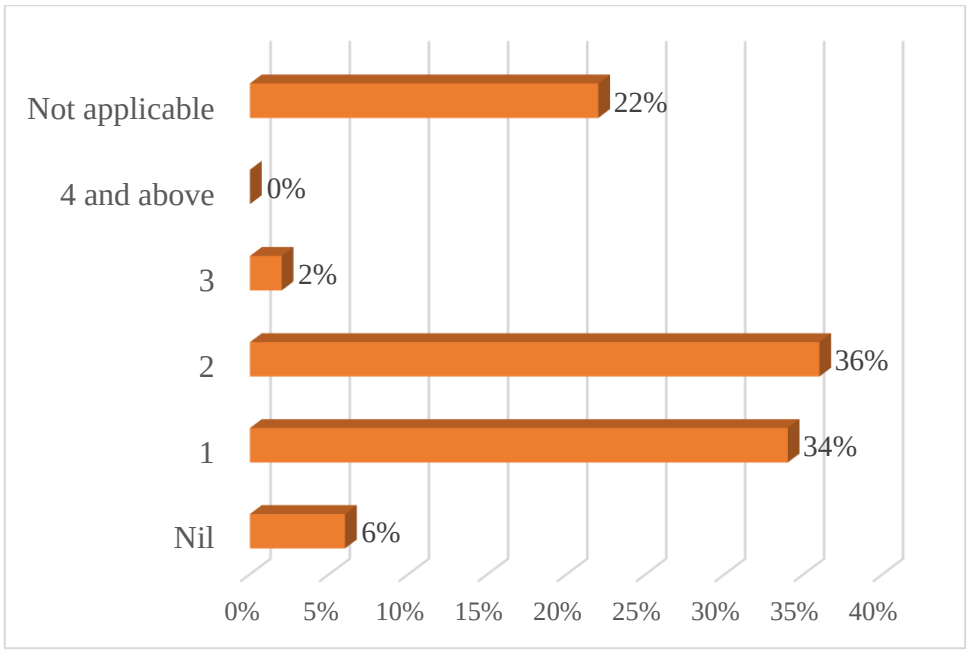

Fig. 8 shows the number of children the respondents have. Of the total respondents, 36% have two children, 34% have one child and 2% have 3 children. No responses from the category 'number of children 4 and above.' 22% of respondents belong to not applicable category which means they responded as no previous pregnancy and 6% belong to nil category, which means they have no children after being pregnant (due to abortion).

Details of Intimate Examinations of the Respondents

Fig. 9: Reason for visiting Hospital/Clinic

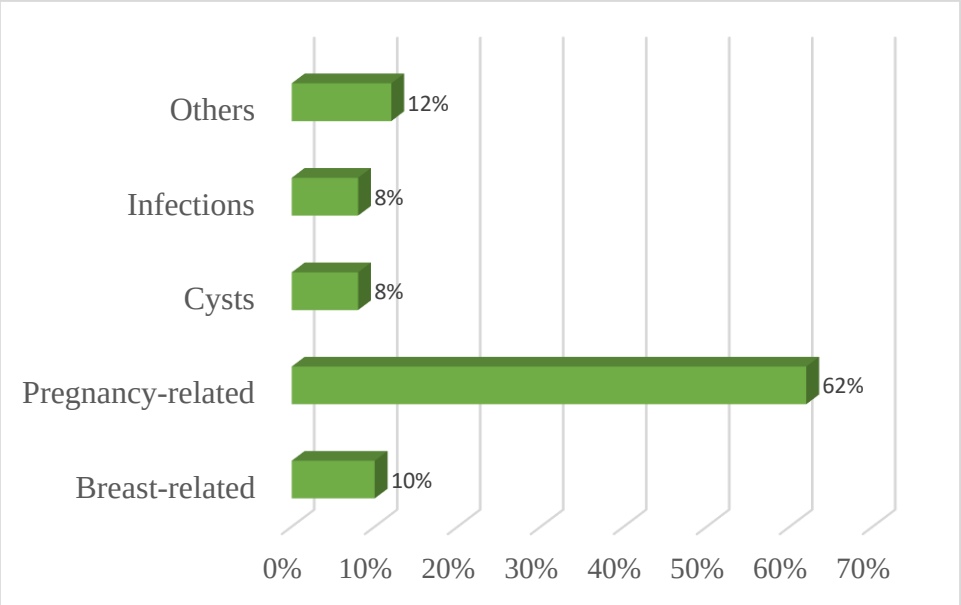

Fig. 9 shows the respondents' reason for visiting the hospital or clinic for undergoing intimate examination. Of the total respondents, 62% have visited the hospital for pregnancy related purpose, 10% for breast related (pain and lump in breasts), 8% have cysts as a reason and another 8% have infections as a reason for visiting the hospital. 12% of the respondents responded 'others' as reason for visiting the hospital.

Fig. 10: Kind of Intimate Examination Underwent

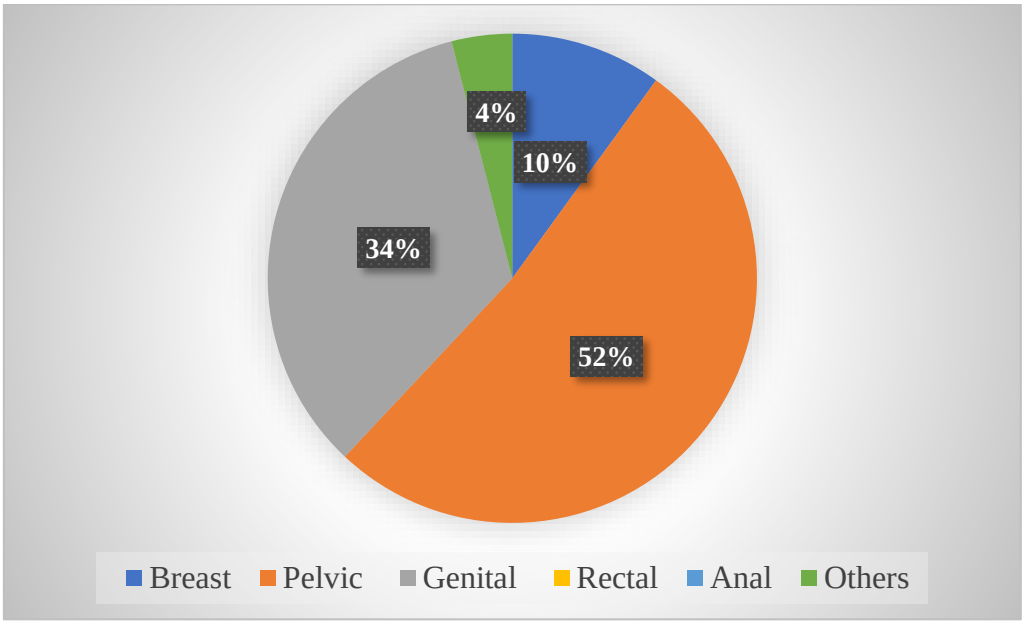

Fig. 10 shows the kind of examination underwent by the respondents. In this study, 52% underwent pelvic examination (internal structures including fallopian tubes, ovaries, uterus, cervix, bladder, urethra, vagina), 34% underwent genital examination (external genital structures including mons pubia, labia majora, labia minora and clitoris), 10% underwent breast examination and 4% underwent others. No responses were recorded for rectal and anal examination.

Fig. 11: Number of Intimate Examinations Underwent

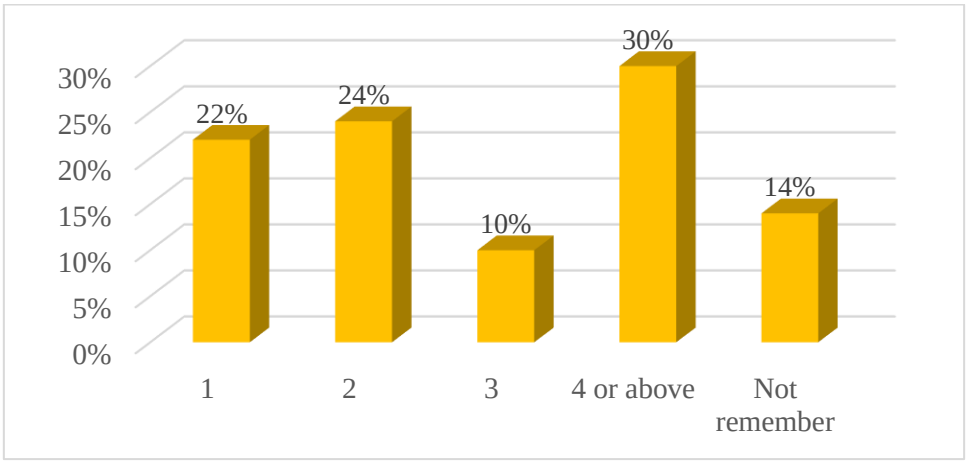

Fig. 11 shows the number of examinations underwent by the respondents. Of the total respondents, 30% underwent 4 or above, 24% underwent two examinations, 22%

underwent one examination, 14% not remember how many examinations they underwent and 10% underwent three examinations.

Fig. 12: Gender of the Doctor Examined

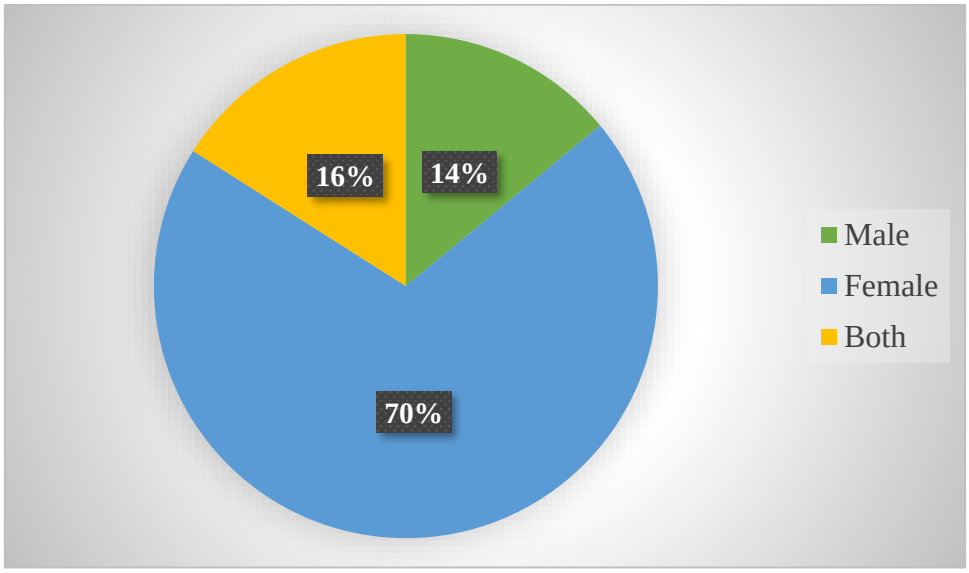

Fig. 12 shows the gender of the doctor examined by the respondents. Of the total respondents, 70% were examined by female, 16% were examined by both (male and female) and 14% were examined by male.

