Establishing a Comprehensive Health Sector Response to Sexual Assault

Cehat

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Centre for Enquiry into
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Preface

The impact of violence on the health of women and children affected by it is well documented in medical literature and recognized by international bodies such as the World Health Organization. Health professionals have a role in providing care to survivors of abuse and also providing medico-legal evidence to strengthen the legal case in the court of law.

Since the year 2000, Dilaasa has been working towards providing sensitization training to health professionals on the issue of domestic violence and also providing counseling services to women facing violence. In the year 2008, we also initiated a comprehensive health sector response to sexual assault, modeled along the WHO guidelines, in three of the hospitals of the Municipal Corporation of Greater Mumbai. As part of this endeavour, a gender sensitive protocol to aid examination, evidence collection and treatment of survivors of sexual assault has been implemented in the hospitals and counseling services are provided to all survivors reporting to these hospitals.

This intervention is the first of its kind in the country and has shown that comprehensive services can be provided by hospitals within their existing resources, while ensuring sensitivity and adherence to obligations under the law. Through this report, we hope to further an understanding of the role of health systems in responding to sexual assault and provide a model for replication in other states. It is hoped that the evidence generated through this collaborative intervention research project implemented by CEHAT and the MCGM will propel other health institutions too, to initiate such endeavours so that survivors who have gathered the courage to report sexual assault are provided with timely and sensitive care.

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Executive Summary

The National Crime Records Bureau (NCRB) estimates that 24, 923 cases of rape and 45, 351 cases of molestation occurred in India in 2012. Given that a large majority of survivors do not even report the crime because of the stigma attached to rape and sexual assault, these numbers are most likely an underestimation. Because sexual assault is a crime, survivors are brought to the hospital for a medico legal examination as prescribed by the Criminal Procedure Code. Also sexual assault results into health consequences which need treatment. Health professionals have a legal and ethical responsibility to respond to those reporting with sexual assault. Unfortunately, the health sector in India is not sufficiently prepared for responding to survivors of sexual assault.

Several issues constrain the health sector response in cases of sexual assault currently, most importantly, the lack of guidelines for sexual assault examination and evidence collection, gender insensitive and unscientific methods for examination, denial of treatment. Health providers generally lack the knowledge about their legal and ethical obligations towards sexual assault survivors hindering survivors' access to justice. The issue of sexual violence has remained at the periphery of both medical practice and medical education. In spite of the long standing critique by women's rights advocates on the stereotypes and biases against sexual assault survivors in medical practice, education and medical textbooks, there has been little serious attempt to reform medical education.

CEHAT is the first institution in India to have directly engaged with the public health sector to develop a health-system based model to respond to sexual assault. This initiative, which began in 2008, has been built on an earlier initiative in which the Public Health department of MCGM and CEHAT had collaboratively developed a model hospital based crisis counselling department (Dilaasa), to respond to women facing domestic violence. The comprehensive health care model for sexual assault survivors included development and implementation of a gender sensitive examination and treatment proforma, operationalization of informed and specific consent, free treatment, provision of crisis intervention services, legal aid and police assistance. Three hour orientation modules were developed to equip health providers to develop a sensitive approach, enable a non-threatening dialogue with the survivor, hands on training on evidence collection procedures and documenting information about the episode. Only trained health providers were vested with the responsibility of managing the sexual assault interventions. This initiative has provided insights and a series of lessons on developing a comprehensive health sector response to sexual assault. This report is based on the experience of establishing such an initiative and is based on the data from the project.

Key Findings:

Profile of the survivors and nature of assault:

1. More than half the survivors reporting to the hospital were children in the age group of 0- 12 years (51/94). At least 1 in every three child survivor reported being lured in to the act by promise of a gift/ a toy / chocolate.
2. The perpetrator of the assault was known by 3 out of every 4 women. Most perpetrators were close relatives such as uncles, grandfathers, fathers and neighbours. (74/94)
3. Nearly half the survivors (41/94) reported directly to the hospital before reaching the police station. 4 out of these survivors disclosed about the assault when they learnt that they were pregnant.
4. Sexual assault reported by survivors was not restricted to peno-vaginal penetration but also included other forms such as penetration by fingers, masturbation, anal penetration, touching of genitalia and breasts.
5. Physical force was seen to be used more commonly among adolescents and adults, rather than children.

Health Consequences of sexual assault:

1. Almost half of the survivors reported to the hospital directly for treatment while the rest of them went first to the police to file a complaint. This underscores the need to recognize voluntary reporting to the health facility, as well as treatment for health consequences.
2. 62 of the 94 survivors reported with physical health consequences including injuries, infections, and unwanted pregnancies. Survivors also reported being examined and not treated. The need for treatment brought them in contact with the hospital where the model was being operationalized. These findings underscore the need to emphasize the role of the health system in providing treatment and psychosocial support to survivors reporting sexual assault.
3. With regard to psychological health consequences, those in the ages of 13 and above demonstrated anxiety and flashbacks while speaking about the episode with 2 survivors reporting thoughts to end their lives. In cases where the perpetrator was related to the survivor, the fear of another episode of sexual assault loomed over them. It was seen that anxiety and feelings of sadness are aggravated because those around them such as carers keep worrying about the future.
4. Survivors with familial support appeared relatively comfortable while speaking to the interventionists. Even in terms of pursuing legal action, these families were supportive and encouraged the survivor.

Medical Evidence in sexual assault:

1. The findings of the intervention project clearly demonstrate the crucial role that the health sector plays in responding to sexual assault survivors. It also highlights that training and consistent dialogue with health care providers enables them to become sensitive in their approach to survivors and increases their confidence in carrying out their medico legal role effectively.
2. The gender sensitive proformas used by health providers as a part of this project enabled them to elicit appropriate history, seek informed consent, carry out relevant general and genital examination, collect body evidence and also provide a medical opinion. The report provides several examples where in health care providers have provided a reasoned medical opinion about both penetrative and non-

penetrative forms of sexual assault taking in to account factors such as delay in reporting to the health facility and loss of body evidence. The analysis of sexual assault medical records brought to light the fact that 47% of survivors had changed clothes immediately after assault, 38% had bathed, 28% had douched, 67% had urinated and 40% defecated. Undertaking such activities drastically reduced chances of finding any evidence on the body in spite of the fact that these survivors reached the hospital within 24 hours post sexual assault. These findings need to be used to educate health providers on a wider scale and call for a re-assessment of how medical evidence is interpreted by the judicial system.

3. Only 21% of the 94 survivors sustained bodily/physical injuries and only 39% survivors sustained genital injuries. Narrations of survivors have brought to light reasons for not being able to resist the assault, these are - fear of being killed, feeling completely numbed / shocked when assaulted , being rendered unconscious during the assault and the nature of assault itself such as fondling, masturbation of the survivor which don't leave any physical injury. Similarly 57 out of 94 sustained no genital injury, the reasons as stated above clearly bring out that intimidation of the survivor can occur using several tactics and there need not be any physical force what so ever. Even in penetrative assaults, injuries may not be seen. It is therefore critical to disseminate widely that absence of physical and genital injuries doesn't mean that the assault has not occurred and in fact detailed recording related to threats, intimidation of the survivor etc can help in interpretation of lack of injuries.

Recommendations

1. A comprehensive response to sexual assault requires a multi-pronged approach. Several entities such as the police, public prosecutors, community based organisations, shelter homes and legal aid institutions play an important role in sexual assault redressal. Unless these allied agencies are trained to understand the long term consequences of sexual assault, the response to survivors would continue to be fragmented.
2. The findings from this intervention research project emphatically present a case for changing obsolete medical practices in sexual assault examination and care, and for urgently adopting progressive and gender sensitive methods of examination and treatment in the health system. The report also provides ways and means of replicating such a health care response at the hospital level. It points to the need for developing standard operating procedures for health systems as well as other agencies such as law enforcement.

