Responding to Sexual Violence
Evidence-based Model for the Health Sector

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This paper is based on the results of establishing a comprehensive health-sector response to sexual violence. Eliminating existing forensic biases to rape and the neglect of healthcare needs of survivors, the model uses gender-sensitive protocol for medico-legal documentation of sexual violence, which focuses on informed consent, documentation of the nature of sexual violence, and collection of relevant forensic evidence. It uses standard treatment guidelines for the provision of treatment, and ensures psychosocial support to the survivor. The results indicate that a sensitive response by health professionals can play a crucial role in healing from sexual abuse.

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Healthcare settings provide a unique opportunity to respond to sexual violence as survivors may be brought for medico-legal examination or may report with health consequences. In the latter instance, health professionals can play a vital role in asking about abuse and creating an enabling environment for the survivour to disclose abuse. Whatever be the pathway, the role of health professionals in responding to survivors of sexual violence is dual, as it comprises both therapeutic and forensic aspects. The therapeutic role comprises provision of medical care and psychosocial support, whereas the forensic role comprises the documentation of sexual violence and the collection of evidence.

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments, advances, and acts to traffic or otherwise directed towards a person's sexuality using coercion, threats of harm, or physical force regardless of the relationship to the victim in any setting, including, but not limited to, the home or workplace (WHO 2003). Survivors commonly experience heightened fear, anxiety, depression, flashbacks, nightmares, withdrawal, and PTSD (post-traumatic stress disorder). Negative consequences of sexual violence have also been documented as sexually transmitted infections (STIs), including HIV, genital fistula, unwanted pregnancy, incomplete abortions, and pelvic inflammatory disease. Beyond the negative psychological effects, studies have also documented long-term mental health sequela, such as acute panic, generalised anxiety, suicide ideation and attempts, and obsessive compulsive disorders (WHO 2007).

Therefore, it is pertinent that the health sector respond in a comprehensive manner to sexual violence. Health professionals have an obligation to create an enabling atmosphere, where a survivor can speak without fear of being judged and receive care as well as medico-legal support, which could subsequently help the survivor in her quest for justice. However, the health system in India falls short of responding to these core needs of survivors. The rape and brutal assault of a young girl in New Delhi in December 2012 has created a furore and brought to light the limitations of various systems. One of the issues highlighted was the insensitivities in the forensic response, particularly the two-finger test and comments about whether or not the survivor is "habituated to sexual intercourse", and the gross neglect of healthcare needs (Bhate-Deosthali 2013; Yee 2013).

It is a shame that despite being a signatory to treaties such as the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in which the

right to health is enshrined, the Government of India is far from ensuring the creation and availability of comprehensive health services for its people, and more so for those who have been subjected to sexual violence. Therefore, survivors of sexual violence encounter insurmountable barriers to the realisation of their right to health. Taking cognisance of this gap in the health sector's response, the Ministry of Health and Family Welfare has recently issued national guidelines and protocol for medico-legal care, which for the first time operationalise the right to healthcare for survivors of sexual violence (Mascarenhas 2014).

This paper highlights the ongoing efforts of the Centre for Enquiry into Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM) in setting up a comprehensive health sector model in three municipal hospitals. The contours of the model, evidence from the service records, and outcomes are presented here to show that such models are possible and sustainable, and must be upscaled by the government.

International Healthcare Initiatives

Internationally, sexual violence has been recognised as not only a medico-legal emergency, but also as a serious health issue that requires focused and long-term healthcare. The United States of America (US) and the United Kingdom (UK) are among the first countries to have developed multidisciplinary and survivor-focused health management models to respond to sexual violence. Sexual assault nurse examiner programmes (SANE), sexual assault response teams (SART), and rape crisis centres (RCC) are some of the pioneering efforts made by these countries. A review of the work done by RCCs in the US and the UK enabled us to understand the importance of psychosocial support services for survivors and their families in helping the survivor cope with the consequences of sexual violence. These centres were either based out of hospitals, or functioned as health entities in the community. The models showed the ways in which a coordinated response can be offered to survivors within the health setting itself. The focus of all the centres was to ensure that survivors received good quality care, psychosocial support, and medico-legal services.

> One of the most pioneering approach[es] to sexual assault was made in the US in Kansas City, Missouri in 1973 as it recognised the need for anonymity by survivors and did not mandate reporting of sexual assault by law. Based on an understanding that a survivor may seek support for health consequences but may not be keen to report the crime, the centre provides the survivors with the choice of declining police intimation. This set up has mechanisms for storing collected evidence for a week in a safe within the hospital premises whereby a survivor had the time to decide on whether she wants to pursue a criminal litigation and if she decides not to pursue a case there is also a well drafted policy to dispose the evidence away (SART Toolkit 2011).

