

ARTICLES

Caring for survivors of sexual assault

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Guidelines in India for the examination and treatment of survivors of sexual assault are inadequate. The guidelines that exist for some aspects may not serve the best interests of survivors or of legal procedures. This paper draws on formal and informal consultations to discuss some of the problems that arise due to the absence of standard guidelines in this context.

Caring for survivors of sexual offences can involve several departments in a hospital, including casualty, gynaecology, paediatrics, radiology and forensics. Law enforcement agencies are also involved because medical evidence forms an important link in any investigation. Any lacunae on the part of any of these departments may result in a disservice to the survivor. However, a paucity of standard guidelines and reference material in India makes it difficult for health professionals to decide on how best to proceed in such cases.

The sexual assault forensic evidence kit

Most developed countries use standardised sexual assault evidence collection kits to ensure better evidence collection as well as care. These kits include protocols and the equipment necessary for examination and care. Such kits are not routinely used in India.

The Centre for Enquiry into Health and Allied Themes (CEHAT) is a health research, action and advocacy organisation based in Mumbai, India. In 1998, an investigation into the sexual assault of a hearing- and speech-challenged teenage girl living in an observation home highlighted serious lapses in medico-legal and other services (1).

CEHAT subsequently formulated a model sexual assault forensic evidence kit, after consultations with forensic experts, gynaecologists, lawyers and women's groups. A programme was launched in 2004 to advocate use of this kit in public hospitals. As part of this programme, about 40 doctors from forensic medicine, gynaecology and public health from Maharashtra, Goa and Karnataka attended a consultation in collaboration with the Mumbai Association of Forensic Experts. Other smaller meetings and informal discussions have also taken place. This paper draws on the formal and informal consultations to talk about the significant problems that arise due to the absence of standard guidelines for examination of, and treatment for, sexual assault.

Taking consent for medical examination

Undergoing a medical examination can be a traumatic

experience for a survivor of a sexual assault. The trauma could be reduced if health-care providers explain what the examination involves, reassure her that she can refuse an examination or stop it any point, and obtain her consent before proceeding. To facilitate this process, the kit contains a one-page consent protocol based on international guidelines for the examination and treatment of ailments caused by the assault, for examination to document forensic evidence, and for permission to disclose this information to police officials for investigation. The three-tier consent emphasises the survivor's right to refuse permission for any of these procedures. It also reiterates her right to treatment even if she does not want to register a case. We studied the kits used by the Ontario Provincial Police, Canada, the Illinois State Police, Chicago, USA, and the kit used in the Province of Kwazulu-Natal Health Services, South Africa.

However, our discussions with health-care providers suggested that many resist the idea of a detailed consent process. Many support a one-line, all-inclusive consent form that gives full permission for examination and use of the findings. Many oppose the sentence: "I know that I can withdraw consent at any time and this will not lead to denial of medical care" on the grounds that it would "unnecessarily complicate matters".

The age of consent for a medical examination

Discussions also suggested that there is a lack of clarity about the age of consent for examination. Most doctors said it was between 16 and 18 years. Gynaecologists in particular said they did not accept the consent of women below the age of 18. Some doctors reported involving family members or guardians even when the person is competent to decide. At least one textbook states that the age of consent for examination in cases sexual assault is 12 years (3). If this is the case, medical professionals are undermining the autonomy of girls between the ages of 12 and 16-18 by not recognising their right to consent. At the same time a gynaecological examination can be an invasive procedure. Is a 12-year-old girl capable of understanding the implications of such an examination and equipped to give consent to it?

And if the age of consent for sexual relations is 16 years, why should the age of consent for examination be 18 years?

Is an FIR necessary before a medical examination?

Survivors of sexual assault need medical treatment and counselling. Some of them may also wish to file a case against their assailant(s). In some countries women can authorise the collection of evidence – which must be done as soon as possible in order to develop a strong case – but they may withhold, for a

reasonable time period, their decision to pursue the case. They may first seek advice on whether they should file a case.