I. Introduction

Sexual Violence: A Health Issue

The crime of sexual assault has a significant impact on women's well-being and is an issue of concern for those working in the field of health. A growing body of evidence suggests that survivors of sexual violence suffer both physical and psychological health consequences. Physical health consequences include unwanted pregnancy, gynaecological morbidity such as pelvic inflammatory disease, genital bleeding, injuries, irritation, pain and in extreme cases even perforation of internal genital organs. Mental health consequences too have been well documented. Studies from developed countries have reported that women who have been sexually abused are more likely to experience psychological distress than non-abused women. (WHO 2007) Suicide too has been linked to a history of sexual abuse, with women who are sexually abused being more likely to attempt suicide than others. Moreover, mental health outcomes are likely to be poorer if the survivor is blamed, encouraged to suppress her feelings or not given an opportunity to talk about the abuse. (Campbell R et.al. 1999) The medical profession specifically, has a critical role to play in the healing of those who have been sexually assaulted, as also in their quest for justice. Indian law prescribes a well-defined role for them in this regard, as do international bodies such as the World Health Organization.

There were 24, 923 cases of rape and 45, 351 cases of molestation reported in India in the year 2012, according to the National Crime Records Bureau (NCRB 2010). However the NCRB figures only take into account those cases that have been reported to law enforcement agencies. The figures may well be an underestimation, as the great stigma attached to sexual assault discourages reporting. Further, survivors who gather the courage to report are known to encounter insensitive treatment at both police stations and health facilities. These institutions routinely express disbelief in the survivor's experience of assault, and display victim blaming attitude. Such beliefs by the health systems and allied agencies leads to secondary traumatisation of the survivor, which can result in poor psychological outcomes and can jeopardize their help seeking behavior. (Ullman 1999)

The National Family Health Survey NFHS 3 shows that in India, 8.5 percent of all women in the reproductive age group (15-49 years) have experienced sexual violence (defined as being forced to have sexual intercourse or perform any other sexual acts) at some point during their life. It is important to note that NFHS captures the prevalence of sexual violence within marriage, something that cannot be estimated through NCRB figures, as it is not recognized by rape law as such. Other community-level studies also show higher percentages of sexual assault being reported. A nation-wide survey on child abuse was conducted by the Ministry of Women and Child Development in 2007 across 13 states, covering over 12,000 children between the ages of 5-18 years. The study found that more than half of the children reported having faced some form of sexual abuse. Further, 21% of children reported 'severe sexual

abuse' (which included sexual assault, making the child fondle private parts, making the child exhibit private body parts and being photographed in the nude). 51% reported 'other forms of sexual abuse (which included forcible kissing, sexual advances made during travel and marriages and exposure to pornographic materials). (Kacker, Varadan, Kumar 2007)

Indian Women's Movement's response to sexual violence

In India, it was the women's movement that brought the issue of sexual violence to the forefront in 1980's by critiquing archaic practices of the courts, police machinery and health systems. Consistent agitations by the movement were especially seen with the custodial rape of Mathura a tribal girl from Maharashtra, who was raped in police custody. Mathura's case brought to light several lacunae both within law enforcement agencies, the judicial system and health systems. The examining doctor in Mathura's case recorded 'habituation to sexual intercourse' and 'lack of injuries' as a component of medical examination, which then was used against her in the court, citing that she was a girl of poor character and that she did not resist the act; had she done so , there would have been marks of injuries on her. Later the Supreme Court too accepted the police defense that Mathura was a sexually promiscuous girl and had a boy friend, so rape could not have occured. It further went on to conclude that there were no injuries seen and so the sexual intercourse must have been 'a peaceful affair'. Such regressive practices both in the court and by the health system led to agitation by the movement across the country. These agitations yielded some achievements, one of which was recognition of 'Custodial Rape' as a separate category in the law and punishment was prescribed at 10 years.

Throughout the 80s and 90s, the autonomous women's movement continued to concentrate on bringing reforms in the legal constitutions of rape, and several gains were made in jurisprudence. Shifting the 'burden of proof' from the victim to the accused (Section 114 A of the Indian Evidence Act, Criminal Law Amendment Act of 1983), deeming past sexual conduct of the survivor irrelevant in sexual assault, and prohibiting questions pertaining to the character of the survivor were landmark reforms in law.

Simultaneously, progressive doctors critiqued the lack of gender sensitive protocols in medical examination of sexual assault and raised concerns about archaic medical examination methods. One such critique was put forth by Dr. Lalitha Dsouza in her paper "Sexual assault – The role of an examining doctor" (D'souza 1998). The paper drew attention to the lacunae in medical examination of sexual assault and brought to light how most medical examinations were restricted to examination of hymenal status and determination of vaginal laxity. This was indicative of preoccupation with virginity of the victim. This bias was seen to be so strong that specialists even resorted to using measuring cones and hymenoscopes to determine the size of the hymenal opening. The paper also criticized forensic medical text books which showed 15 different types of hymens, but did not even mention other aspects of genital and general examination in sexual assault.

A similar critique of Forensic Medicine was undertaken by Adv Agnes in 2005 which pointed out that a popular textbook on Medical Jurisprudence by Modi introduced the subject of rape as follows: "Beware – A charge of rape, of attempted rape or of indecent assault may be made against the doctor or dentist

– which may arise from a genuine misunderstanding of the nature of medical examination (especially of breasts or genitalia). A nurse or a female attendant/ witness should be present while a male doctor examines a female patient”. Further, the section titled ‘false charges’ goes on to make the doctor suspicious of women who levy charges of rape. (Agnes 2005) These critiques provided an insight into the biased and archaic notions that inform the approach of health care providers in carrying out medical examinations pertaining to sexual assault.

A more recent study conducted by Human Rights Watch in 2010 looked at a specific medical practice called ‘two-finger test’. The test is used to check the laxity of the vaginal introitus, which then provides the examining doctor the scope to determine whether survivor was sexually active or not. (HRW 2010) Despite the unscientific nature of the test and changes in the law rendering past sexual conduct irrelevant in cases of sexual assault, the report found that results of the two finger test were recorded routinely in medico-legal documents and used against the survivor in the court of law. The changes that the women’s movement fought so hard to bring about in law, had not translated into practice.

Yet another study conducted in a tertiary care public hospital in India in 2011 identified several lacunae in the management of sexual assault cases besides the two finger test. Lack of gender sensitive protocol for medical examination, lack of informed consent seeking, either incomplete treatment or denial of treatment, police coordinated examination process with absolutely no provision of health care (which is the primary responsibility of health care providers) were some of the lacunae in the hospital approach to sexual assault. In-depth interviews with health professionals revealed biases, gender stereotypes and misconceptions about sexual assault survivors. Health providers drew conclusions about veracity of a complaint depending on presence or absence of injuries and the medical opinions given by doctors commented on ‘habituation to sexual intercourse’ of the survivor. (Contractor 2012)

The efforts by the women’s movement as well as research studies drew attention to the problems in the health system’s response to sexual assault and also demanded reforms in the health system. But no direct engagement with the health sector was undertaken to establish a comprehensive model to respond to sexual assault. Even today, the issue of sexual assault continues to remain at the periphery of both medical practice and medical education in India.