Thus, internationally, there is a far more nuanced approach as far as healthcare for sexual violence is concerned. In fact, violence against women has itself been recognised as a public health issue, and efforts have been made at different health settings to provide comprehensive services.

Existing Gaps in Response

Returning to the Indian context, one is confronted with a rather bleak picture where the health-sector response to sexual violence is concerned. The current practice in sexual violence examination procedures is fraught with problems with regard to providing care, as well as carrying out a forensic role. With regard to the latter, there is neither uniformity in examination and documentation, nor any use of gender-sensitive protocols, to the extent that every hospital – and even different doctors in the same hospital – may follow a different practice while dealing with sexual violence survivors (CEHAT 2010).

In spite of the fact that health professionals have a legal mandate to seek informed consent before embarking on any examination or treatment, these obligations are not met, or, if they are followed, then consent-seeking is viewed as a formality. An observation study conducted in one government hospital in Mumbai found that consent was sought by the clerk in the department by asking the survivor whether she was "ready for examination by a male doctor or not". The clerk also sought a history of sexual violence while sitting in the corridor (CEHAT 2010). No information or rationale for the examination was provided, nor were the benefits of such an examination explained. In other settings, too, consent sought is often "blanket", and survivors are not given the option of refusing any part of the examination or choosing only to avail of treatment. A dominant perception amongst health professionals is that consent is not necessary in medico-legal cases (Rege 2011).

While operationalising the forensic role, too, health professionals are preoccupied with determining the past sexual conduct of the survivor and whether or not she is habituated to sex, or whether she is a virgin. So irrelevant "findings" such as old tears of the hymen, size of the vaginal introitus, and comments on "habituation to sexual intercourse" are routinely recorded. Despite the fact that by law Indian Evidence Act (Section 146), the past sexual history of the survivor has been rendered irrelevant to cases of sexual violence, such parameters still find their way in medical examination proformas. An analysis of court judgments shows that such "findings" are used in courts to pronounce the survivor "promiscuous".

Further, several stereotypes and misconceptions regarding sexual violence inform the examination. Doctors look for injuries to establish lack of consent, and if they are not found (which is often the case due to the circumstances of sexual violence), they opine that rape did not occur. The fact that the survivor may have been unable to resist because of threats, or the use of restraint or intoxicants, is not taken into account at all. There is no emphasis on seeking history, so the details of the assault – such as the nature of sexual violence, time lapsed since the incident, use of lubricants or condoms, activities such as bathing, washing, or urinating – are not recorded. All of these facts determine whether any evidence would be found, and should ideally inform the process of examination and evidence collection. However, in practice, no such assessment is made by health professionals and swabs are collected mindlessly, irrespective of the history. What also emerges is the preoccupation with medico-legal procedures and a complete neglect of the therapeutic needs of survivors (Reddy et al 2010).

The World Health Organization (WHO), in its guidelines concerning the medico-legal care for sexual assault (2003), states that "the overriding priority in cases of sexual assault must always

be the health and welfare of the patient". This, however, is far from true in the Indian context. Psychosocial support, an important part of the health system's role, is absent in health facilities across the country. There are no standard guidelines for the treatment of sexual violence, and health professionals are given no training on identifying the health consequences of sexual violence. The medico-legal forms have no space for recording "treatment provided", which often results in neglecting those needs if the survivor does not have serious physical injuries.

Even in tertiary care hospitals, despite their state-of-the-art medical facilities, there is no standard treatment protocol for sexual violence survivors. More so, referral and follow-up services are entirely at the police's discretion; even advice of treatment to be taken, further tests to be conducted, and follow-up services were provided to the police and not the survivor herself. If the police thought it important, they would take the survivor for all the treatment and tests. But if they did not, this would be neglected (Contractor et al 2011).

It was within this context that CEHAT, along with the MCGM hospitals, set out to operationalise a comprehensive healthcare model for ensuring the right to healthcare for survivors of sexual violence.