Fig. 13: Type of Hospital Visited

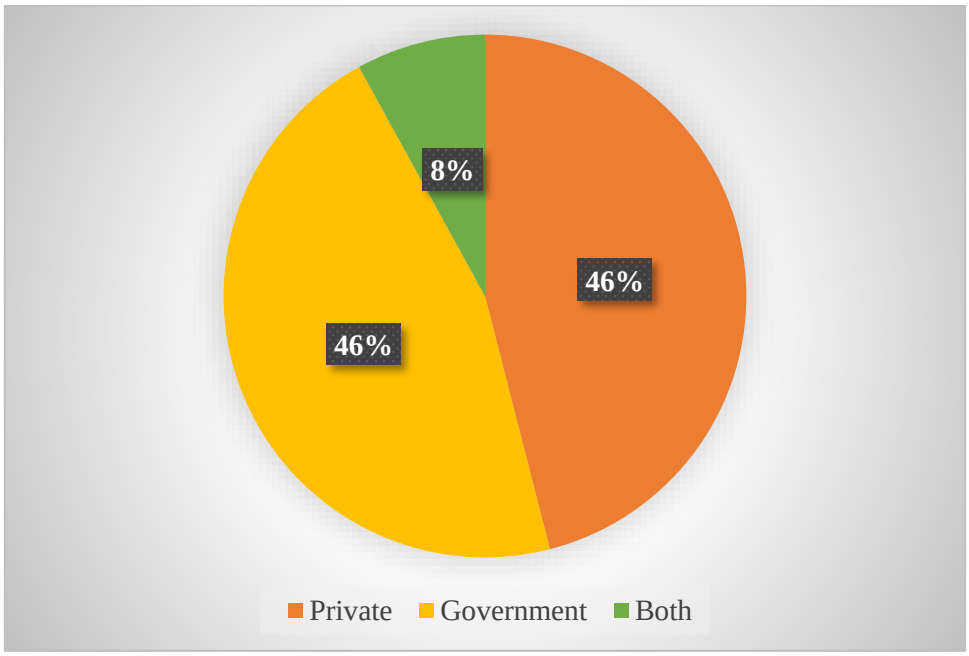

Fig. 13 shows the type of hospital visited. In this study, 46% visited private hospital, another 46% visited government hospital and 8% visited both (private and government).

Objective 1: To investigate women's feelings during intimate examination

Fig. 14, Statement 1: I feel anxious about my health.

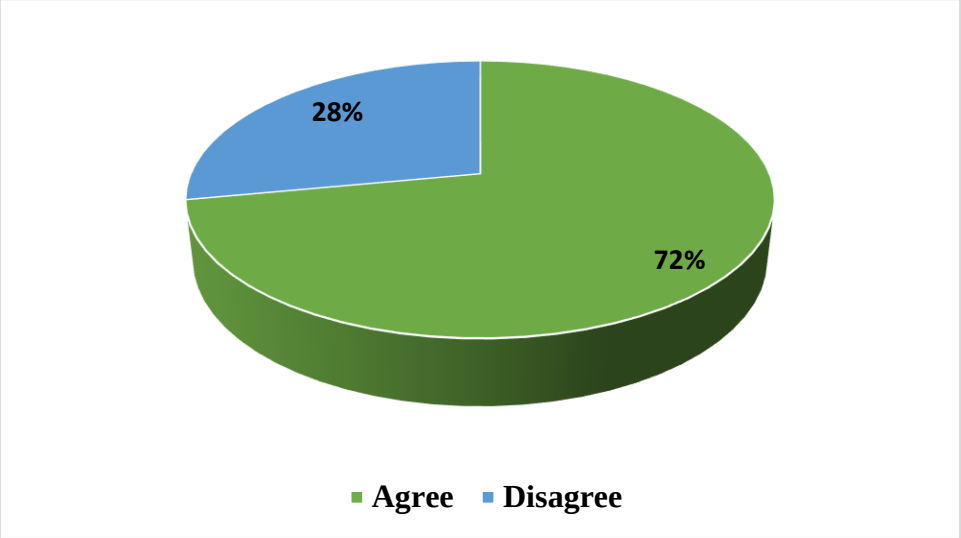

Fig. 14 shows the response of women towards the statement 'I feel anxious about my health'. Of the total respondents, 72% agreed and 28% disagreed to the statement.

Fig. 15, Statement 2: I am embarrassed of being undressed before a stranger.

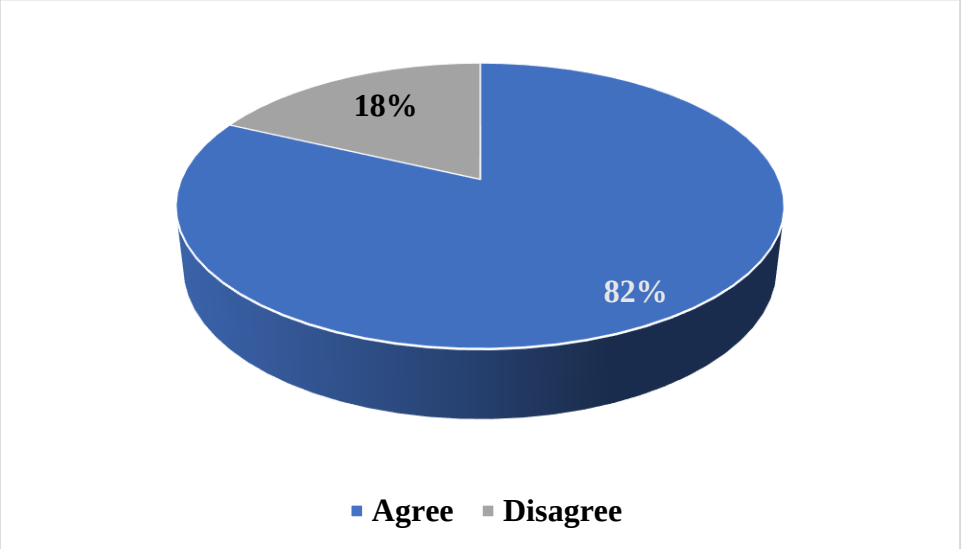

Fig. 15 shows the response of women towards the statement 'I am embarrassed of being undressed before a stranger.' Of the total respondents, 82% agreed and 18% disagreed to the statement.

Fig. 16, Statement 3: I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed).

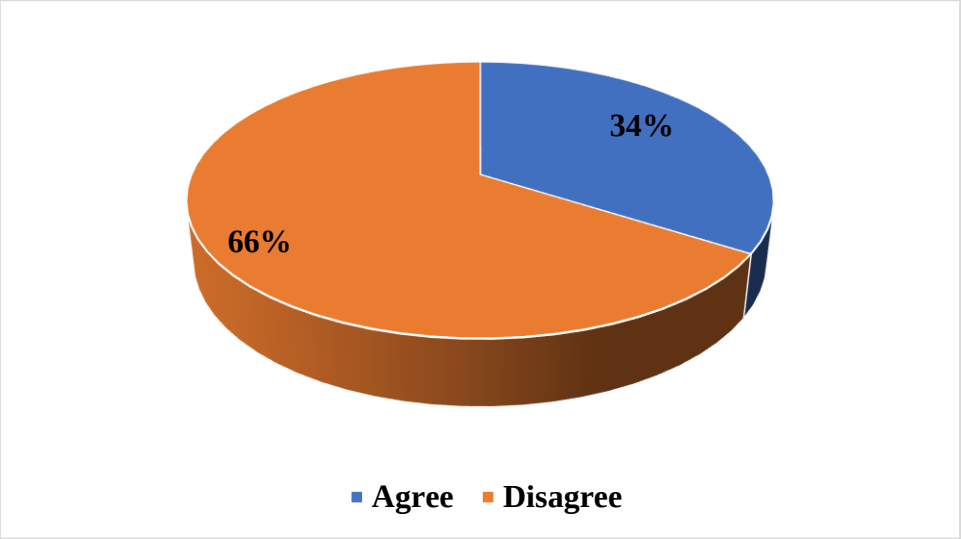

Fig. 16 shows the response of women towards the statement 'I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed).' Of the total respondents, 34% agreed and 66% disagreed to the statement.

Fig. 17, Statement 4: I am worried about cleanliness or fear about equipment being unsterile.

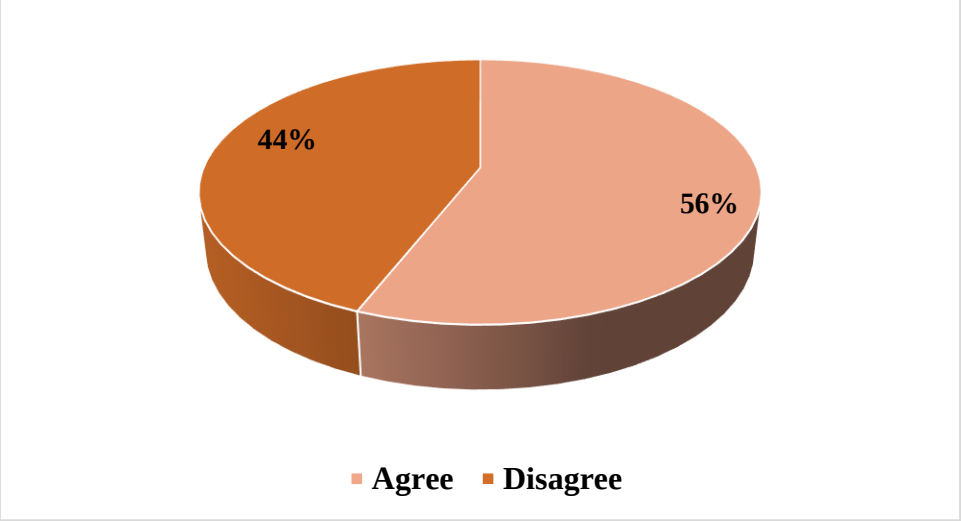

Fig. 17 shows the response of women towards the statement 'I am worried about cleanliness or fear about equipment being unsterile.' Of the total respondents, 56% agreed and 44% disagreed to the statement.

Fig. 18, Statement 5: I didn't feel excited

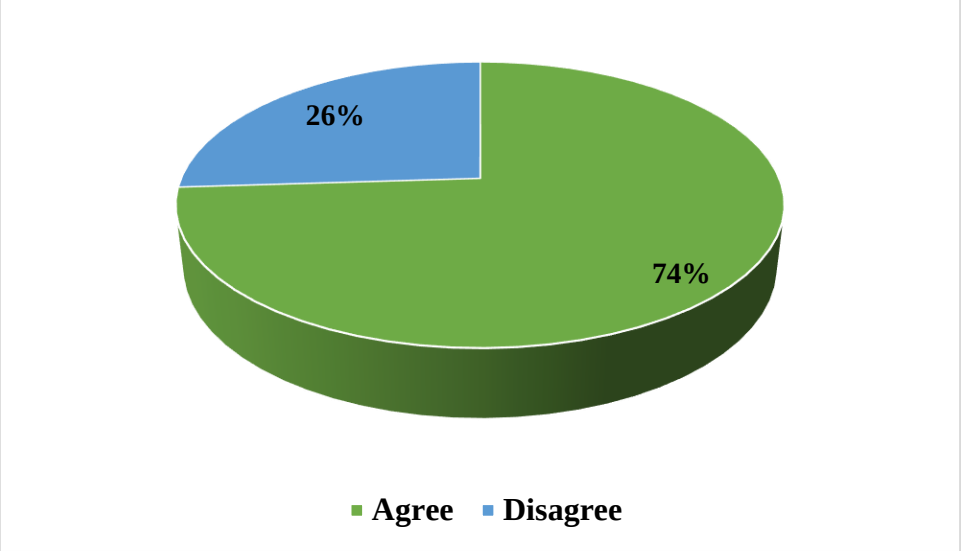

Fig. 18 shows the response of women towards the statement 'I feel excited.' Of the total respondents, 26% agreed and 74% disagreed to the statement.