Unlike the Western context, provision of treatment to survivors of sexual assault is not recognized as important in health facilities in India, and the focus is almost entirely on forensic examination. Therefore there is an urgent need for the health system to address: (1) ensuring right to holistic treatment to survivors, and (2) ensuring gender sensitive forensic examination and evidence collection.

International Models of Engaging the Health Sector in responding to Sexual Assault

Unlike in India, in the West sexual assault has been addressed not just as a legal issue but also as a health issue. Researchers and activists have made an effort to address the gaps in provision of healing and rehabilitative services for survivors even while drawing attention to the insensitivity of the health system to these issues. In consequence health systems in the US have long been involved in the response to rape and sexual assault. They provide comprehensive services and have progressively modified protocols for forensic examination and evidence collection. Secondly, the efforts to respond to sexual assault have addressed the aspect of health and healing - both physical and psychological - even while advocating changes in laws and protocols.

The Rape Crisis Center (RCC) Movement gained momentum in the United States and the UK in the 1970s. The trajectory of the RCCs began largely as a volunteer-led movement, with feminist origins, that provided crisis counselling services to survivors of sexual assault, and advocated for changes in law. While there are similarities in the trajectories of the movements in UK and in India, the difference lies in their engagement with law enforcement and health systems to make them sensitive. While RCCs were diverse, with different 'models' located in the hospital emergency departments and community centres, they typically, relied on rigorously trained volunteer 'rape victim advocates' who accompanied the survivor through the law enforcement and medical systems. A key role of the RCC was to provide counseling services to survivors - some RCCs provided such services in an autonomous capacity, while others did so by engaging with systems. (WHO 2007) For example, the Rape Crisis Center in Beth Israel Hospital which was one of the first hospital-based Rape Crisis Centers in the United States has trained health professionals who respond to sexual assault survivors including collection of medical evidence and provision of treatment. They have trained counselors who provide psychological support to clients and their families and friends. (Mezey 1987) Being housed in health facilities, such crisis centers are able to ensure comprehensive treatment and follow up for survivors and also provided sensitization training to health professionals.

The 1970s also saw the development of multi-disciplinary Sexual Assault Response Teams (SARTs) in the US that attempted to synchronize and sensitize different agencies responsible for responding to survivors of sexual assault, thus ensuring that their needs are prioritized. The SARTs typically consisted of law enforcement agencies, health professionals, forensic laboratory personnel, and prosecutors. One of the earliest and largest SARTs in the US was established in Kansas City, Missouri in 1973 with the initiative of the Kansas City Missouri Police Department. (Office of Victims of Crime) The initiative recognized the role of the health system with a city hospital, St.Luke's Hospital being designated specialized sexual assault victim treatment center. This centre is one of the first of its kind to recognize the survivors' need for anonymity. It recognizes that a survivor may seek support for health consequences and counselling but may not be interested in pursuing a criminal case. Of critical note is the fact that that even as early as in 1970s, some hospitals did recognize "voluntary reporting" as a concept. The center in St.Luke's hospital and Beth Israel Hospital Rape Crisis Center, are a few that provide such

anonymity to the survivors. These hospitals safely store and hold the collected evidence for a week, allowing the survivor the time to decide whether to pursue a criminal litigation.

Yet another early initiative in 1975 was the Sexual Assault Nurse Examiner Program (SANE) in Memphis, Tennessee. It equipped nurses with the skills to conduct forensic examinations and provide care to sexual assault survivors. These programs were initiated with the intention of providing specialized services, reducing waiting time at the hospitals and to address survivors' preference for female examiners instead of male ones. (Ledrey 1999) The program spread to other parts of the US and other areas of the world such as the UK and South Africa, where SANEs now routinely conduct sexual assault examinations. In 1988 the University of Tennessee also began to integrate sexual assault-related educational material into the curriculum for physicians and nurses.

Other than these US initiatives, integrated models for service provision with the health system, have also been established in the UK and South Africa. The London Rape Crisis Center was set up as early as 1970s, and later in the 90s hospital-based crisis centers such as 'The Haven' emerged. Located in the King's College Hospital, the center is staffed with specially trained health care providers and crisis counselors who conduct examinations, appear in court and also provide treatment and psychological care to survivors. (Kerr 2003) In South Africa, the Thuthuzela Centres focus on provision of integrated services to survivors and reduce secondary traumatization caused by legal aid and health systems. (National Prosecuting Authority, South Africa) In the South African context, health consequences of sexual assault, particularly transmission of HIV/AIDS are well-recognized and form the basis for locating sexual assault response centers in hospitals. Given the level of awareness in the community about HIV, survivors of sexual assault sometimes access these centers only for treatment, and may not necessarily register police complaints.

Closer to home, the Philippines, Thailand and Malaysia too have established health-system based responses to violence against women, in the form of One-stop crisis centers, integrated in health facilities. They provide medical, mental health, legal and other support such as shelter, under one roof.

While health facility-based models for responding to sexual violence are well established in the West, in several countries the role of the health system in providing treatment to survivors is recognized as part of policy. In South Africa for instance, the Department of Health's 'National Sexual Assault Policy', 2005 recognizes up front that responding to sexual violence is a public health challenge. The policy lays down its goals not just as improving the quality of evidence gathered by the health system, but to promote a 'holistic approach towards management of sexual assault together with an overall focus on improvement of the woman's health and quality of life'. (National Sexual Assault Policy 2005, Republic of South Africa) Similarly in Malaysia, the Ministry of Health issued a directive in 1996 to the health system to manage cases of violence against women, including setting up of one-stop crisis centers that would provide necessary services to all survivors of abuse. (Colombini 2011)

In India, although the issue of sexual violence has been in public consciousness since the 1980s, the crucial aspect of provision of psychosocial support services and crisis intervention services has remained

neglected. It is this gap in services that this intervention project initiated by CEHAT and the MCGM sought to bridge. Given that the MCGM had already established a hospital based crisis centre dealing with domestic violence in 2000 (Dilaasa), initiating a response to sexual violence seemed opportune and appropriate.

Structure of the Report

This report describes the experience of implementing this intervention in three Municipal Hospitals in Mumbai. The report is divided into seven sections. Section one has discussed sexual violence as a public health issue, models for engaging with the health sector in responding to it as well as the situation in the Indian context. Section two on 'Methodology' describes how the comprehensive model response that was opertionalized - the components of the intervention and the sources of data for this report. Section three describes the profile of survivors and the nature of sexual assault that was reported by survivors across different age groups. Section four discusses health consequences of the assault, how survivors came in contact with the health facility and what prompted disclosure. It also discusses the nature of medical treatment and psychosocial support that was provided to survivors as part of the model, and challenges to following up. Section five deals with the medico-legal response of the health facilities to survivors including the manner in which the components of informed consent, documentation, evidence collection and opinion formulation were operationalized and the quality of documentation so obtained. It also discusses that nature of medico-legal evidence that has been seen in the cases. Section six on 'Inter-Agency Coordination' describes the ways in which the hospital liaised with different stakeholders such as the Forensic Science Laboratory (FSL), police, courts and community based organizations, with the aim of ensuring smooth functioning of the model and catering to the various needs of survivors. The last section, namely section seven discusses issues that this intervention has highlighted and recommendations to various agencies in ensuring a comprehensive, sensitive and coordinated response to survivors of sexual assault.