Setting Up the Comprehensive Healthcare Model

The model was established in three municipal hospitals of Mumbai under the leadership of the chief medical superintendent of peripheral hospitals, Bombay Municipal Corporation in 2008. The initiative was built on the experience of running two crisis centres for survivors of domestic violence for more than a decade. The most critical element of the model was formulating gender-sensitive and uniform proformas, a manual that provided step-by-step instructions on how to conduct an examination and established standard operating procedures for comprehensive care. Senior officials of the Forensic Science Laboratory reviewed the protocol and offered their suggestions.

Evolving Components

A comprehensive healthcare response to sexual violence was evolved, which was informed by Indian law.

Table 1: Components of the Healthcare Response

Components	Why Is It Important?	Legal Provision
Informed consent	Enables survivors to exercise autonomy before embarking on medico-legal examination. Gives survivors the opportunity to understand the procedures and steps pertaining to medico-legal examination. Enables them to voice apprehensions and receive complete information about the examination and evidence collection procedures. A survivor aged 12 years and above can consent to examination and treatment independently. The age of 12 as the consenting age is crucial, especially in the context of incest.	Section 164(A) of the CrPC mandates the need for informed consent for sexual violence examination. It directs the physicians to seek specific consent for each component of the examination and evidence collection, as against a blanket consent. Section 89 of the IPC states that a person aged 12 years and above is empowered to provide consent for examination and treatment.
Medico-legal history and documentation related to sexual violence episode	No information should be sought on past sexual history, as it has no relevance to the currently reported sexual violence. History documented in the words of the survivor as against the old format of documentation, such as "alleged history of rape". Enabling the survivor to narrate all forms of sexual violence, such as licking, sucking, forced masturbation, and not restricting history seeking to mere "peno-vaginal acts", as sexual violence is known to occur in various forms – anal, oral, non-penetrative, use of objects, fingering, and so on.	Section 146 (Indian Evidence Act) states that the past sexual conduct of the victim and comments about "habituation to sexual intercourse" are irrelevant. Therefore, such history should neither be sought nor recorded for medico-legal purposes.
Medico-legal examination and evidence collection	Medico-legal examination is guided by the history sought from the survivor and the time lapsed after the assault, as against mechanical evidence collection, which is a routine practice amongst health professionals in India. Genital and physical evidence collected only if the survivor reported to the hospital within four days of the assault. This is based on scientific evidence from WHO, which states that bodily evidence erodes rapidly with time, and so chances of finding evidence reduce drastically. Examination focuses on body and genital examination for evidence of injuries, seminal stains, etc. Genital examination notes only injuries related to assault and not old tears to the hymen or size of vaginal introitus.	Section 146 of the Indian Evidence Act makes the two-finger test to determine the size of vaginal introitus in cases of sexual violence completely irrelevant. Several court judgments have repeatedly stated that this test is violative and must not be used. Courts have said that the presence of injury is not necessary to prove rape.
Provision of medical opinion	Medical opinion focuses on whether the assailants can be identified by any means. Evidence of assault by determining the use of force, time lapsed between the assault to reaching a medical facility. Actual age of the survivor in the case of minor survivors below the age of 12. Reasons provided for the absence of injuries and negative forensic science reports.	Section 164 (A) of the CrPC states that the medical examination report must state reasons for each conclusion in the medico-legal report.
Medical treatment and psychosocial support	The protocol for treatment for all survivors included treatment and prophylaxis for sexually transmitted infections, including HIV. Pregnancy prophylaxis and management (including emergency contraception, pregnancy testing, and abortion, if required). Surgical management, analgesics and tetanus toxoid for injuries. Psychosocial support focuses on demystifying medical procedures, and addressing fears and concerns that survivors may have about their lives post the assault. Involving families and friends to deal with the aftermath of the assault, and creating an enabling environment for healing from the effects of assault.	The right to health is recognised as a fundamental right under the Constitution of India, judicially recognised as emanating from the right to life, Article 21. Thus, the primary responsibility of a physician is to provide treatment to his/her patients. The Code of Ethics Regulations, 2002, also states that doctors must ensure that patients receive appropriate healthcare, and should not be negligent towards their primary duties.
Chain of custody	Designated the role and responsibility of each employee in the hospital for the management of the evidence collected.	

The focus was on informed consent, detailed documentation of the assault, formulation of medical opinion based on clinical findings, factors leading to the possible loss of evidence – such as delay in reporting, bathing/douching/menstruating/urinating – circumstances of abuse such as verbal threats, numbing due to fear, and so on. An important component of this model was building the capacity of healthcare providers to carry out medico-legal examinations, understand the impact and health consequences of assault, and the provision of care. The training also included a perspective on the dynamics of sexual violence, and the myths related to it to enable them to overcome biases. A crisis interventionist was available at all times, responding to any query of the examining physicians, dealing with the police and the CWC, and providing crisis intervention services to the survivor and her family.