Fig. 19, Statement 6: I feel anxious about examination not being performed correctly.

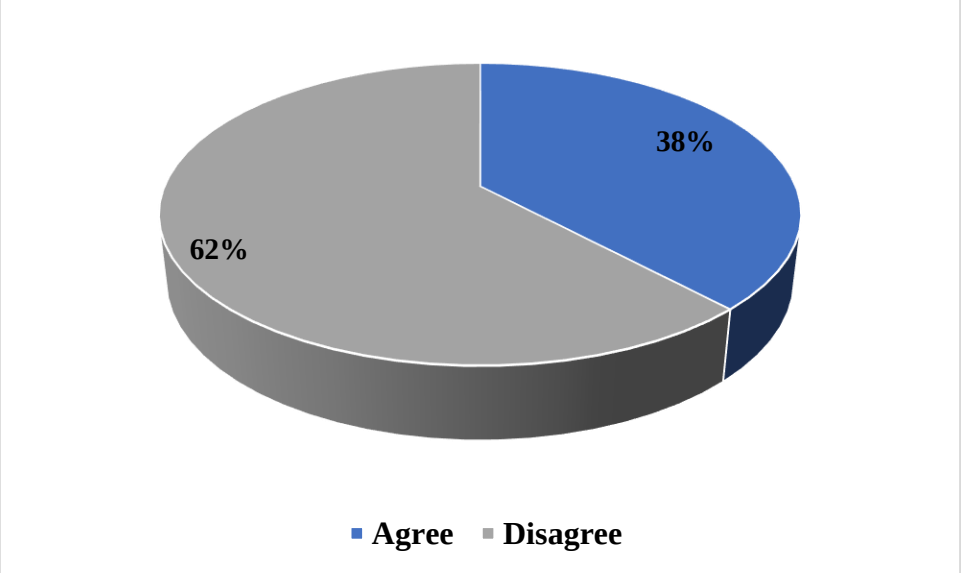

Fig. 19 shows the response of women towards the statement 'I feel anxious about examination not being performed correctly.' Of the total respondents, 38% agreed and 62% disagreed to the statement.

Fig. 20, Statement 7: I did not feel anything

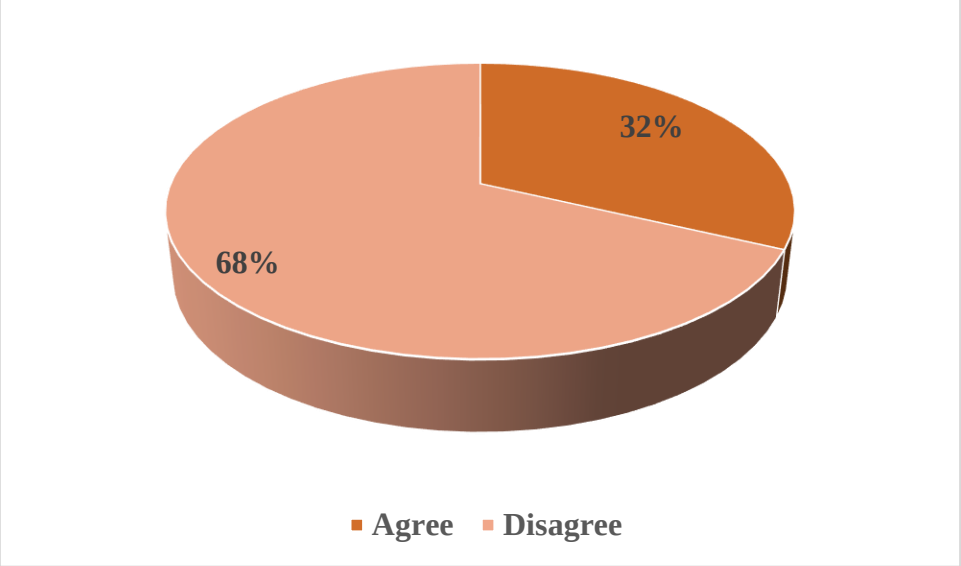

Fig. 20 shows the response of women towards the statement 'I did not feel anything.' Of the total respondents, 32% agreed and 68% disagreed to the statement.

Table 4.3.1: Cross Tabulation 1

Age * I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)					
			I feel fear of discovery of a pathological condition		Total
			Disagree	Agree	
Age	20-29	Count	14	9	23

		% within I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)	42.4%	52.9%	46.0 %
	30-39	Count	6	6	12
		% within I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)	18.2%	35.3%	24.0 %
	40-49	Count	13	2	15
		% within I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)	39.4%	11.8%	30.0 %
Total		Count	33	17	50
		% within I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)	100.0%	100.0%	100. 0%

The above crosstabulation table indicate the distribution of responses related to the fear of the discovery of a pathological condition (fear that a severe illness will be diagnosed) based on different age groups. Overall, the total sample size was 50 respondents. The findings show that fear of the discovery of a pathological condition varies across age groups, with the highest agreement observed among the 20-29 age group (52.9%) and the lowest agreement among the 40-49 age group (11.8%). This suggests that younger individuals may be more concerned about the possibility of being diagnosed with a severe illness compared to older individuals.

Table 4.3.2: Crosstabulation 2

Age * I feel anxious about examination not being performed correctly					
			I feel anxious about examination not being performed correctly		Total
			Disagree	Agree	
Age	20-29	Count	12	11	23
		% within I feel anxious about examination not being performed correctly	38.7%	57.9%	46.0%
	30-39	Count	9	3	12
		% within I feel anxious about examination not being performed correctly	29.0%	15.8%	24.0%
	40-49	Count	10	5	15
		% within I feel anxious about examination not being performed correctly	32.3%	26.3%	30.0%

Total	Count	31	19	50
	% within I feel anxious about examination not being performed correctly	100.0%	100.0%	100.0%

The crosstabulation table indicates the distribution of responses regarding feeling anxious about examinations not being performed correctly across different age groups.

Among respondents aged 20-29, 38.7% disagreed that they feel anxious about examinations not being performed correctly, while 57.9% agreed with this anxiety. A total of 23 respondents were included in this age group. In the age group of 30-39, 29.0% disagreed and 15.8% agreed that they feel anxious about examinations not being performed correctly. This age group consisted of 12 respondents. Among respondents aged 40-49, 32.3% disagreed and 26.3% agreed with feeling anxious about examinations not being performed correctly. This age group included a total of 15 respondents. There is a varying degree of anxiety across age groups regarding the accuracy of examinations. The higher agreement with this anxiety among the 20-29 age group may indicate that younger individuals have heightened concerns about the precision and correctness of medical examinations.

Objective 2: To understand the attitude of women towards intimate examinations.

- **To identify if women have a preference for the doctor's gender**

Fig. 21: Preference for the doctor's gender

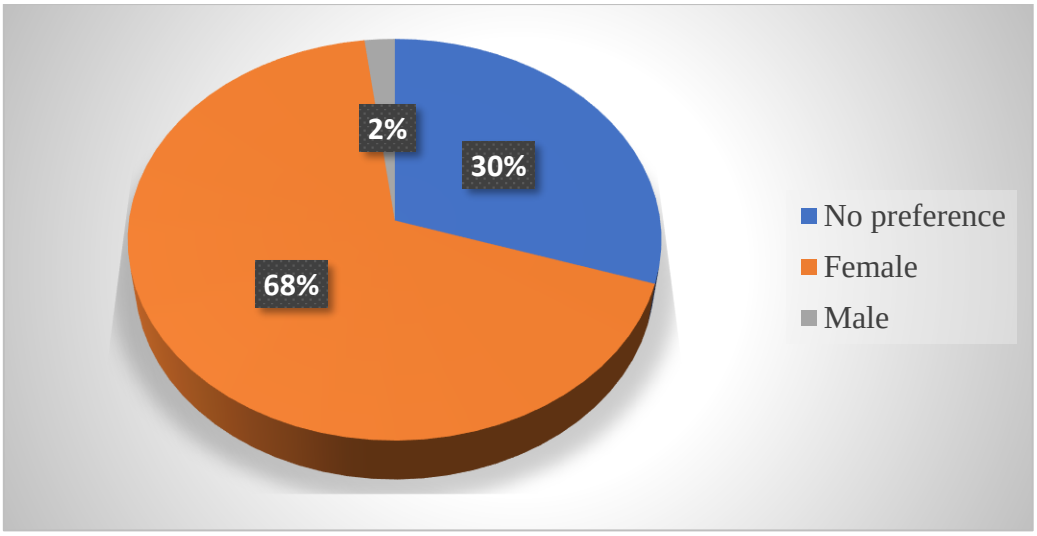

Fig. 21 shows the response of women towards their preference for the doctor's gender. Of the total respondents, 68% preferred for female doctor, 30% have no preference and 2% preferred for male doctor.

- **To understand women's preference of another person being present during the examination.**

Fig. 22: Preference for another person

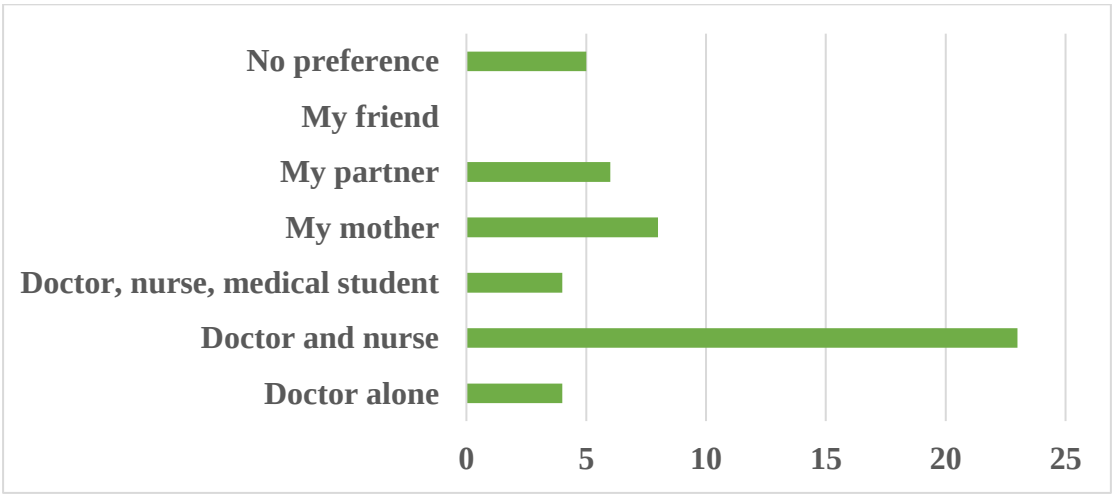

Fig. 22 shows the preference of women for the presence of another person being present during the examination.