II. Methodology

CEHAT's Background of Working with the Health System to Address Sexual Violence

In 2000, CEHAT collaborated with the Municipal Corporation of Greater Mumbai to establish a response to domestic violence at a public hospital in Mumbai. This initiative, called 'Dilaasa', was the first such attempt in India to make the health sector sensitive and accountable to the issue of Violence Against Women. Health care providers were sensitized to the issue and trained to recognize and respond to women reporting violence. A crisis intervention department was established where women who were identified as facing domestic violence could receive psychosocial support. In order to sustain the sensitization programs, a core-group of doctors and nurses was selected who could train their peers on responding to women facing domestic violence. Such training was conducted across four other hospitals as well. This consistent engagement with health care providers led to the emergence of a committed group of about 60 health professionals across these hospitals, who expressed the need for a comprehensive response to survivors of sexual violence. They observed that the protocols for examination were not systematic across the hospitals and neither were doctors trained for this purpose. Using this as an opportunity, CEHAT initiated an effort to establish a model for providing comprehensive services to survivors of sexual assault with three of the hospitals that receive substantial number of survivors of sexual assault.

Comprehensive Model for Health Sector Response to Sexual Assault

The goal of this project was to implement a comprehensive and gender sensitive health care response to sexual assault. It was informed by the understanding that the existing response of the health care system tends to neglect its therapeutic role and contributes to secondary trauma. In order to correct these problems, it was first important to arrive at a model that adequately addressed all the needs of survivors such as treatment, psychological support and linking the survivor to different agencies. Such a model was developed, based on the World Health Organization's 'Guidelines for medico-legal care for victims of sexual violence', 2003 as well as the provisions under section 164 (A) of the Criminal Procedure Code of India. Further, there have also been recent changes in the Criminal Procedure Code, Indian Evidence Act and new progressive case laws that were used to inform the model. These included Supreme Court judgments such as that recognizing voluntary reporting, pronouncing the testimony of the survivor sufficient as 'evidence', condemning use of the two-finger test etc. The components of the model that emerged are as follows:

1) **Seeking Informed Consent from the survivor**: The survivor was provided information about the medical procedures that will be performed as a part of medico legal examination and treatment,

and she was also explained benefits and consequences of the examination. Health providers were trained to seek specific consent for each component such as treatment, examination and forensic evidence collection and information to the police. This meant that when a woman refuses any part of the examination or even full examination, health professionals were trained to respect her decision and provide treatment unconditionally. Such a practice is legally informed by Section 164A CrPC. Similarly, health providers were also trained to seek consent from the survivor herself if she was 12 years of age and above and was mentally sound. Such a practice was developed as per Section 89 IPC and also empowered survivors as young as 12 years to understand the steps of medical examination, medico legal formalities and the like.

2) **Comprehensive medico-legal documentation and evidence collection:** This included a gender-sensitive medical examination proforma which comprised of detailed documentation of history including details of the assault, meticulous examination and documentation of findings, and collection of forensic evidence based on history elicited. Along with the proformas, an instructional manual was developed for the examining doctor. It provided them with a step by step approach of examination, treatment, evidence collection and counselling. Evidence collection was carried out with the help of a SAFE kit (Sexual Assault and Forensic Evidence collection kit).[1] It comprised of all paraphernalia required to conduct an examination and so the examining doctor did not have difficulty in locating materials at the time of examination.
3) **Maintaining a fool-proof-chain of custody:** A chain of custody regarding management of forensic evidence was created. It comprised of steps and method of collection of evidence, use of labels, ways of air drying and so on. Chain of custody also included assigning responsibility to specific health professionals for storing evidence under lock and key to avoid scope for tampering with evidence.
4) **Coordination with external agencies:** Steps for coordination and dialogue with the forensic science laboratory, police, media and courts was evolved and was found to be crucial as sexual assault requires a multi-sectoral response.
5) **Provision of medical treatment:** for injuries sustained and prophylaxis to prevent sexually transmitted infections and HIV, Tetanus Toxoid and Hepatitis B prophylaxis was decided.
6) **Provision of psychosocial support services:** Crisis intervention services were provided for every survivor of sexual assault. This included interface with the police, provision of shelter if she was unsafe, putting her in touch with a lawyer, reference to other organizations as required.

The model was piloted for 20 cases in 2008 and then further refined, based on problems that were observed in the field. A team of experts with extensive experience of working on the issue was constituted, who regularly reviewed the progress of the intervention and helped us overcome barriers to operationalizing the model.

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[1] The SAFE kit comprises of a box containing all the materials required for conducting a medical examination in sexual assault cases. This includes swabs, slides, catchment papers, vaccutainers, urine containers, scissors, nail-cutter, bags for packing clothes and labels. The kit also consists of a gender sensitive proforma for documenting history, examination findings, evidence collection etc, as well as an instructional manual to guide doctors in conducting a medicolegal examination.

Responding to sexual assault in a comprehensive manner requires a great deal of coordination between different agencies particularly the police, forensic science laboratories, hospitals and social workers. While our intervention was grounded in the health system, it was crucial that we work with these other systems in order to ensure smooth functioning. Changes that were being introduced in the health system would have to be accepted by other agencies and this was a challenge. At the initial stages, for instance, since a new proforma and packaging of evidence was being used, it was important to ensure that these were accepted by the Forensic Science Laboratory as well as the police. This required us to dialogue with relevant authorities. The Chief Medical Superintendent who was in-charge of the hospitals , was sensitive to the issue and put in efforts to influence other agencies to accept the evidence collected by way of SAFE kits. She sent an official request to the police stations as well as the forensic science laboratory to this effect. The director of the Forensic Science Laboratory, having been familiar with the problems in the health system too was open to the idea of a new protocol and saw value in its implementation.

Description of the intervention

Initially in 2008 two hospitals of the MCGM were selected to implement this model. One of these was a 500-bed hospital on the eastern suburbs, equipped with all major departments (H1). The second was a smaller 100-bed maternity home (providing only obstetric and gynaecological services) located in the western suburbs, serving as a satellite center to a larger hospital in a neighbouring suburb (H2). These hospitals were selected because they receive the maximum number of sexual assault cases across the peripheral hospitals of the MCGM. Moreover, both of these hospitals had already been a part of gender sensitization trainings that CEHAT had been conducting for health care providers of all cadres since 2005. In the year 2010, a third hospital, 400-bed large, also expressed interest in implementing such a model and so this was initiated (H3).

Operationalizing the model required changes in the hospital protocols and the practices of the staff. The administrator of the hospitals fully supported these changes and facilitated the process.

This was accomplished by implementing the following:

A standardized and gender sensitive proforma: for recording history, examination findings, evidence collection, medical opinion and treatment was implemented. After the proforma was used in 20 cases, certain modifications were made to it based on feedback from doctors and an assessment of how the forms were being filled out. The MCGM hospitals agreed to implementat this proforma, the manual and standardized kit in order to streamline the documentation and treatment.

Capacity building for Health Care providers: Health care providers, (HCP) were provided with a three-hour orientation training which included an overview on the issue of sexual violence, its health consequences and the role of the health care provider. Myths related to sexual assault were dispelled through presenting evidence and facilitating an understanding of sexual violence as rooted in gender-inequality brought about and perpetuated through patriarchy. Participants were orientated to the comprehensive health care response including the proforma for medical examination and the SAFE kit.

Through the use of case studies, skills were built to seek history, determine relevant evidence collection and formulate medical opinions.

The training was aimed not just at doctors who conduct examination, but also included nurses as well as the staff of the medical records unit because each of these professionals had a role to play in responding to patients reporting sexual assault and handling evidence. Among doctors, it was usually lecturers, residents and house officers who attended the training as they were the ones conducting examinations. Medical Officers were also a part of the training as they were often decision makers in administrative matters related to cases. Since the population of residents and house officers is a floating one, we had to make efforts to ensure that trainings were held every 6 months so that those conducting examinations had definitely been through orientation training.