Learnings from the Interventions

The learnings are based on the experience of implementing a comprehensive healthcare response to sexual violence survivors in three municipal hospitals of Mumbai (2008-12), and an analysis of the case records of 94 survivors. Fifty-one of these 94 survivors were children.

Recognising Voluntary Reporting

A whopping 41 out of 94 survivors reported to the hospital voluntarily for healthcare and treatment, which is a very unique situation in all three hospitals. This is because hospitals across the country demand a police requisition for a sexual violence examination and also deny treatment. Although the provision of seeking treatment and accessing a hospital voluntarily was brought in with a landmark judgment in *Manjanna v/s state of Karnataka* in 2000, the information has not percolated down to the level of health systems across the country. Thus, even 13 years after this judgment, survivors reaching hospitals on their own are routinely denied treatment. In fact, seven of the 41 who voluntarily reached these three hospitals revealed that they were refused treatment in other hospitals because they did not come with the police.

Voluntarily reporting survivors expressed fears for their health, which ranged from STIs and HIV, to unwanted pregnancies. When it came to child survivors, caretakers, including parents, expressed apprehensions about whether their child would be able to lead a "normal life" after such an assault. Trained health professionals were able to recognise the importance of voluntary reporting, and also responded to the queries of parents and survivors, and reassured them that they would receive complete healthcare.

Operationalising Informed Consent

As per Section 164(A) of the CrPC (Code of Criminal Procedure), no examination or evidence collection can be carried out – even if it is court directed – in the absence of consent from survivors. In order to carry out informed consent in its true spirit and empower survivors about the process, health professionals in the three hospitals were equipped via training to break down consent into specific sections, such as consent for examination and evidence collection, consent for treatment, and consent for information to the police. This meant that survivors had a right to decline any component of the consent. It was observed that survivors' participation in informed consent enabled them to ask questions, discuss apprehensions, and even express fear about procedures to health professionals, which is a rare phenomenon, given the power differentials between the patients and health professionals.

Operationalising informed consent also gave rise to a complex issue – the request by survivors/families not to inform the police about the crime. Such survivors had reached the hospital only for treatment.

Health professionals in such situations prioritised the health needs of survivors, as that was their immediate concern. Once this was taken care of, efforts were made to explain the benefits of registering the crime. When health professionals probed the reasons for such refusal, survivors revealed a fear of social stigma, shame, and its effect on their future. These fears were dealt with by explaining how the information would be kept confidential, and what the steps in the justice delivery process are. Survivors were also told that it is not they who should be ashamed, as they had done no wrong. Such a dialogue enabled survivors to gain in confidence and also register police complaints. Offering treatment immediately and having a dialogue with survivors and their families gave them the confidence to register a police complaint.

However, it was also seen that the process of dialogue revealed that some survivors (five out of the 94 survivors) did not want to file a police complaint at all. As per the law, the consent of a survivor has to be respected; a health professional cannot override her consent and intimate the police about a crime against her wishes. Doing so would jeopardise her health, as, fearing police intimation, she might leave the hospital. The situation at hand in these hospitals was about respecting the survivor's consent, while at the same time ensuring that health professionals do not come in for criticism for not informing the police. In order to achieve this, a system of "informed refusal" was developed. This means that the benefits and consequences of informing the police are explained to the survivor, but if she decides not to inform the police, the process of explanation and her subsequent refusal is documented, and the document signed by the survivor and the examining doctor.

Such an approach is legal and ethical because it does not compromise on the survivor's rights. However, this is still a radical approach, given that hospitals across the country do not even recognise such an aspect of non-reporting to the police as the right of the survivor.

Understanding the Circumstances of Sexual Violence

Recording the details of the sexual violence and the circumstances in which it occurred is a critical aspect of the medico-legal role of health professionals. Health professionals were trained to seek a detailed history, such as whether survivors were assaulted orally, anally, or vaginally; the nature of the threats received; if they were offered a drink; if they felt giddy or fell unconscious; and the nature of the activities undertaken by them post the assault. Detailed history seeking was found to be extremely helpful by health professionals, not only in assisting survivors to articulate abuse, but also in deciding upon the nature of examination and evidence collection. In the case of children, the use of body charts, dolls, and paper-pencil helped health professionals to seek information about the nature of the assault faced by them.