- **To understand women's expectations of nurses and doctors during intimate examinations.**

Fig. 23: Expectations of nurses and doctors

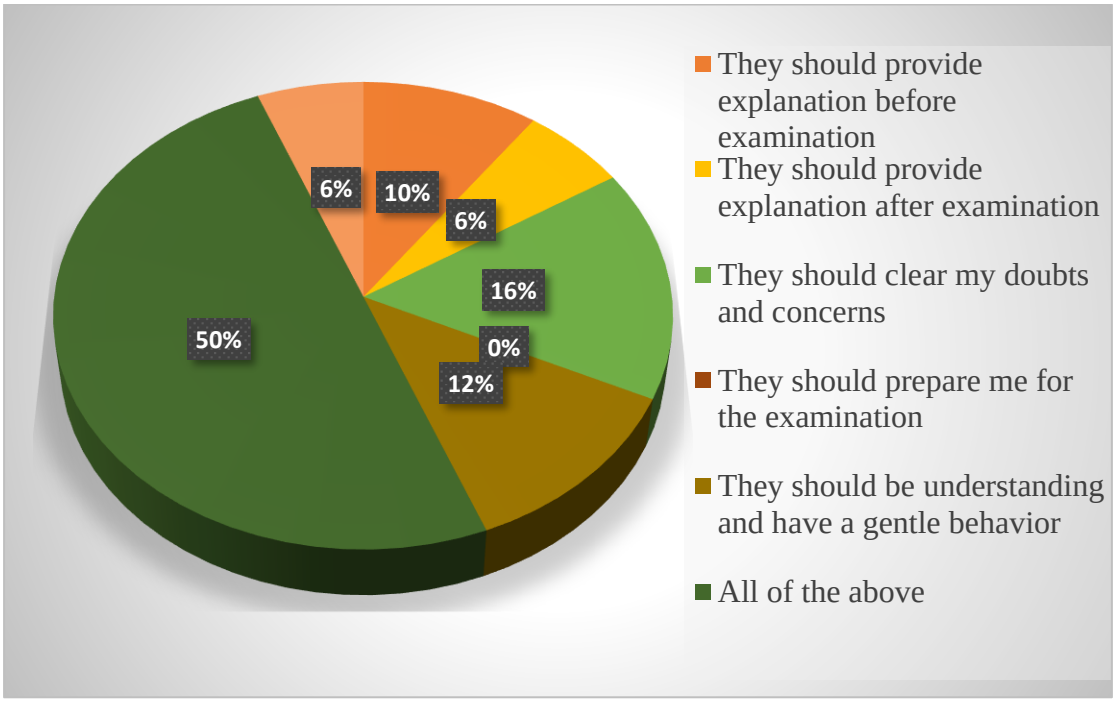

Fig. 23 shows women's expectations of nurses and doctors during intimate examinations. Of the total respondents, 50% expect the doctors or nurses to provide explanation before examination, provide explanation after examination, should be able to clear doubts and concerns, should prepare women for the examination and should be understanding and have a gentle behaviour.

Objective 3: To investigate women's perceptions of their intimate examination experiences.

The findings for the 20-item Likert scale on aspects of the women's intimate examinations are shown in Table 4.3.3.

Table 4.3.3

Sl. No	Statement	Number of responses	Strongly agree	%	Agree	%	Neither agree nor disagree	%	Disagree	%	Strongly disagree	%
1	(a)The staff gave me excellent information about intimate examinations	50	3	**6**	24	**48**	5	**10**	13	**26**	5	**10**
2	(b)I knew I could always refuse an intimate examination	50	5	**10**	12	**24**	8	**16**	23	**46**	2	**4**
3	(c)The staff always asked my permission before performing an intimate examination	50	4	**8**	13	**26**	3	**6**	20	**40**	10	**20**
4	(d)Intimate examinations were	50	2	**4**	22	**44**	12	**24**	13	**26**	1	**2**

	always performed with great sensitivity											
5	(e)The subject of intimate examinations was never properly discussed*	50	6	**12**	28	**56**	7	**14**	6	**12**	3	**6**
6	(f)Intimate examinations were done with dignity	50	3	**6**	26	52	12	**24**	9	**18**	0	**0**
7	(g)I felt that I always gave my consent before an intimate examination was carried out.	50	1	**2**	17	34	7	**14**	21	**42**	4	**8**
8	(h)I always felt well supported during the intimate examination	50	6	**12**	23	46	9	**18**	11	**22**	1	**2**
9	(i)Privacy was always maintained during intimate examinations	50	8	**16**	31	**62**	5	**10**	5	**10**	1	**2**
10	(j)Intimate examinations caused me great embarrassment. *	50	3	**6**	28	54	9	**18**	10	**20**	0	**0**
11	(k)During each intimate examination, I was	50	1	**2**	13	**26**	9	**18**	25	**50**	2	**4**

	always told what was happening											
12	(l)I did not find intimate examinations distressing.	50	3	**6**	23	**46**	8	**16**	16	**32**	0	**0**
13	(m)I felt like I was given too many intimate examinations*	50	5	**10**	32	64	2	**4**	9	**18**	4	**8**
14	(n)Coping with intimate examinations caused me great anxiety*	50	1	**2**	12	24	8	**16**	23	**46**	6	**12**
15	(o)Intimate examinations were far more unpleasant than I ever imagined*	50	3	**6**	20	40	10	**20**	16	**32**	1	**2**
16	(p)I found intimate examination painful/uncomfortable*	50	2	**4**	12	**24**	7	**14**	20	**40**	9	**18**
17	(q)I wish the staff had explained more about intimate examinations*	50	1	**2**	11	**22**	3	**6**	32	**64**	3	**6**
18	(r)The information gained from intimate	50	3	**6**	19	**38**	9	**18**	18	**36**	1	**2**

	examination caused me anxiety*											
19	(s)The information gained from intimate examination was reassuring	50	3	**6**	38	**76**	6	**12**	3	**6**	0	**0**
20	(t)I felt the intimate examination was roughly handled at times. *	50	3	**6**	24	**48**	14	**28**	9	**18**	0	**0**

*(*indicates negative statements)*

Table 4.3.3 represents how many respondents and the percentage of respondents strongly disagreed, disagreed, neither agreed nor disagreed, agreed and strongly agreed to each of the 20 statements on the scale.

Item (a) shows that, almost half the women (48%) thought that the staff imparted excellent information about vaginal examination, almost one-third (26%) disagreed, one-tenth (10%) strongly disagreed, another one-tenth (10%) neither agreed nor disagreed and 6% strongly agreed. Item (b) shows that 46% did not know that they could always refuse an intimate examination, whereas 24% know that they could refuse an intimate examination. The largest number of positive responses were associated with items (s), (i), (e), (q), (f), (p), (h) and the largest numbers of negative responses with items (c), (t), (j) and (m) (Table). These items are further addressed in Table 6. From a total of 1000 responses, 474 (47.4%) were positive, 373 (37.3%) were negative, and the remaining 153 (15.3%) neither positive nor negative.

In order to gain a better impression of how satisfied participants were with their intimate examinations, and to derive some form of intimate examination satisfaction index, the 20 items were re-scored on a five-point scale in such a way that the higher the score, the more satisfied the respondent. Positive statements such as (a) ‘The staff gave me

excellent information about vaginal examinations,' were scored from 5 = strongly agree to 1 = strongly disagree, whereas negative statements such as (q) 'I wish staff had explained more about vaginal examinations,' were scored from 1 = strongly agree to 5 = strongly disagree.

Although these are ordinal rather than interval data, a respondent totally satisfied with all 20 elements related to intimate examination would generate a theoretical maximum score for the complete matrix of 20 x 5 = 100. Thus, all 50 respondents, if they replied to each question, could in theory generate a maximum score of 20 x 5 x 50 = 5000. The data show that 20 Likert scale items were answered by all 50 respondents. Of the total 1000 responses, the maximum possible score for the matrix was 1000 x 5 = 5000. This scoring system allows each respondent, totally disenchanted with the management of intimate examinations, to generate a minimum score of 20 x 1, and the entire group a minimum score of 1000.

The total score for the matrix, calculated as 3118 of a possible maximum of 5000, yields a notional figure of 62.36%. Although these data are strictly ordinal, a score of around 62.36% would imply a commendable measure of satisfaction of how intimate examinations were managed.

Table 4.3.4

Sl. No	Statement	Number of responses	Total score	Mean score	Standard deviation	Rank
1	(a) The staff gave me excellent information about intimate examinations	50	157	3.14	1.2	11
2	(b)I knew I could always refuse an intimate examination	50	145	2.90	1.1	12

3	(c)The staff always asked my permission before performing an intimate examination	50	131	2.62	1.3	17
4	(d)Intimate examinations were always performed with great sensitivity	50	161	3.22	1.0	10
5	(e)The subject of intimate examinations was never properly discussed*	50	178	3.56	1.1	3
6	(f)Intimate examinations were done with dignity	50	173	3.46	0.9	5
7	(g)I felt that I always gave my consent before an intimate examination was carried out.	50	140	2.80	1.1	15
8	(h)I always felt well supported during the intimate examination	50	172	3.44	1.0	7
9	(i)Privacy was always maintained during intimate examinations	50	190	3.80	0.9	2
10	(j)Intimate examinations caused me great embarrassment. *	50	126	2.52	0.9	19
11	(k)During each intimate examination, I was always told what was happening	50	136	2.72	1.0	16
12	(l)I did not find intimate examinations distressing.	50	163	3.26	1.0	9
13	(m)I felt like I was given too many intimate examinations*	50	121	2.42	1.0	20
14	(n)Coping with intimate examinations caused me great anxiety*	50	171	3.42	1.1	8
15	(o)Intimate examinations were far more unpleasant than I ever imagined*	50	142	2.84	1.0	14
16	(p)I found intimate examination painful/uncomfortable*	50	172	3.44	1.2	6

17	(q)I wish the staff had explained more about intimate examinations*	50	175	3.50	1.0	4
18	(r)The information gained from intimate examination caused me anxiety*	50	145	2.90	1.0	13
19	(s)The information gained from intimate examination was reassuring	50	191	3.82	0.6	1
20	(t)I felt the intimate examination was roughly handled at times. *	50	129	2.58	0.9	18
			3118 Mean: 155.9		1.02	

Table 4.3.4 shows the number of responses, total score, mean score and standard deviation of each statement. Based on the total score and mean score, each statement is ranked. The statement which is highly scored ranked first and the statement which is least scored ranked last.

Respondents ranked highest of all shared a view that the information gained from intimate examination was reassuring (Table 4.3.5). The second highest ranked item related to women believing that privacy was always maintained during intimate examinations. Areas concerned no proper discussion of the subject of intimate examinations, wishing that staff had explained more about intimate examination procedure, dignified conduct of intimate examinations, painful/uncomfortable nature of intimate examinations, support during the intimate examination, anxiety and non-distressing feeling towards intimate examinations ranked highly. Lowest ranking perceptions, about which there was sensitive conduct of intimate examinations, information provided was adequate, opportunities to refuse vaginal examination, information gained caused anxiety, unpleasant nature, given too many intimate examinations, embarrassment caused a rough handling of examination, permission taken and consent given for conducting intimate examination.

On the basis of the scoring system outlined above, Likert scale data, scored and ranked in descending order according to mean scores, are presented in Table 4.3.5.