A periodic review of cases and problems faced by the doctor in handling them informed the content of trainings as well. Special training sessions were held from time to time, jointly for all three hospitals, to address specific problems that were identified such as communicating with survivors of sexual assault and formulating medical opinion. External experts from the forensic science laboratory, senior forensic medicine specialists and gynecologists with experience of working on the issue were invited periodically to conduct such trainings.

Providing assistance to the examining doctor: Although health care providers went through capacity building training, the protocol being implemented was new and so the CEHAT team provided assistance to them on a case-to-case basis, in order to facilitate the use of the protocol, negotiate administrative hassles, or explain the components of the comprehensive health care response if required. Often, questions from doctors were related to seeking informed consent, eliciting history from the survivor particularly children, collection of relevant evidence, filling out FSL requisition forms and formulating the opinion. Problems faced with external agencies such as the police, forensic science laboratory were also addressed. In a few cases where doctors were called to court as expert witnesses, they were also prepared by the interventionist to formulate the final opinion and depose.

Crisis Intervention Services to Survivors: Though the hospital was geared to providing good quality health care and medico legal services, interventionists from CEHAT- Dilaasa played a crucial role in provision of psycho social support to survivors of sexual assault. An interventionist from the CEHAT-Dilaasa team would visit the hospital each time a sexual assault survivor was received at the hospital , in order to provide crisis intervention services. Within the hospital, all procedures related to examination and treatment was facilitated as and when required. The survivor and her family were provided emotional support and offered assistance including provision of legal aid, help in filing a police complaint, shelter facilities etc. After leaving the hospital, survivors were encouraged to follow up for counselling services at Dilaasa.

Coordination with Forensic Laboratory and the Police: The samples collected and documentation done by the hospital were handed over to the police and eventually analysed by the forensic science laboratory. For this reason, it was essential that constant dialogue be maintained with these players.

Regular meetings were conducted with the authorities of the FSL to seek feedback about the method of evidence packaging and documentation, and suggestions about its improvisation too. Any errors identified by FSL were fed back into the training of HCPs as well as modification of the protocol.

Sources of data

Since this initiative was conceptualized as an intervention research project, data of each case was routinely entered into an management information system. The sources of data included:

1. The Sexual Assault Examination Proforma: that provided demographic information, details about the incident of sexual assault, examination findings, nature of evidence collected, opinion of the doctor and treatment provided.
2. In-patient Department case papers: these were available for those patients who had been admitted to the hospital. They provided detailed information about treatment provided. In cases that were referred from other hospitals, or only for counselling, these papers also provided information about the details of assault and examination findings as recorded in those hospitals.
3. A detailed documentation of our intervention with the survivors of sexual assault. For every case that was attended to, the interventionist did a detailed recording of proceedings from the time she had been informed of the case, until follow up. This involved documenting problems that were faced with the hospital system in terms of ensuring that all components of the comprehensive health care response are met, and in liaisoning with other agencies such as the police and FSL. Observations pertaining to the manner in which the survivor was spoken to by health care providers and others were also recorded. An intake for counseling provided information about her psychological state, the counseling process, chief concerns of the survivor, the nature of social and legal support required by her and what was provided. Further, follow up regarding the cases with police stations to ascertain status of the case and outcomes was also done. In cases where we were in touch with the survivor, we also accompanied her to the police as well as courts and the documentation of these has provided data as well.

III. Profile of survivors facing sexual assault

A total of 94 cases were recorded between April 2008 and April 2012. A large majority (88) of these survivors came to us through the three hospitals where the intervention was being implemented, and a small number (6) were those that were directly referred to us, only for counseling. Most cases were received from H1 as it is the largest of the three hospitals and serves as a referral centre for smaller hospitals on the eastern suburbs. H3 received the smallest number of cases, as it began implementing the protocol only in September 2010, more than 2 years after the other two hospitals **(Table 1)** Consistent with this, we also found that in terms of area of residence, the maximum number of survivors come from the Eastern Suburbs (53/94), while, fewer were from the western suburbs (34/94) **(Table 2)**. The number of cases being received in the hospitals also increased over the three years, owing to the trainings that we conducted with police officials as well as community based organisations (CBOs) in the area surrounding the hospital. **(Table 3)**

Socio-demographic profile of survivors seen: More than half (51/94) of the survivors were children between the ages of 0-12 years. Other survivors were in the age group of adolescents in the age group of 13-18 years (27/94). Very few survivors (16/94) were in the age group of 19 and above. Even amongst children, the largest category was between 0-6 years (30/51), who form one third of the sample. In terms of gender, the survivors that we have seen are overwhelmingly female. Only two males were seen, both children. Given the age profile, as expected, most of the survivors were single/never married (82/94). Among the 16 adults, 9 were married, and 2 separated/divorced. With respect to religion, 71% (67/94) are Hindus, 27% (25/94) are Muslims and the rest are Christians. This is consistent with the general profile of patients who access these hospitals. **(Table 4)**

With regard to economic status of a total of 94 sexual assault survivors, a large majority (64) belonged to the economically under-privileged section of the society. Of 64 survivors, 21 were extremely poor with almost no means of sustenance, most dwelt in make shift houses of tin and plastic or on the pavement. The other 43 families were involved in daily wage occupations such as working on construction sites, house maids, ironing clothes, delivering newspapers, cleaning vehicles, and the like. Only 6 of the 94 survivors belonged to middle/upper-middle class. Families of these 6 survivors were involved in occupations such real estate management, retail business, and the like.

The profile shows a large number of survivors who are economically underprivileged. While setting up the health care model for sexual assault, we realized that setting up such services in a public hospital may lead to missing out on a section of survivors who belonged to upper class and may not reach public hospitals at all. However, because of the marginalization that economically poor people already face, we found it most appropriate to locate the comprehensive health care model in public hospitals where in survivors from this section can easily access good quality medico legal care.

Profile of assault

Survivor age group of 12 years and below: Challenging the popular belief that most sexual abuse is perpetrated by strangers, most of the perpetrators (36/51) here were known to the child survivor. Perpetrators ranged from the child's own father, uncle, neighbour, shop keeper and an older friend who the child was accustomed to playing with. The child therefore shared a relationship of trust and comfort with the perpetrator **(Table 6)**. At least 17 child survivors narrated that they were promised a toy, or a chocolate, money or simply time to play. **(Table 7)** Because the children shared a close relationship with the perpetrator, the primary care givers such as mothers, grandparents, or relatives were also not suspicious of the motives of the perpetrator in acts like calling the child to play, etc. Children are conditioned to trust people around them at home and school, and are therefore easily misled. Owing to the fact that the perpetrator was well-known to the survivor in most cases and also because of the age of the children, there was rarely any resistance offered by child survivors. An illustrative example is as follows:

R, a 6 year girl was staying with her maternal grandmother for the past 6 months. Her mother was pregnant and unable to take care of R along with managing the household chores, and therefore she was sent to live with the grandmother. One of the neighbours, an adult man, would often play with the children and was popular in the neighbourhood. He was a known person and shared a cordial relationship with R's grandmother. R would often go to play in his house too. One afternoon, he asked R to come to his place and also offered her some money. R sought permission from her grandmother and went to the house of the neighbour. He sexually assaulted her. When R came back, she was in a lot of pain and revealed the episode to the grandmother.