This option does not exist in India. Some hospitals require the survivor to file a first information report (FIR) before the hospital will proceed with an examination. Most public hospitals inform the police before they examine the woman or child. In many cases the police bring the survivor in for examination. In our interaction the police said that either an FIR or a formal request from the police is essential before an examination. There do not seem to be any guidelines for this practice but at least one textbook clearly states: "The victim should not be examined without requisition from investigating police officer or magistrate." (4) One public prosecutor we spoke to said that prior examination would amount to collecting evidence before filing an FIR, which could not be admissible in a court of law.

Some legal decisions address this problem. One judgement has noted: "The refusal of some government hospital doctors, particularly in rural areas, where hospitals are few and far between, to conduct any medical examination of a rape victim unless the case of rape is referred to them by the police would not be proper. Such a refusal to conduct the medical examination necessarily results in delay in the ultimate examination of the victim, by which time the complainant herself may have washed the evidence of the rape away or (the evidence may) be otherwise lost. It is expected that the State will ensure that such situation does not recur in future." (5) However, such decisions have not been translated into clear guidelines for practice.

Recording relevant information

Developed countries no longer document the marital status of a survivor of sexual assault because it is accepted that sexual contact and assault can take place within as well as outside of marriage. It is also recognised that information about marital status is of no relevance in proving a sexual assault. But the doctors we spoke to said the legal system functions differently in India, where a woman's marital status and history of previous sexual contact are both treated as relevant. Evidence of sexual contact outside of marriage tends to be viewed as weakening the case against the alleged assailant. The chances of conviction are more when the victim is a minor or unmarried young woman and especially when there are clear findings of a ruptured hymen. Notations on the medical records such as "habituated to sex" are used to discredit the accuser. Doctors should be aware of what can be included in a medical examination report and what can be irrelevant or discredit the case.

Examination by male doctors

Some states have interpreted Section 53 (3) of the Criminal Procedure Code (only women doctors may examine women in custody) to mean that only women doctors may examine cases of sexual assault under all circumstances. This was stated by participants at the medical consultation held on December 18, 2004, at KEM and repeated in subsequent personal communications. The Punjab and Haryana high court asked the director of health services to take strict action against doctors violating these instructions.

Apparently as a result of these directions, male doctors in the southern states hesitate to examine female survivors of sexual assault. This can delay the examination when no women doctors are available, which is often the case in rural areas. Thus a pro-women decision may actually do a disservice to women.

Prophylaxis for HIV and Hepatitis B

There are no guidelines on the use of prophylaxis against HIV and Hepatitis B for sexual assault survivors in India. One doctor said that survivors of sexual assault should be given the same prophylaxis as is given health professionals with a needle-stick injury. For this to become part of a model protocol, money must be available for the drugs, especially if the same level of evidence collection and care is to be achieved at primary health centres. In any case women must be given appropriate advice on the risk they have been exposed to and what can be done about it.

Court testimony

How doctors should behave while examining the survivor and when testifying in court remains contentious. Examinations and testimonies that do not take the woman's situation into consideration can work against women. For example, when a local councillor raped a 16-year-old girl in Jalgaon in Maharashtra, she did not speak up fearing that her parents would be victimised. Five months later, the councillor was arrested for his involvement in a major sex scandal and the girl felt emboldened to report the crime. A medical examination was conducted though it was not expected to give evidence. The doctor in charge of the medical investigation, called by the prosecution, restricted his opinion to the fact that the girl had had sexual contact. The defence called on the testimony of a second, woman doctor who described the girl's vagina as distal or "spread apart", which led to a debate on whether she was "habituated to sex" and had consented. The defence testimony did not affect the outcome of the case and the accused was later convicted (6). We recommend that doctors weigh the consequences of their evidence so as not to lead the discussion to the character of the woman.

Conclusion

UNICEF has developed a manual to guide doctors while examining victims of trafficking and child sexual abuse (7). The World Health Organisation has developed comprehensive guidelines for care and evidence collection in cases of sexual assault (8). We advocate using these guidelines to develop locally appropriate best practices, standardised protocols and evidence collection kits. These will guide doctors and help them to resolve dilemmas and provide comprehensive care to survivors of sexual assault.

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