Table 4.3.5 Ranking of Statements	
Statement	Rank
(s)The information gained from intimate examination was reassuring	1
(i)Privacy was always maintained during intimate examinations	2
(e)The subject of intimate examinations was never properly discussed*	3
(q)I wish the staff had explained more about intimate examinations*	4
(f)Intimate examinations were done with dignity	5
(p)I found intimate examination painful/uncomfortable*	6
(h)I always felt well supported during the intimate examination	7
(n)Coping with intimate examinations caused me great anxiety*	8
(l)I did not find intimate examinations distressing.	9
(d)Intimate examinations were always performed with great sensitivity	10
(a) The staff gave me excellent information about intimate examinations	11
(b)I knew I could always refuse an intimate examination	12
(r)The information gained from intimate examination caused me anxiety*	13
(o)Intimate examinations were far more unpleasant than I ever imagined*	14
(g)I felt that I always gave my consent before an intimate examination was carried out.	15

(k)During each intimate examination, I was always told what was happening	16
(c)The staff always asked my permission before performing an intimate examination	17
(t)I felt the intimate examination was roughly handled at times. *	18
(j)Intimate examinations caused me great embarrassment. *	19
(m)I felt like I was given too many intimate examinations*	20

Table 7 shows the ranking of statements according to the mean score. The mean score is 155.9, and it can be seen that 11 items are above it and 9 below.

50 women who completed all the questions are shown in Table 4.3.6.

Table 4.3.6

Sl. No.	Total score	Mean	Sl. No	Total score	Mean
1	78.00	3.90	26	68.00	3.40
2	63.00	3.15	27	64.00	3.20
3	60.00	3.00	28	60.00	3.00
4	62.00	3.10	29	62.00	3.10
5	60.00	3.00	30	59.00	2.95
6	67.00	3.35	31	65.00	3.25
7	62.00	3.10	32	65.00	3.25
8	63.00	3.15	33	68.00	3.40

9	70.00	3.50	34	58.00	2.90
10	65.00	3.25	35	60.00	3.00
11	67.00	3.35	36	68.00	3.40
12	63.00	3.15	37	65.00	3.25
13	54.00	2.70	38	65.00	3.25
14	61.00	3.05	39	62.00	3.10
15	58.00	2.90	40	55.00	2.75
16	61.00	3.05	41	67.00	3.35
17	56.00	2.80	42	63.00	3.15
18	65.00	3.25	43	56.00	2.80
19	66.00	3.30	44	61.00	3.05
20	61.00	3.05	45	61.00	3.05
21	57.00	2.85	46	55.00	2.75
22	63.00	3.15	47	65.00	3.25
23	54.00	2.70	48	70.00	3.50
24	62.00	3.10	49	58.00	2.90
25	65.00	3.25	50	55.00	2.75
				Average Mean	**3.12**

Table 4.3.6 shows the total score and mean score of each respondent after answering all the 20 statements. The average mean calculated is 3.12.

Table 4.3.7

	N	Minimum	Maximum	Mean	Std. Deviation
Sum of Experience	50	2.70	3.90	3.12	0.23771

Table 4.3.7 shows the minimum and maximum score of each respondent. Based on the maximum mean score 3.90 and minimum mean score 2.70, 0.4 is calculated as the measure of difference. A mean score over the 20 questions of 3.5 or higher (corresponding to at most 10 3s and at least 10 4s is interpreted as 'more than satisfied'; a mean score from 3.1 to less than 3.5 is interpreted as 'satisfied'; and a mean score less than 3.1 is interpreted as 'less than satisfied'.

Table 4.3.8

Number of women completing all 20 questions	Mean (SD)	95% CI for mean	Number of women		
			More than satisfied (mean score 3.50 or higher)	Satisfied (mean score 3.10 – 3.50)	Less than satisfied (mean score under 3.10)
50	3.12	3.1 to 3.2	1 (2%)	23 (46%)	26 (52%)

Table 4.3.8 shows the number and percentage of women who are more than satisfied, satisfied and less than satisfied with their intimate examination experience. Overall, 1

(2%) were more than satisfied, 23 (46%) were satisfied and 26 (52%) were less than satisfied.

Fig. 24: Satisfaction Level

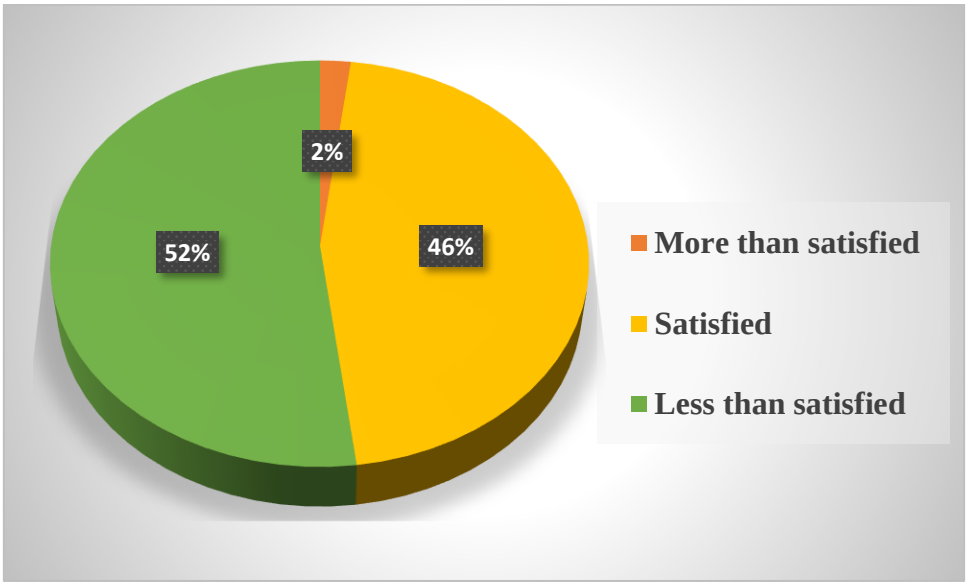

Table 4.3.9

Statement	Rank
Rights-based	
(i)Privacy was always maintained during intimate examinations	2
(e)The subject of intimate examinations was never properly discussed*	3
(q)I wish the staff had explained more about intimate examinations*	4
(f)Intimate examinations were done with dignity	5
(d)Intimate examinations were always performed with great sensitivity	10
(a) The staff gave me excellent information about intimate examinations	11

(g)I felt that I always gave my consent before an intimate examination was carried out.	15
(k)During each intimate examination, I was always told what was happening	16
(c)The staff always asked my permission before performing an intimate examination	17
Experience-based	
(s)The information gained from intimate examination was reassuring	1
(p)I found intimate examination painful/uncomfortable*	6
(h)I always felt well supported during the intimate examination	7
(n)Coping with intimate examinations caused me great anxiety*	8
(l)I did not find intimate examinations distressing.	9
(b)I knew I could always refuse an intimate examination	12
(l)The information gained from intimate examination caused me anxiety*	13
(o)Intimate examinations were far more unpleasant than I ever imagined*	14
(t)I felt the intimate examination was roughly handled at times. *	18
(j)Intimate examinations caused me great embarrassment. *	19
(m)I felt like I was given too many intimate examinations*	20

The highly ranked items in rights-based statements are (i), I, (q) and (f). Based on the 50 responses, privacy was maintained during the intimate examinations. The statement (e)The subject of intimate examinations was never properly discussed was ranked higher indicates that they are agreeing to the statement. The statement (q)I wish the

staff had explained more about intimate examinations was also ranked higher indicates that the respondents didn't receive proper information regarding the procedure. The statement (f)Intimate examinations were done with dignity was ranked higher indicates that the respondents are of the opinion that those examinations are done with dignity. The least ranked items in rights-based statements are (d), (a), (g), (k) and (c). The respondents are saying that intimate examinations were not always performed with great sensitivity. The statement "The staff gave me excellent information about intimate examinations" was ranked 11 which indicates that respondents were not at all provided with excellent information. The statements (g)I felt that I always gave my consent before an intimate examination was carried out, (k)During each intimate examination, I was always told what was happening and (c)The staff always asked my permission before performing an intimate examination are also ranked lower which indicates that the respondents didn't felt that they have given their consent prior to the examination, they were not told what was happening during an intimate examination and the staff wasn't asked for a permission for performing the intimate examination.

The highly ranked statements in experience-based statements are (s), (p), (h), (n) and (l). The statement (s)The information gained from intimate examination was reassuring means the information shared during the examination helped alleviate any concerns, fears, or anxieties the individual may have had and provided a sense of reassurance regarding their health or the examination process itself. The respondents are of the opinion that they didn't find intimate examination painful or uncomfortable and the respondents also felt well supported during the examination. The experience didn't cause them anxiety when coping with intimate examinations and they don't feel distressed either. The least ranked items in experience-based statements are (b), I, (o), (t), (j) and (m). The statement (b)I knew I could always refuse an intimate examination ranked lower indicates that there may be a lack of awareness or understanding among the respondents about their right to refuse an intimate examination. The negative statements (l)The information gained from intimate examination caused me anxiety, (o)Intimate examinations were far more unpleasant than I ever imagined, (t)I felt the intimate examination was roughly handled at times, (j)Intimate examinations caused me great embarrassment and (m)I felt like I was given too many intimate examinations* are ranked lower indicates a positive experience from the respondents.

In the study "Women's experiences of vaginal examinations in labour" conducted by David Lewin, the highest ranked perception confirmed that privacy was always maintained. In this study, it confirms that privacy was maintained which was the highly ranked statement.

About one-third of the respondents wished the staff had provided additional information about vaginal examination in Lewin's study. This raises the issue of informed consent and the extent to which women currently receive sufficient information to make truly informed choices. In this study, one of the highly ranked items is the statement "I wish the staff had explained more about intimate examinations". This is a negative statement which is highly ranked means this study also raises the issue of informed consent and improper communication. Thus both studies independently found that information provision during vaginal examinations was lacking, this strengthens the argument for the need to improve informed consent practices and information delivery to women undergoing such examinations.

4.4. Mixed Method Data Analysis

Table 4.4.1

Themes from Qualitative Interview Guide	Sample Quotes	Corresponding Quantitative Data
Privacy and Dignity	*"When the examination was going on, other patients are being consulted by another doctor in the same room. A properly closed space was not there in the room."*	The statement privacy was maintained during the intimate examination was ranked 1 out of the 20 statements.
Consent taken prior to the examination	*"Consent was taken when the main doctor was examining, but when a group of medical*	The statement "The staff always asked my permission before

	students unexpectedly entered into the room, I was not informed prior or the consent was not taken."	performing an intimate examination" was ranked 17, which is one of the least ranked.
Communication	*"If they try to provide me with some information like 'it will be painful' or 'it will be uncomfortable' might help me to get prepared for the examination."*	The statement "The staff gave me excellent information about intimate examinations" ranked 11 and the statement "I wish the staff had explained more about intimate examinations" ranked 4.
Feelings during the examination	: "*The same female doctor was examining another woman and told her that ' Don't you feel pain while lying with your husband?', 'you have to bear this'. After hearing all this, I felt very disappointed and feared whether there is another examination for me today."*	The statement "I found intimate examination painful/uncomfortable" ranked 6.
Health care provider's attitude	*"The major reason which contributes to the distressing experience was the attitude of the doctor. She was not understanding, she was not*	The statement "I always felt well supported during the intimate examination" was ranked 7.

	supportive and she was very rude to me.”	

CHAPTER 5: FINDINGS, SUGGESTIONS AND CONCLUSIONS

CHAPTER 5: FINDINGS, SUGGESTIONS AND CONCLUSIONS

5.1. Introduction

The final chapter deals with the outputs that the research revealed. It can be used as indicators that need to be studied in planning an intervention for the future. The purpose of the discussion is to interpret and describe the significance of findings that was already known as research problem. Researcher here also tried to explain new understanding and insights that emerged as a result of this study respective to areas that need to be focused with interventions.