S. Barge and P. Ramesh (2008) have in their paper described the dynamics of incestuous abusive relationships in India as follows: "This relationship of trust is what incestuous sexual abusers count on. They use their position within the household to gain access to the children, and then count on the familial relationship-and the fear that they manage to drill into the child's head-to keep their misdeeds a secret. Concept of family and its binding continues to hold its root in the country" . These findings were corroborated in the information received from our clients themselves and their parents. It was seen that the perpetrator in most cases shared a cordial relationship with the child's family and therefore the family was also seen to be relying on their support. The care givers of the child survivors informed that often the perpetrator would come home, share a meal, play with the child, teach the child and so on. Having shared such a bond the family too relied on the person and also asked him to look after the child for a few hours in their absence or send the child to their home. Therefore some parents were not keen to register an offence.

Forms of sexual assault against children ranged from forced peno vaginal sexual intercourse, insertion of fingers in the child's vagina, insertion of penis in child's anus or mouth and forced masturbation.
Very few children (7/51) stated that they screamed and shouted in order to resist the abuse. This was also due to the fact that most reported being terrified to scream or shout. They narrated that perpetrators used threats to kill or beat them if they reveal the episode at home. 27 out of 51 children were too small

to physically resist the act **(Table 8)**. Out of 51 survivors, most acts related to sexual assault took place in the residence of the perpetrator (15/51), the neighborhood area (13/51) or in the survivor's house (6/ 51). This indicates that the act was planned in a manner that there was no one at home and that the child was taken advantage of and manipulated **(Table 9)**.

Survivor age group of 13-18:

There were 27 sexual assault survivors in the age group of 13 to 18 years. This was an adolescent group experiencing dramatic physiological and psychological changes. Although this is perhaps the most critical ages in a person's life most families fail to discuss with them the many changes that they are going through; even fewer parents discuss sexuality, sexual feelings and sexual relationships. Adolescents are left on their own to understand these bodily and emotional changes. This awkwardness, uncertainity and confusion on the issue of sexuality and sexual changes, makes it difficult for them to talk about/ disclose episodes of sexual abuse to their families. Only 4 out of 27 survivors confided about the sexual assault to either parent or guardian. When the perpetrator was the father, survivors found it all the more difficult to talk about the incident with anyone. Of the 27 survivors, at least 3 girls reported being raped by the father, stepfather or an 'uncle' (friend of the father).

Fear of being physically hurt, being killed, or the sheer shock of what was happening to them paralysed the survivors from resisting the abuse or disclosing the incident to anyone. Eight of the survivors reported being physically abused by the perpetrators when they tried to resist the abuse. **(Table 10)** Physical abuse ranged from hands and legs being tied with a rope, to being hit with a cable wire, sticks, blows and slaps and mouth being closed forcibly. For survivors who were promised employment opportunities and better job prospects by known people, they reported being stunned by the sexual assault and unable to overcome the feeling of betrayal from the person who promised them the job. Out of the 27 survivors, the perpetrator was known to the survivor in sixteen cases. Survivors followed their daily routine such as watch television in neighbour's house or buy grocery from the shop / play with the neighbor and so on. The perpetrator had kept a watch on their movements and seized the opportunity when the survivor was alone. It was the relationship of trust which was exploited by perpetrators. In one case it was only when the survivor realized that she was pregnant that she revealed the abuse to her parents, while in other cases it was only after persistent probing by the parents / guardians that the survivors revealed the assault.

Survivor age group of 19 and above:

Sixteen survivors out of the 92 belonged to the age group of 19 years and above. Two out of the 16 women were gang raped. The motive behind the rape was to teach a lesson to the family or the husband of the survivor. One of them was a pregnant woman in an advanced stage of pregnancy. She was raped by two men on account of a property dispute; her marital family had thrown out the perpetrators because they had failed to pay their rent. In another instance, the survivor was gang raped because she refused to wake up her drunk husband. The perpetrators had an on-going dispute with her brother about which she argued with them, after which they threatened and raped her. They also warned her that they would be back the following day and handed over a packet of condoms. Another two survivors

were over 60 years, the motive in one case was again a property dispute and in the second the survivor suffered from severe mental illness, which made her vulnerable to abuse.

Most survivors in this age group had approached a health facility first for treatment of health consequences of the assault and after that filed a police complaint. In instances where the motive for sexual assault was clear - such as property disputes, revenge against the survivor's family or vulnerability such as severe mental illness - families offered support and had decided to file a police complaint. However in situations where the survivor had been abducted, or been rendered unconscious, the survivor herself and her family had tried to avoid making a formal complaint. An often cited reason was that the filing a complaint would jeopardise the future prospects of marriage of the survivor.

IV. Sexual Assault and Health Consequences

Sexual assault has both short term and long term health consequences for the survivors. These could range from sexually transmitted infections including HIV infections, unwanted pregnancies, abortions, genital and physical injuries, suicide ideation/attempts, depression, post-traumatic stress, anxiety (WHO, 2007). These health consequences often bring survivors in contact with the health system. It especially brings those survivors who might not yet have decided to file a police complaint directly in contact with the hospital. Therefore health systems have to recognise not just their medico legal role with respect to sexual assault survivors (as expected by the law) but also their therapeutic role.

Reporting to the hospital: Of 94, 42 survivors reported to the hospital directly to seek treatment for health consequences arising out of the assault. **(Table 12)** Over the past three years in the hospitals where comprehensive health care response has been implemented, voluntary reporting of survivors has been recognized so that survivors are provided treatment immediately. This enabled the survivors to access treatment without a police requisition. Almost half the survivors in the age group of 13-18 years (13/27) self-reported to the hospital and the same pattern was seen in the age group of 19 and above too (12/16) **(Table 13)**. Girls and women in this age group did not report to the police station perhaps due to stigma of the assault and fear that no one would believe them. But survivors and their families were worried about the health consequences of the assault such as HIV/ STI infections, pregnancy, irregular menstruation, genital /physical injuries and the like. Out of the 42 survivors, 4 reported as late as one month and that too because they were pregnant as a result of the sexual assault. Providing survivors with immediate and unconditional medical care became a critically important responsibility of the health professional. The fact that such a large number of patients actually reported voluntarily to these hospital means that survivors saw these facilities as places that would provide the required services unconditionally without needing a police requisition.

An illustrative example is provided below -

> Y a 14 year girl was brought to the hospital after she complained to her parents of being sexually assaulted. The parents were extremely scared of community reactions and did not want anyone to know about the assault. But they brought Y to the hospital as they were afraid that she could get pregnant from the assault. In such a situation the doctor explained the need for a general examination and gave the survivor an emergency contraception. Due to the efforts made by the examining doctor vis a vis explaining advantages of registering a police case and at the same time enabling the family to make an informed decision, parents and survivor felt reassured.

Further, among self-reporting survivors, seven had visited other hospitals (private or public) where they did not receive medical treatment and were eventually referred to our hospitals. The health complaints that they reported ranged from pregnancy as a result of the assault, to burning micturition and abdominal pain. **(Table 14)**

Physical Health consequences

Out of 94 survivors, 62 survivors reported with at least one health complaint ranging from genital and physical injuries to pain in different parts of the body, pregnancy and infections **(Table 15)**.

Genital injuries were reported in 38% of the cases. Most were in the form of abrasions, lacerations and redness but in a few cases with deep perineal tears were also seen. We found that children as young as three years did not disclose the assault immediately, but spoke of pain in the genital region, burning sensation while passing urine, or pain while defecating and the like **(Table 16)**. It was only when the guardians/ parents examined the genital area that they noticed redness and suspected that the child may have been assaulted. They presented to the hospital with these complaints.