Thirty of the 94 survivors reported non-penetrative sexual violence, such as forced masturbation of the survivor and touching and fondling, whereas 21 reported non-penile penetrative forms, such as the use of fingers and objects. The rest reported a combination of peno-anal, peno-oral and peno-vaginal assault. This evidence could only be brought to light because of the skills acquired by health professionals to seek an in-depth history of assault. This also challenges the dominant perception that all sexual violence is peno-vaginal in nature. Besides the history of the assault, it also brought to light the fact that 26 out of the 51 child survivors had been lured with toys, chocolates and money. Such information is critical to understanding the tactics that perpetrators use to sexually violate children.

Gender Sensitivity in Examination and Evidence Collection

Based on the details of the sexual violence provided by survivors, health professionals are expected to carry out a general and genital examination, collect relevant evidence, and document findings related to the assault. In this regard, health professionals in the three hospitals were trained to not restrict themselves to identifying injuries per se, but to also record the health consequences possibly resulting from the assault, which could be in the form of pain, discharge oedema and tenderness. Such an engagement enabled health professionals to take one step further and record the reasons for the lack of injuries. Health professionals were able to record that survivors reported being unable to resist because of threats of being killed or harmed, or because they were rendered unconscious or were too scared to resist. Sometimes, the very act of sexual violence may not be penetrative and so may not leave any injuries. Such evidence is crucial, and needs to be disseminated to the health fraternity at large in order to move away from an overemphasis on injuries.

Evidence collection and the examination of a survivor go hand in hand, because the process of evidence collection cannot be a mechanical one. Body evidence can only be collected within a period of 72 hours from the time of assault. At the same time, it has to be recognised that bodily evidence erodes rapidly with time, and also through certain activities such as gargling, urinating, bathing, defecating, and menstruating. Therefore, seeking such information is critical before embarking on evidence collection.

The testimonies of survivors at these three hospitals brought to light the fact that an immediate step after assault was to wash and clean themselves, which was understood by health professionals as a natural, reflexive response. Any mention of such activities was documented by health professionals in the proforma in order to explain why evidence was not collected after 72 hours, or why the swabs did not test positive when they were sent to the forensic science lab. Such documentation provides a reasoned explanation when the forensic evidence reports have negative results.

Gender-Sensitive Documentation Protocol

In all three hospitals, a uniform and gender-sensitive proforma was used for treatment, examination and evidence collection. In order to make it gender-sensitive, the categories below were omitted.

- Size of the vaginal introitus/hymenal opening/number of fingers admitted by the opening.
- Comments on old tears to the hymen.
- Comment on habituation to sexual intercourse.
- Irrelevant obstetric history (such as a history of past abortions).

The use of a gender-sensitive proforma brought to light that as many as 74 of the 94 survivors did not have any physical injuries, and 57 of the 94 did not have any genital injuries, despite reporting within 48 hours of assault to these hospitals. This is an important finding, especially to break the myth that sexual violence must leave injuries, either physical or genital. Trained health professionals also recorded the reasons for the lack of such injuries, and documented the circumstances of the assault. Such documentation brought to light the several tactics used by perpetrators to intimidate survivors. Survivors reported being too scared and shocked by the attack, whereas children reported tactics such as being offered a candy, space to play, permission to watch television, and the like.

Increased Ability to Provide a Reasoned Medical Opinion

Under Section 164A of the CrPC, health professionals are expected to interpret the medical findings and provide a medical opinion. However, most health professionals provide neither a provisional nor a final medical opinion. They often see the FSL reports in court, and rarely correlate the clinical findings, evidence and history. This model enabled health professionals to understand that the purpose of the opinion was to determine whether there is any evidence pertaining to either penetrative or non-penetrative sexual violence, or whether the survivor was incapable of consenting (as she could have been drugged, been suffering mental incapacitation, mental retardation, or any other illness).

One of the issues related to medical evidence in rape cases is that medical evidence is rarely found. This model intervention helps doctors to present the circumstances of the incidents of sexual violence, factors that are likely to lead to a loss of evidence, as well as time lapse and activities undertaken by the survivor post assault, and present a report that correlates the history, clinical findings and forensic reports. This ensures that the reasons behind a lack of medical evidence are explained by the doctor, and so the courts then rely on the survivor's testimony alone and do not interpret the medical evidence as not supporting or contradicting her testimony. Because of this intervention, in some cases the courts ruled in favour of the survivor in spite of classic negative medical evidence such as "no injuries and no semen", as the doctor was able to explain their absence as being due to a time lapse, or menstruation or bathing, and so on.