5.2. Findings and Discussion

5.2.1. Objective 1: To understand the experiences of women undergoing intimate examinations through qualitative method (Interview Guide). The number of participants is five. The themes emerged after conducting the interview are:

(i) Attitude towards the examination: Women's experiences with intimate examinations can vary in terms of fear, discomfort, anxiety, and nervousness.

Fear, discomfort, anxiety, and nervousness are common emotional responses reported by the participants. This indicates that healthcare providers should be aware of these emotions and strive to create a supportive and empathetic environment to alleviate these concerns. Furthermore, the findings suggest that the presence of a partner during intimate examinations may provide emotional support for some women.

(ii) Privacy and Dignity: There are instances where privacy and dignity were not adequately maintained. Lack of physical privacy, presence of medical students, shared spaces are some of the concerns raised by the participants.

Maintaining physical privacy by implementing measures such as curtains or private rooms is crucial to preserving a woman's sense of modesty and comfort. However, it is important to recognize that physical privacy alone may not be sufficient to guarantee a woman's perception of privacy and dignity. The presence of medical students or multiple healthcare professionals in the examination room can contribute to a sense of vulnerability and compromise a woman's privacy.

(iii) Healthcare provider's approach

findings underscore the crucial role that healthcare providers play in creating a positive and supportive environment during intimate examinations. It is essential for healthcare professionals to prioritize empathy, compassion, and effective communication to ensure the emotional well-being and comfort of their patients. The negative experiences reported by Participant A and Participant D indicate the potential harm caused by healthcare providers who display impatience, anger, or indifference. These behaviours can significantly impact a patient's experience, causing distress and eroding trust in the healthcare provider. It is vital for healthcare providers to recognize the vulnerability of patients during intimate examinations and strive to maintain a respectful and empathetic demeanour throughout the process.

(iv)Consent taken prior to the examination

The findings emphasize the importance of obtaining informed consent prior to intimate examinations. The instances where consent was not obtained or was inadequately obtained, as reported by Participant A, Participant B, Participant D, and Participant E, highlight a breach in the patient's rights. This can lead to feelings of violation, loss of trust, and potential psychological distress.

(v)Communication

The findings highlight the critical role of communication in enhancing the patient experience during intimate examinations. Effective communication can help alleviate anxiety, build trust, and empower patients to actively participate in their healthcare decisions. On the other hand, inadequate or absent communication can lead to heightened distress, decreased patient satisfaction, and compromised patient-provider relationships.

Participant A's perspective underscores the importance of healthcare providers acknowledging patients' feelings and providing information to prepare them for the examination. By explaining the process, potential discomforts, and addressing any concerns, healthcare providers can help patients feel more empowered and better equipped to navigate the examination. The positive communication experience described by Participant A, where a medical student provided explanations and visual

aids, demonstrates the value of patient education and clear communication. Visual aids, diagrams, or simple illustrations can enhance patients' understanding and facilitate their active involvement in the examination process.

(vi) Feelings during the examination

The findings underscore the significance of considering and addressing the emotional experiences of patients during intimate examinations. Healthcare providers should be aware of the potential impact of their words, actions, and the overall environment on patient emotions and well-being.

Participant A's experience highlights the negative effect of insensitive remarks made by healthcare providers. Such comments can lead to disappointment, fear, and increased anxiety for patients. It is crucial for healthcare providers to choose their words carefully, demonstrate sensitivity, and provide reassurance to patients during the examination process. The confusion reported by Participant B regarding the necessity of repeated breast examinations emphasizes the importance of clear and thorough communication. The positive experience described by Participant C, attributed to the gentle behavior of the doctor and nurse, demonstrates the impact of a supportive and empathetic approach. Participant E's discomfort due to lack of privacy and informed consent emphasizes the need for healthcare providers to prioritize these aspects.

(vii) Factors contributing to make intimate examination a negative or positive experience.

The findings shed light on various factors that contribute to either a negative or positive experience during intimate examinations. The research underscores the importance of a supportive and compassionate healthcare environment, effective communication, and the attitudes of healthcare providers.

Participant A's experience highlights the impact of a restricted environment, such as limited communication and lack of emotional support, on the patient's emotional well-being. Participant B's suggestion regarding proper explanation and communication aligns with the principle of patient-centered care. Participant E's perspective highlights the importance of a supportive environment, including the presence of a bystander and a female doctor

(viii) Effects of experience

The findings highlight the significant emotional, psychological, and behavioral effects that negative experiences during intimate examinations can have on individuals. The impacts range from immediate distress and fear to long-lasting psychological consequences, influencing an individual's willingness to seek future medical care and their overall well-being.

Participant A's experience reflects severe psychological distress, including anger, sadness, and suicidal thoughts. Negative experiences during intimate examinations can have a profound impact on an individual's mental health, leading to depression, anxiety, and a loss of quality of life. Participant B's ability to overcome fear indicates the potential for positive experiences and effective communication to alleviate anxiety and build resilience

(ix) Improvements or changes needed

The findings highlight the need for improvements in various aspects of intimate examinations to enhance patient experiences and ensure their comfort and well-being. The attitudes of healthcare providers, communication practices, privacy, safety, and informed consent play critical roles in creating a positive and supportive environment for patients.

Participant A's emphasis on improving the attitude of healthcare providers underscores the significance of empathy, understanding, and respect. Participant B's suggestion regarding communication and consent aligns with the principles of patient autonomy and informed decision-making. The call for empathy and addressing patient concerns, as mentioned by Participant C, highlights the importance of healthcare providers adopting a patient-centered approach. Participant D's emphasis on privacy and safety aligns with the ethical principles of healthcare. Healthcare providers should prioritize providing physical privacy during examinations, ensure confidentiality, and create a safe space where patients feel comfortable and respected.

Quantitative data was collected through questionnaire.

Personal Profile

- Less than half of the respondents are from the age group 20-29.
- More than half of the respondents have income status equal to outgoings.
- Majority of the respondents are married.
- Less than three fourth of the respondents had previous pregnancy.
- Less than three fourth of the respondents has children.

Details of Intimate Examinations of the Respondents

- A significant number of respondents visit the hospital/clinic for pregnancy related purpose.
- More than half of the respondents underwent pelvic examination.
- A significant number of respondents underwent more than one examination.
- A significant number of respondents were examined by female doctor.
- Less than half of the respondents visited government and same number of respondents visited private hospitals.

5.2.2. Objective 2: To understand the attitude of women towards intimate examinations

- A significant number of respondents have preference for their doctor’s gender as female

A significant number of respondents expressed a preference for their doctor's gender to be female. This finding suggests that women may feel more comfortable and at ease with a female healthcare provider during intimate examinations. It highlights the importance of considering gender preferences when assigning healthcare professionals to perform these examinations. The preference for female doctors highlights the influence of patient-provider gender dynamics on women's attitudes towards intimate examinations. It suggests that matching the gender preferences of patients with the gender of their healthcare providers may enhance their comfort and overall experience.

- Less than half of the respondents (46%) have preference for doctor and nurse being present during the examination.
- Half of the respondents have expectations such as,
    - They should provide explanation before examination
    - They should provide explanation after examination
    - They should clear my doubts and concerns
    - They should prepare me for the examination
    - They should be understanding and have a gentle behaviour

These expectations reflect the desire for clear communication, empathy, and support from healthcare providers during intimate examinations.

5.2.3. Objective 3: To investigate women's feelings during intimate examination

- Less than three fourth of the respondents have anxiety towards their health. This finding indicates that many women experience concerns or worries about their health status when undergoing these examinations.
- Majority of respondents have embarrassment of being undressed before a stranger. This highlights the common experience of embarrassment or discomfort related to the intimate nature of the examination and the presence of an unfamiliar person.
- A significant number of respondents didn't have fear of discovery of a pathological condition.
- More than half of the respondents are worried about cleanliness or fear about equipment being unsterile. This finding underscores the importance of maintaining strict hygiene protocols and addressing patient concerns regarding infection control.
- Less than three fourth of the respondents disagreed that they are excited.
- A significant number of respondents feel anxious about examination not being performed correctly. This finding suggests that many individuals undergoing intimate examinations have apprehensions about the accuracy, thoroughness, or adequacy of the examination process.
- A significant number of respondents disagreed to the statement "I didn't feel anything." It indicates that they did feel something during the intimate

examinations. This finding suggests that the respondents experienced various sensations, emotions, or physical discomfort during the examinations, and therefore, they disagreed with the statement that they didn't feel anything.

5.2.4. Objective 4: To investigate women's perceptions of their intimate examination experiences.

- The highest ranked items in 20 item Likert scale shows that information gained was reassuring and privacy was maintained, but respondents felt like the subject was not properly discussed and they wish for more explanation from the staffs.
- The lowest ranked items shows that the respondents didn't feel like they have given too many examinations, and they didn't feel greatly embarrassed. Seeking permission and consent were least ranked shows proper consent and permission were not taken. They also felt like proper information was not given to the respondents.

The higher ranking for the statement indicating insufficient discussion about intimate examinations indicates a need for improved communication between healthcare providers and patients. The respondents' desire for more information about intimate examinations suggests a potential gap in providing clear explanations and expectations. While respondents ranked the statement about intimate examinations being conducted with dignity higher, the lower rankings for statements related to consent, being told what is happening, and permission-seeking indicate potential issues with sensitivity during the examinations.

- Of the total respondents, more than half of the participants are less than satisfied, less than one-fourth are satisfied and a very few is more than satisfied.

Statements which seek whether informed consent was taken, proper information was provided, being told what was happening and staff seeking permission are ranked lower which might be the reason why the respondents who are more than satisfied are very few in number.

5.3. Suggestions

- To enhance the quality of healthcare services, it is imperative to advocate for the implementation of patient-centered care, ensuring that patients' preferences,

needs, and values are at the forefront of decision-making and treatment planning. Healthcare providers should provide empathy and support when conducting intimate examinations and should receive training and education on patient-centered care.

- Healthcare institutions should encourage women to provide feedback on their experiences of intimate examinations. This feedback can help identify areas for improvement, address specific concerns, and shape policies and practices that prioritize patient satisfaction and well-being.
- Develop standardized protocols and guidelines for intimate examinations that prioritize patient rights, consent, privacy, and sensitivity. These guidelines should provide clear instructions for healthcare providers on how to conduct examinations with dignity and respect while maintaining patient comfort and autonomy.
- Create a supportive environment during intimate examinations by ensuring the presence of gentle and empathetic healthcare providers and nurses. Encourage open communication, actively listen to patients' concerns, and address any questions or anxieties they may have. Creating a collaborative and supportive environment empowers patients and fosters a sense of dignity and agency.
- To promote informed choices and empower women in their healthcare journey, it is essential to prioritize providing comprehensive health education about intimate examinations, ensuring they have a clear understanding of the procedures, potential benefits, and any associated risks or concerns.
- Offer mental health support services to individuals who have experienced psychological distress as a result of negative experiences during intimate examinations. Collaboration between healthcare providers and mental health professionals can ensure comprehensive care for patients.
- Utilize visual aids, diagrams, or demonstrations to supplement verbal explanations, especially for complex procedures. These visual aids can improve patient understanding, reduce anxiety, and facilitate informed decision-making.