It is alarming to note that five survivors in the age group of 13- 18 years, came to the hospital with a pregnancy as a result of the assault that had occurred more than a month earlier indicating that they were, for whatever reason unable to access a health facility in time. **(Table 17)** These survivors were brought to the hospital mostly by their parents whose biggest concern was community response if the incident of sexual assault was revealed, and the fact that it would ruin their daughter's marriage prospects. These fears delayed accessing of health services for termination of pregnancy.

In the age group of 19 and above, it was seen that survivors access a health facility when problems such as the above become acute and cannot be managed on their own. Some survivors have sustained severe physical injuries along with the sexual assault and have reported to the hospital for care. For instance, R a 21 year woman tried to push away her attacker in the course of the assault; this angered him so much that he hit her on the eye and face. Survivors also reported problems such as bed wetting, sleep disorders and white discharge.

Provision of medical care and treatment

A response to sexual assault can be defined as comprehensive only when health care of a survivor is prioritized and treatment and support is provided without delay. All survivors were provided immediate medical treatment at the hospital. In situations, where survivors required to surgery, social workers of the hospital were able to assist by getting the charges waived off.

Treatment included provision of antibiotics, analgesics, tetanus toxoid vaccine, pregnancy prophylaxis and testing for HIV and HBsAg. **(Table 18)** Antibiotics were provided in all cases while analgesics were provided in all but 4 cases. The differential provision of analgesics may have been because the injury was minor and the survivor did not complain of pain. This is usually up to the discretion of the treating

doctor. Tetanus toxoid injections were given to those who were not immunized in the past 5 years. In cases where there was penetrative sexual assault and the survivor reported within 5 days, survivors were given emergency contraception. For survivors who had come after a delay of a few weeks, a urine pregnancy test was advised and carried out. HIV and HBsAg tests were advised, however it is not possible to ascertain from the records, whether the patients followed up and tests were done.

Certain investigations such as testing for HIV and HBsAg are provided in public hospitals in the OPD. When survivors reported after OPD (Out-Patient Department) hours, they were advised to get admitted in the hospital for 24 hours to 48 hours. Admission in the hospital enabled the survivors to avail of all investigations, follow up treatment and also receive results of the investigations conducted. This also saved travel time as most survivors coming to public hospitals cannot afford repeated travel expenditure to come for investigations. But in some instances survivors wanted to return home immediately after the examination and first aid. In such situations, health care providers suggested that the survivors come back for the rest of the investigations on the following day and also explained the importance of undergoing those tests. Health providers routinely explained to the survivors that certain injuries or infections could appear at a later stage and these would need to be treated for which they needed to follow up after a period of two weeks.

Psychological health consequences

Psycho social support is perhaps the most neglected aspects of health care. As a component of the comprehensive health care response we wanted to ensure that survivors accessing these three public hospitals were able to get counselling as well as crisis intervention services. Evidence from other countries has clearly documented the need for trauma counselling within health care services and their importance in helping survivors deal with the post-rape trauma.

We were able to speak with 76 of the 94 survivors survivors. The rest were treated on an out-patient basis in the early hours of the morning or midnight. Thus one to one contact was not achievable. Getting in touch with them was difficult because of the lack of contact information. The phone numbers were often invalid and rest did not have contact numbers at all. The concerns of survivors and their care givers were different across age groups and so the support that was provided to them varied accordingly.

Survivors under 12 years of age were more communicative, although they were irritated by having to stay in the hospital instead of being allowed to go home. But in the age group of 13- 18 years, at least a third of the survivors were uncomfortable speaking with the interventionists and did not make eye contact while speaking. They also demonstrated anxiety and flashbacks while speaking about the episode. V, an 18 year old girl refused to speak saying that since her parents did not believe her it was unlikely that the police would. Similarly in another instance, a 17 year old girl was distracted throughout the time she spoke with the interventionist. She was raped by her step father over a year, it was only after a year that she was able to run away from his house and reach her mother's place. This was probably the first time that she was speaking about the episode. Survivors in the age group of 19 years and above seemed comfortable while speaking to the interventionists. Their only comfort was the fact that they

had support from their families. Families had in fact advised survivors to pursue legal action. In this age group, survivors were also able to articulate the reason for the sexual assault. Some of them were property disputes, forced sex in the marriage, sexual assault by brother-in-law when the survivor refused sexual advances and the like. In one instance, a 19 year pregnant woman was raped by three men in front of her husband because the husband spat from the balcony. The saliva fell on the head of those men and this angered them. They barged into the house and following a heated argument, decided to teach the man a lesson by raping his pregnant wife. The families felt responsible for what had happened to the woman and were by her side throughout.

In instances where the perpetrator was known to the survivors, they expressed feelings of sadness, feelings of being cheated, and loss of trust. R, a 23 year old survivor stated that she went out with a group of friends as she trusted them and never imagined that they would actually assault her. She said that after such an episode she would not be able to trust any male friend. In cases where the perpetrator was related to the survivor, such as brother-in-law, cousin etc., the fear of another incident of sexual assault recurrence loomed over them.

The anxiety and the feelings of sadness among survivors get aggravated because those around them such as carers keep worrying about the future. Inadvertently they convey the impression that they believe the survivors reputation has been permanently tarnished and that her future, especially her marital future, is compromised. For instance, a survivor who was pregnant because of the assault was constantly apprehensive as her mother was very worried about her marriage prospects. In fact the family had hidden the assault for almost a month, but only when they realized that the survivor was pregnant was she brought to the hospital.

Survivors said that their anxiety was not only about the assault but also because of the constant police interrogation, and being repeatedly called to the police station. In one instance, P remarked "Every time there is a new woman police constable, she asks me, what exactly did he do? How did he assault you? Do they think it is easy to speak about it? I feel like ending my life, I can't bear to repeat the same information again!" Such insensitive remarks and repeated questioning by police further increases anxiety among survivors.

Provision of psycho social support to survivors of sexual assault

Under 12 years:

In this age group of 0- 12 years most survivors were communicative and playful. Some of them were too young to have understood what had happened. The communication by the interventionist was often with the care givers of survivors. This was done with the intention of building rapport with the family and communicating our role as interventionists. In a few cases, when the child was too tired or not willing to talk, the counsellor only spoke to the caregiver. Care givers were often women, either mother or grandmother. Interventionists helped the care givers to vent their emotions. Some expressed feeling worried and tense about their child's future while others who knew the perpetrator expressed anger and feelings of betrayal. These feelings were seen amongst women who were working out of

home as domestic help, or as daily wage earners, where the children would be left in the custody of an older sibling, or a neighborhood woman. Interventionists discussed with care givers the need to speak with their children about good and bad touch, and ways to teach the child to not allow anyone except the care giver to touch their underwear. Efforts were also made to explain reasons why people known to the child sexually assault them - the fact that it is a planned act and that the perpetrators feel that they will not get caught. Interventionists explained to the parents the need to encourage survivors to speak about their feelings, their fears and apprehensions about the episode as speaking out about it helps the survivor to deal with their unexpressed emotions. The immediate response of most care givers was to remove the child from school and home school them or send the child to the village where the grandparents resided so that the survivor is protected. However, it was explained that after a traumatic episode such as sexual assault, it is important not to distance the child as she may find it traumatic. It was also stressed that if the child goes to school and plays with her friends, it would provide her a sense of normalcy. It was important therefore to not restrict her and keep the channel of communication open. The need to follow up for counselling and health care was also stressed upon by discussing that children may feel anxious, may have inability to sleep and may express fear so counselling would help in addressing these issues. In instances, where the child was under the care of grandparents, aunts and other family members, the care givers did not want to report anything about the episode to either the police of parents of the survivor as they feared being blamed for the episode.