In one situation, a 15-year-old girl reported one day after being sexually assaulted. However, she was menstruating, and therefore the collected evidence tested negative after the FSL analysis. In the court, when the doctor was asked why the evidence turned out negative in spite of the girl having come to the hospital in a matter of 24 hours, the doctor was able to provide a sound analysis, stating that evidence, if any, is washed away with menstrual blood, and therefore the chances of getting any positive evidence is reduced significantly. Thus, a conviction was secured on the basis of the survivor's testimony alone.

Provision of Medical Care

The treatment protocol included immediate pain management along with antibiotics, STI assessment inclusive of HIV testing, and emergency contraception, all of it provided free of cost. Health professionals also discussed with survivors the possibility of certain health consequences appearing at a later stage (which could be in the form of any infections that the perpetrator may have passed on to the survivor), and the importance of follow-up for treatment. Such information provision and medical care is critical in order to mitigate health consequences.

All survivors received immediate medical aid and care. Such an immediate response was critical, especially in the context of fear of infections such as STI, HIV, unwanted pregnancy, and pain while urination and defecation, and generalised body ache. Five out of the 94 survivors reported to the hospital almost one to two months later, seeking abortion services as they realised they had become pregnant after the assault. The resulting pregnancy prompted them to disclose the assault.

Crisis Intervention Services

Health professionals followed a survivor-centric approach, wherein they were encouraged to view sexual violence as a brutal form of physical violence and violation of bodily integrity, and not as a loss of honour. They encouraged survivors to disclose their fears about their lives post the assault, and while doing so, the focus of the interventions was to place the onus of abuse on the perpetrator and not on the survivor. Explaining the relevance of the medical examination and providing information about the treatment plan helped survivors to clear their doubts and fears regarding the medical examination. Safety assessment formed an important component of interventions, as many survivors have to return to the same social environment and may face hostility from the perpetrator's family. Interventions comprised of discussing ways in which they can keep themselves safe if the perpetrator is not arrested, or if he is out on bail.

The experience of counselling survivors through this initiative also brought to light the fact that not all survivors are keen on pursuing legal redress. With child sexual abuse (CSA) survivors, parents often wanted to forget the entire episode and move on, while in the case of adult survivors, families and caregivers were found to be worried about marriage prospects. Survivors themselves wanted to move on and not think of the episode. In such situations, it was critical to respect their decision, but continue making efforts to follow up for counselling. Working with the family members of survivors also helps them to deal with their own trauma and apprehensions regarding the survivors and their future. We found that positive messaging, such as dealing with rape as a severe physical assault, uncovering feelings of shame, helplessness and hopelessness, and linking them to the social context in which rape occurs helps in reducing self-blame (CEHAT 2013).

> R, a 25-year-old pregnant woman, met with a lot of hostility when she decided to pursue a legal case. Fearing social and community backlash, her own parents and in-laws were pressurising her to back out from the case. R voiced her feelings of despair and during the process of dialogue, it came to light that the withdrawal of support from both families had resulted in making her feel somehow responsible for the rape. During counselling, R was encouraged to see that she had been targeted for having questioned authority – she had stood up to the perpetrators when they attacked her husband. Therefore, she should view her actions as resisting abuse; also, because she had questioned the perpetrators, her husband was still alive. Efforts were also made to speak to the family to encourage them to see the sexual violence in this light, and to impress upon the family members the need to support R in her quest for justice.

This comprehensive healthcare model, set up to respond to sexual violence, is an important milestone in strengthening the health system's response to this issue. The learnings from the ongoing implementation demonstrate that health settings can be sensitised to the issue of sexual violence through capacity building, and adhering to the standards of care.

Conclusions

Setting up services for the survivors of sexual violence must be prioritised. The evidence from this model shows that it is possible to set up such services within health settings even with the current resources if training is provided and clear protocols laid down. As stated earlier, this model in India builds on global evidence, which shows that prioritising medical response to sexual violence can in fact increase reporting. What is needed is a clear policy direction for the health system, one that lays down protocols and procedures for medico-legal care. The Ministry of Health and Family Welfare guidelines pave the way forward, and we hope that state governments and health professionals will take cognisance of this evidence-based model and replicate it across health settings. A coordinated and sensitive response by the various systems will enable survivors to cope with the trauma, as well as pursue their case in the court of law. With greater awareness and better access to services, survivors and their families will not have to face any stigma from the system and/or society.

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