5.4. Recommendations for Further Research

- The present study was limited to women in a specific village in Kottarakkara Taluk of Kollam District and limited number of participants was available for

the study. The study can be replicated among a large group of participants to get wider results.

- The present study was conducted using a mixed method research. An in-depth study can be conducted through case studies (qualitative research) by considering the sensitive nature of the topic.
- It is possible to explore how cultural norms, societal attitudes, and religious beliefs in a specific village and region impact women's perceptions of intimate examinations and patient rights.
- Explore the impact of education and awareness campaigns on patients' understanding of their rights and the responsibilities of medical professionals and assess whether women who are more informed about their rights are more likely to assert them during medical procedures. Investigate the training programs and curricula for healthcare professionals in the region. Are patient rights, informed consent, and effective communication adequately covered in their training? This could shed light on potential areas for improvement in medical education.
- Studies can be done focusing on the long-term effects of the issues identified in research on women's physical and mental well-being.

5.5. Implications for Social Work Practice

The findings of this research have significant implications for social work practice, presenting an opportunity for social workers to collaborate with healthcare institutions, advocate for patient rights, and contribute to the development of interventions that foster a more respectful, empowering, and culturally sensitive healthcare environment.

i. Promotion of patient-centered care and advocacy

Social workers can be essential in pushing for patient-centered care inside healthcare organizations. To spread the word about the significance of upholding patient rights, gaining informed consent, and ensuring sensitive communication during intimate examinations, they can work with hospital administrations, policy makers, and healthcare professionals. Social workers can advocate for a healthcare system that values patients' autonomy, comfort, and dignity by pushing for the adoption of patient-centered policies and procedures.

ii. Patient Empowerment and Feedback processes

Social workers can collaborate with healthcare organizations to set up feedback processes for gathering patient feedback on their experiences with intimate examinations. This can entail setting up confidential suggestion boxes, online feedback forms, or even organizing patient focus groups.

iii. Cultural Sensitivity and Competence

Social workers can participate in educational and training programs for healthcare professionals to improve their cultural sensitivity and competency. Women's opinions on intimate examinations might be significantly influenced by cultural standards, societal attitudes, and religious convictions.

iv. Mental Health Support

Social workers can fill the gap between medical treatment and mental health services in the area of mental health support. Social workers can offer emotional support, counseling, and referrals to mental health professionals for women who have gone through psychological distress as a result of unpleasant experiences during intimate examinations.

5.6. Conclusions

The research sheds light on women's experiences of intimate examinations and their perceptions of patient rights. The findings highlight the need to prioritize patient-centered care, ensuring healthcare providers approach intimate examinations with empathy, sensitivity, and effective communication. Adequate measures should be taken to maintain privacy and dignity during examinations, while obtaining informed consent becomes crucial to respecting patients' rights. By addressing these aspects, healthcare systems can enhance the quality of care, empower women in their healthcare decisions, and foster a positive and supportive environment for patients during intimate examinations. This research underscores the importance of patient-centered practices to promote better healthcare experiences for women.

REFERENCES

1. ACOG Committee Opinion No. 754: *The Utility of and Indications for Routine Pelvic Examination.* (2018). American Congress of Obstetricians and Gynecologists, 132(4), e174e180. https://doi.org/10.1097/aog.0000000000002895.
2. Albers, L. (2007). *The evidence for physiological management of the active phase of the first stage of labor*. Journal of Midwifery & Women's Health, 52(3), 207–215. doi:10.1016/j.jmwh.2006.12.009
3. American Medical Association, *Code of Medical Ethics*, Chapter 2: Opinions on Consent, Communication & Decision Making, 2.1 Informed Consent & Shared Decision Making, Adopted June 1957; revised June 1980; revised June 2001, AMA Principles of Medical Ethics (ama-assn.org).
4. Arasoo, V. J. T., Dominic, N. A., Ratnasingam, V., Islam, I. U., Lee, E., Wong, J. J. M., Kong, F. W. Y., Pemasiri, W., Jeganathan, R., & Ramadas, A. (2021). *Patients' Perception towards General and Pelvic Examination by Male Medical Students: A Cross-sectional Study in a Multi-ethnic Population.* International Medical Journal Malaysia, 20(4). https://doi.org/10.31436/imjm.v20i4.1680
5. Armitage, A. J., & Cahill, D. J. (2018). *Medical students and intimate examinations: What affects whether a woman will consent?.* Medical teacher, 40(12), 1281–1286. https://doi.org/10.1080/0142159X.2018.1428736
6. Baker, R., Mulka, O., Camosso, J., Sinfield, P., & N. C. (2008). *Patients' views on and professionals' use of chaperones during intimate examinations in primary health care: A review*. Radcliffe Publishing. https://www.researchgate.net/publication/233713947_Patients'_views_on_and

_professionals'_use_of_chaperones_during_intimate_examinations_in_primary_health_care_A_review

7. Bal, Z., Uçar, T., & Kantar, E. C. (2022). *The Analysis of the Woman's Feeling of Discomfort During the Gynecological Examination and Associated Factors*. Middle Black Sea Journal of Health Science, 8(2), 269–278. https://doi.org/10.19127/mbsjohs.1066185
8. Baron, R. A. (1999). *Social Psychology* (10th ed.). Allyn & Bacon. https://books.google.co.in/books/about/Social_Psychology.html?id=kN5PPwAACAAJ&redir_esc=y
9. Bodden-Heidrich, R., Walter, S. D., Teutenberger, S., Küppers, V., Pelzer, V., Rechenberger, I., & Bender, H. (2000). *What Does a Young Girl Experience in Her First Gynecological Examination? Study on the Relationship Between Anxiety and Pain.* Journal of Pediatric and Adolescent Gynecology, 13(3), 139–142. https://doi.org/10.1016/s1083-3188(00)00056-5
10. Brown, K. N. (2020, October 14). *Obtaining Patient Consent Before Pelvic Exams*. Empowered Women's Health. https://www.volusonclub.net/empowered-womens-health/obtaining-patient-consent-before-pelvic-exams/
11. Coldicott, Y., Pope, C., & Roberts, C. (2003). *The ethics of intimate examinations-teaching tomorrow's doctors.* BMJ (Clinical research ed.), 326(7380), 97–101. https://doi.org/10.1136/bmj.326.7380.97
12. Cream, P. (2019). 179-Intimate Examinations. In *Cambridge Handbook of Psychology, Health and Medicine* (3rd ed., pp. 643–644). essay, Cambridge University Press. https://doi.org/10.1017/9781316783269

13. de Klerk, H. W., Boere, E., van Lunsen, R. H., & Bakker, J. J. H. (2018). *Women's experiences with vaginal examinations during labor in the Netherlands*. Journal of psychosomatic obstetrics and gynaecology, 39(2), 90–95. https://doi.org/10.1080/0167482X.2017.1291623
14. Dean, J. R. (1998). *ABC of sexual health: Examination of patients with sexual problems.* BMJ, 317(7173), 1641–1643. https://doi.org/10.1136/bmj.317.7173.1641
15. Evans, K. (2023). *Intimate Examination, Procedure, Care and Chaperoning Policy*. A Whittington Hospital Clinical Management Guideline.
16. Ferng, A., B. S. (2022, October 10). *External female genitalia: Anatomy and Bloodsupply*.KENHUB.https://www.kenhub.com/en/library/anatomy/external-female-genitalia
17. Friesen P. (2018). *Educational pelvic exams on anesthetized women: Why consent matters*. Bioethics, 32(5), 298–307. https://doi.org/10.1111/bioe.12441
18. G Komen, S. (2022, November 29). *Clinical Breast Exam*. Susan G. Komen® Organization. https://www.komen.org/breast-cancer/screening/clinical-breast-exam/
19. G. Kalyani. (2016). " *The Two Finger Test: Legal and Ethical Issue*", International Journal of Scientific Research in Science and Technology(IJSRST), Print ISSN : 2395-6011, Online ISSN : 2395-602X, Volume 2, Issue 2, pp.81-85, March-April-2016. Journal URL : https://ijsrst.com/IJSRST162242
20. Goldstein, E. B. (2019). *Introduction to Perception*. Sensation and perception. Cengage Learning, https://www.studocu.com/en-gb/document/university-of-southampton/perception/introduction-to-perception-c1/25909376

21. Griffith R. (2005). *The law and intimate examinations and treatments*. British journal of community nursing, 10(3), 137–140. https://doi.org/10.12968/bjcn.2005.10.3.17620
22. Griffith R. (2015). *Intimate examinations and treatments*. British journal of nursing (Mark Allen Publishing), 24(3), 178–179. https://doi.org/10.12968/bjon.2015.24.3.178
23. Hassan, S. J., Sundby, J., Husseini, A., & Bjertness, E. (2012). *The paradox of vaginal examination practice during normal childbirth: Palestinian women's feelings, opinions, knowledge and experiences*. Reproductive health, 9, 16. https://doi.org/10.1186/1742-4755-9-16
24. Hilden, M., Sidenius, K., Langhoff-Roos, J., Wijma, B., & Schei, B. (2003). *Women's experiences of the gynecologic examination: factors associated with discomfort*. Acta Obstetricia Et Gynecologica Scandinavica, 82(11), 1030–1036. https://doi.org/10.1034/j.1600-0412.2003.00253.x
25. Kahneman, D. (2011): Thinking, Fast and Slow. 55(3).doi:10.1007/s00362-013-0533y
26. Karim, M. A., Ahmed, S. I., Ferdous, J., Islam, B. Z., Tegegne, H. A., & Aktar, B. (2019). *Assessing informed consent practices during normal vaginal delivery and immediate postpartum care in tertiary-level hospitals of Bangladesh*. European journal of midwifery, 3, 10. https://doi.org/10.18332/ejm/109311
27. Larsen, S. B., & Kragstrup, J. (1995). *Expectations and knowledge of pelvic examinations in a random sample of Danish teenagers*. Journal of psychosomatic obstetrics and gynaecology, 16(2), 93–99. https://doi.org/10.3109/01674829509042784

28. Lazare A. (1987). Shame and humiliation in the medical encounter. Archives of internal medicine, 147(9), 1653–1658.
29. Lewin, D., Fearon, B., Hemmings, V. J., & Johnson, G. V. (2005). *Women's experiences of vaginal examinations in labour*. Midwifery, 21(3), 267–277. https://doi.org/10.1016/j.midw.2004.10.003
30. Lorber, J. (1994). *Paradoxes of gender.* Yale University Press.
31. Maaita, M., Al-amro, S.Q., & Fayez, I.A. (2017). *Jordanian Women's Feelings, Opinions and Knowledge of Vaginal Examination during Child Birth*. Journal of the Royal Medical Services, 24, 58-69.
32. Mankuta, D. (2016). *Failure to Obtain Informed Consent for Intimate Examinations by Medical Students*. Open Access Journal of Gynecology. https://doi.org/10.23880/oajg-16000102
33. Millstein, S. G., Adler, N. E., & Irwin, C. E. (1984). *Sources of anxiety about pelvic examinations among adolescent females*. Journal of Adolescent Health Care, 5(2), 105–111. https://doi.org/10.1016/s0197-0070(84)80008-x
34. Milne E. (2022). *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability*, edited by Camilla Pickles and John Herring. European journal of health law, 1–2. Advance online publication. https://doi.org/10.1163/15718093-bja10088
35. Moncrieff G, GyteGML, DahlenHG, ThomsonG, Singata-MadlikiM, CleggA, DowneS. *Routine vaginal examinations compared to other methods for assessing progress of labour to improve outcomes for women and babies at term*. Cochrane Database of Systematic Reviews 2022, Issue 3. Art. No.: CD010088. DOI: 10.1002/14651858.CD010088.pub3.

36. Moore, S. M., Gridley, H., Taylor, K. L., & Johnson, K. (2000). Women's views about intimate examinations and sexually inappropriate practices by their general practitioners. Psychology & Health. https://doi.org/10.1080/08870440008400289
37. Muliira, R., Seshan, V., & Ramasubramaniam, S. (2013). *Improving vaginal examinations performed by midwives*. Sultan Qaboos University Medical Journal, 13(3), 435–442. doi: 10.12816/0003268
38. National Centre for Farmer Health. (2014). *Patient's Rights and Responsibilities*.http://www.ncfh.org/uploads/3/8/6/8/38685499/1._patient_rights_and_resp_introduction_[06.20.2014].pdf
39. NHRC (National Human Rights Commission). (2018). *Charter of Patients' Rights for adoption by NHRC*. https://main.mohfw.gov.in/sites/default/files/PatientCharterforcomments.pdf
40. O'Laughlin, D. J., Strelow, B., Fellows, N., Kelsey, E. J., Peters, S. M., Stevens, J., & Tweedy, J. M. (2021, January 1). *Addressing Anxiety and Fear during the Female Pelvic Examination*. Journal of Primary Care & Community Health. https://doi.org/10.1177/2150132721992195
41. Pillay V V, *Handbook of Forensic Medicine and Toxicology,* 13th ed., Paras Publication, Hyderabad (2003). pp.24-5
42. Rees, C. E., & Monrouxe, L. V. (2011). *Medical students learning intimate examinations without valid consent: a multicentre study*. Medical Education, 45(3), 261–272. https://doi.org/10.1111/j.1365-2923.2010.03911.x
43. Robinson, J. (2001). *Intimate examinations: the complexities of consent*. British Journal of Midwifery, 9(11), 708–709. https://doi.org/10.12968/bjom.2001.9.11.9406

44. Rogstad K. E. (2007). *Chaperones: protecting the patient or protecting the doctor?*. Sexual health, 4(2), 85–87. https://doi.org/10.1071/sh07022
45. Royal College of Obstetricians and Gynaecologists, & Crowley. (1997). *Intimate Examinations: Report of a Working Party ; [working Party Chairman, Patricia Crowley]*. Royal College of Obstetricians and Gynaecologists. https://books.google.co.in/books?id=ZxbJzQEACAAJ
46. Stattin, H., Magnusson, D., Olah, A., Kassin, H., & Reddy, N. Y. (1991) *Perception of threatening consequences of anxiety-provoking situations,* Anxiety Research, 4:2, 141-166, DOI: 10.1080/08917779108248770
47. Sung H, Ferlay J, Siegel RL, Laversanne M, Soerjomataram I, Jemal A, et al. Global cancer statistics 2020: *GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries*. CA Cancer J Clin. 2021:71:209–49. doi:10.3322/caac.21660.
48. Tancman, S., HaCohen, N., Lazarus, G., Solt, I., & Sagi-Dain, L. (2022). *Silent voices that must be heard - women's perceptions of gynecologic examinations*. Journal of psychosomatic obstetrics and gynaecology, 43(2), 190–197. https://doi.org/10.1080/0167482X.2020.1864727
49. The Indian Contract Act, Chapter II of Contracts, Voidable Contracts and Void Agreements. Illustrations 13 (1872), Indian-Contract-Act-1872-20200816140128.pdf (cag.gov.in)
50. Walker, H. K., Hall, W. D., & Hurst, J. W. (1990b). Clinical Methods: The History, Physical, and Laboratory Examinations. Annals of Internal Medicine, 113(7), 563. https://doi.org/10.7326/0003-4819-113-7-563_2

51. Walker, H. K., Hall, W. D., & Hurst, J. W. (Eds.). (1990). Clinical Methods: The History, Physical, and Laboratory Examinations. *Pap Test* (3rd ed.). Butterworths.
52. Wendt, E., Fridlund, B., & Lidell, E. (2004). *Trust and confirmation in a gynecologic examination situation: a critical incident technique analysis*. Acta obstetricia et gynecologica Scandinavica, 83(12), 1208–1215. https://doi.org/10.1111/j.0001-6349.2004.00597.x
53. World Health Organization. (2017). *WHO Strategic Communications Framework for Effective Communications*. Department of Communications. https://www.who.int/docs/default-source/documents/communicating-for-health/communication-framework.pdf
54. Yanikkerem, E., Özdemir, M., Bingol, H., Tatar, A., & Karadeniz, G. (2009). *Women's attitudes and expectations regarding gynaecological examination*. Midwifery, 25(5), 500–508. https://doi.org/10.1016/j.midw.2007.08.006

ANNEXURES

Annexure 1: Consent Form

Topic: Women's Perceptions of Intimate Examination and Patient Rights

Purpose of the Study: To understand attitudes and preferences of women prior to intimate examinations, experiences of women undergoing intimate examinations and to know how far their rights are respected.

Eligibility: Participants must be women between the age category of 20 and 50 and must undergo any kind of intimate examination.

Informed Consent: If you wish to participate in the study, the researcher will ask you for your personal information. The information collected will be strictly in the hands of the researcher and the researcher will not disclose the identity and the information will only be used for the research purpose.

Remember that you have the right to withdraw from the study at any time.

I will be very grateful if you could participate in this study by giving your valuable time.

Thank You.

Annexure 2: Interview Guide

1. **Sociodemographic Profile**
    a) Name
    b) Age
    c) Level of Education
    d) Income Status
    e) Marital Status
    f) Occupation
    g) Previous Pregnancy
    h) Number of Children
2. **Details of Intimate Examination Procedures**
    a) Reason for visiting Hospital
    b) Kind of examination underwent
    c) Number of examinations underwent
    d) Gender of the doctor examined
    e) Type of hospital
3. **Experience of women**
    a) Overall experience of the examination
    b) Overall comfort level during intimate examination
    c) Factors contribute to making intimate examinations a positive or negative experience for women
    d) Comfortability in the room/place where the intimate examination took place. What makes you comfortable and what makes you uncomfortable and what changes do you suggest?
    e) Feeling of discomfort or pain during an intimate examination. If so, causes and how it was addressed?
    f) Healthcare provider's approach
    g) Addressing concerns and doubts
    h) Kind of consent the doctors or nurses or medical students obtained.
    i) Improvements or changes would you like to see in the way intimate examinations are conducted?

Annexure 3: Questionnaire

I. Sociodemographic Profile

1. Name

   _____

2. Age
   - ○ 20-29
   - ○ 30-39
   - ○ 40-49

3. Gender
   - ○ Female
   - ○ Transgender
   - ○ Prefer not to say

4. Level of education
   - ○ Illiterate
   - ○ Elementary
   - ○ Matriculation
   - ○ Higher Secondary
   - ○ Graduation
   - ○ Post-graduation and above

5. Income status
   - ○ Income is higher than outgoings
   - ○ Income is equal to outgoings
   - ○ Income is lower than outgoings

6. Occupation
   - ○ Student
   - ○ Homemaker
   - ○ Employed – part time
   - ○ Employed – full time
   - ○ None

7. Marital status
   - ○ Married
   - ○ Unmarried
   - ○ Divorced
   - ○ Widow

8. Previous Pregnancy
   - ○ Yes

- ○ No

9. Number of children
   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4 and above
   - ○ Nil
   - ○ Not applicable

II. Details of Intimate Examination Underwent

10. Reason for visiting hospital
    - ○ Breast related
    - ○ Pregnancy related
    - ○ Cysts
    - ○ Infections
    - ○ Others _____

11. Kind of examination underwent
    - ○ Breast
    - ○ Pelvic (internal structures including fallopian tubes, ovaries, uterus, cervix, bladder, urethra, vagina)
    - ○ Genital (external genital structures including mons pubia, labia majora, labia minora and clitoris)
    - ○ Rectal
    - ○ Anal
    - ○ Other: _____

12. Number of examination/s underwent
    - ○ 1
    - ○ 2
    - ○ 3
    - ○ 4 or above
    - ○ Not remember

13. Gender of the doctor examined
    - ○ Male
    - ○ Female
    - ○ Both

14. Type of hospital visited
    - ○ Government
    - ○ Private
    - ○ Clinic

ATTITUDE AND PREFERENCES PRIOR TO INTIMATE EXAMINATIONS

Purpose: To understand the attitudes and preferences of women prior to the intimate examination

Women's feelings towards Intimate examinations

Sl. No	Statement	Agree/Disagree
1	I feel anxious about my health	
2	I am embarrassed of being undressed before a stranger	
3	I feel fear of discovery of a pathological condition (fear that severe illness be diagnosed)	
4	I am worried about cleanliness or fear about equipment being unsterile	
5	I feel excited	
6	I feel anxious about examination not being performed correctly	
7	I did not feel anything	

Women's Preferences towards Intimate Examinations

1. I prefer the gender of the doctor be,

   - ☐ Male
   - ☐ Female
   - ☐ No preference

2. Preference for another person being present during intimate examination

   - ☐ Doctor alone
   - ☐ Doctor and nurse
   - ☐ Doctor, nurse and medical student
   - ☐ My mother
   - ☐ My partner
   - ☐ My friend

- ☐ No preference

3. Expectations of doctors and nurses during intimate examinations

- ☐ They should provide explanation before examination
- ☐ They should provide explanation after examination
- ☐ They should clear my doubts and concerns
- ☐ They should prepare me for the examination
- ☐ They should be understanding and have a gentle behavior
- ☐ All of the above
- ☐ No expectations

PERCEPTION OF WOMEN REGARDING THEIR INTIMATE EXAMINATION EXPERIENCES

This section is made to assess the patient's knowledge of the rights involved when conducting the intimate examinations and how far the aspects of patients' rights are taken into consideration while conducting the intimate examination.

The responses in this section are noted as strongly disagree, disagree, neither agree nor disagree, agree and strongly disagree respect to each statement.

Sl. No	Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	(a)The staff gave me excellent information about intimate examinations					
2	(b)I knew I could always refuse an intimate examination					
3	(c)The staff always asked my permission before performing an intimate examination					
4	(d)Intimate examinations were always performed					

	with great sensitivity					
5	(e)The subject of intimate examinations was never properly discussed*					
6	(f)Intimate examinations were done with dignity					
7	(g)I felt that I always gave my consent before an intimate examination was carried out.					
8	(h)I always felt well supported during the intimate examination					
9	(i)Privacy was always maintained during intimate examinations					
10	(j)Intimate examinations caused me great embarrassment. *					
11	(k)During each intimate examination, I was always told what was happening					
12	(l)I did not find intimate examinations distressing.					
13	(m)I felt like I was given too many intimate examinations*					
14	(n)Coping with intimate examinations caused me great anxiety*					
15	(o)Intimate examinations were far more unpleasant than I ever imagined*					
16	(p)I found intimate examination painful/uncomfortable*					
17	(q)I wish the staff had explained more about intimate examinations*					
18	(r)The information gained from intimate examination caused me anxiety*					
19	(s)The information gained from intimate examination was reassuring					
20	(t)I felt the intimate examination was roughly handled at times. *					