13-18 years:

As discussed above, breaking the ice with survivors in the age group of 13 and 18 years was the most difficult task. In two instances, the survivors were to undergo a medical abortion for pregnancy out of the sexual assault and had reported to the hospital after almost a month. Their biggest fear was related to filing a police complaint. A lot of effort had to be made to explain that we were not associated with the police and we were there to provide any form of support required for them. It was also communicated that they had a right to refuse filing a police complaint if they were not prepared for it and we would provide them the required assistance. Only after they were convinced about our approach, they revealed their feelings. Some of their concerns were related to: family blaming them for the sexual assault, police not believing them, fear that their education would be stopped, fear that they would be married off, fear of recurrence of the assault and the like. Efforts were made by interventionists to deal with their feelings and also explain that the assault was not their fault and in fact was an act to humiliate the survivor. It was crucial for the survivor to regain her confidence and counselling was offered as a suggestion to them and their families. In this age group, because many care givers seemed apprehensive about their daughters' future, they wanted them to be married off immediately and forget that such an episode occurred. In one instance the survivor was studying to become a graduate. She was raped in her college toilet by an unknown person. But she was extremely scared and told her parents about the assault only when she missed her periods. Her father worked as a night watchman and had no relatives in the city. He brought her to the hospital for an abortion and wanted to send her back to the village. When efforts were made to speak with the parents, they categorically stated that their decision was final and that she would have to return to the village. Interventionists cautioned them not to rush the survivor into marriage as she would need time to heal from the abuse, gain confidence and make decisions pertaining to her

life. After discharge, the family could not be contacted and would have probably sent the daughter to their home town.

In another instance, a 16 year old girl was mugged and raped over a period of 72 hours. She somehow managed to escape and reach home after which her parents filed a police complaint. When we met the girl at the hospital, she refused to speak. It was only after 2 days that she opened up and spoke with us. She said that people around her blamed her for the episode and some even claimed that it was consensual sex. This had agonised her tremendously. We appreciated her efforts and determination to speak out about the assault and discussed with her the need for counselling and follow up care. However after her discharge from the hospital her parents were not able to bring her for counselling, but they pursued the legal case with the help of a private lawyer; they also had the economic wherewithal and were able to secure conviction in the case. In instances that survivors and their families had decided to pursue a legal case, they had already thought of ways and means of doing so at their own cost. While some had accessed political leaders from within the community to register a case, others had hired private lawyers. These steps were taken almost immediately after the assault and therefore these needs were not expressed by the families who had decided to pursue litigation.

19 and above:

Out of the 14 survivors, eight were interested in pursuing a legal case. Those interested in pursuing the case had hired private lawyers and some of them also had links to political parties. 2 of these 8 women were gang raped and were pregnant at that time. Both women were determined to file police complaint. Interventionist appreciated their courage and also offered a variety of services such as legal aid in terms of having a watching advocate, importance of counselling and prepared them for community reactions once they go back. Additionally, we also had discussions about the fact that they may feel anxious during sexual contact with their husbands/partners, these feelings are a natural reaction to the sexual assault. Survivors were encouraged to therefore also follow up with their spouses for counselling. Both these survivors had very good family support, and therefore we hoped that they would be able to follow up. When contacted after a few months, one of them had gone to the village for delivery along with her husband, while the other survivor had delivered a baby. Consent was sought for home visit as she found it difficult to visit the counselling centre. At her home she discussed that the matter is pending in the court and that she was doing fine. She was not able to speak at length as she had other household responsibilities to manage. The in-laws spoke with the interventionists and assured that they would contact us in case such a need arises.

Two women in this age group were suffering from a severe mental illness and at the time of their hospital contact, were not in a position to speak as they were not oriented in time or place. We spoke with their families, but none were able to identify the perpetrator. Arrangements were made to transfer them to a specialized hospital for psychiatric care as both were suffering from psychosis. We discussed with the family the need to follow up for psychiatric care and medication coupled with counselling. But in one of these cases, the son was worried that if the information pertaining to the rape of his mother became public knowledge his sister's marriage prospects would be jeopardised. He had already explained to the police that they were not interested in pursuing any case. We explained to him the difference in

pursuing the case and follow up for counselling, but he stated that he would revert when he has the time to bring his mother to the hospital.

This age group also had one survivor who reported marital rape. She was traumatized and disclosed that she had decided to now move in with her parents. Efforts were made to enable her to deal with the situation and also appreciate her courage for taking the step to make a police complaint. She expressed guilt over the fact that this was her second marriage and that too had fallen apart. Her feelings were validated and she was explained that making the marriage work was not purely her responsibility. She was encouraged to think of all the efforts she had made to make it work, but her husband had continued to abuse her. It was reiterated that she had taken the correct step by stopping the abuse. Her parents were very supportive and stated that they would stand by her decision. The interventionist discussed with the parents the need for counselling to deal with the situation. It is pertinent to note that because it was a case of marital rape, the police did not know which section of the law needed to be applied. This also goes to show that there is hardly any awareness about the existence of marital rape and the role of the police.

Challenges in follow up

Follow up with the survivor was initiated by the interventions team as none of the survivors followed up on their own. Out of 76 survivors, 26 followed up while 50 did not. **(Table 22)** There are various reasons for the lack of follow up **(Table 23)**. To begin with, at least seven survivors were on the verge of destitution, one of the parents who was a daily wage earner was not paid wages for almost five months. Though we tried to ensure that they could avail of basic amenities from community based organisations (CBO), the family found it difficult to access even these facilities. Because they had no contact information, not having a residence, we gave them our contact information, but none of them contacted us. Another reason for the lack of follow-up was because most carers (women) had several other domestic responsibilities making it difficult for them to find the time to avail counselling services. Carers invariably said that the child was "normal" and that she would be brought for a follow-up when the carer could spare the time. Our offers to visit were turned down because that would have meant explaining the assault that many had not revealed to family or community. 17 out of the 76 survivors had formal support from either a political party, panchayat, jamat and the like and therefore they shared that they would get in touch with us when the need arose. An additional 18 survivors were vague on coming for counselling; these were also the same survivor group that did not want to pursue a legal case. Due to the fact that most survivors belonged to economically under privileged communities, spending time and money to travel was difficult. The follow up for not just counselling but also for medical aid is therefore almost negligible. Survivors and their families are unable to access psycho social support because of lack of resources. When a sexual assault takes place, the survivor and her family face several implications. Coming to the hospital and availing of any follow up are not always priorities and may not be possible given their resource constraints.

Issues emerging out of provision of psycho social support to survivors:

1. An important lesson in the course of our interface with survivors was that in spite of offering services such as counselling, legal aid and allied services, most were not even able to come back for one follow up. Families of survivors reported how they lost daily wages because they had to stay at the hospital with their child. Women reported that they had left the other children in the care of a neighbour or a known person as they had to stay with the survivor at the hospital. The challenge was to communicate the importance of the survivor availing complete health services.
2. Survivors who had already reported to the police and then come to the hospital for examination, evidence collection and treatment, did not voice any specific expectations. This was also connected to the fact that they had hired private lawyers and had political backing from the local corporators.
3. In instances where the survivor and families did not want to file a police complaint, we ensured that they were not forced to file any complaint against their will. But at the same time, efforts were made to discuss the need for counselling and healing from the abuse. Despite all efforts, these survivors were not able to follow up for services. It was seen that while some were sent back to the village, few were also married off and settled. It is important to note that families also suffer tremendous pressure from the extended community related to being defamed and ostracized. These notions of honour are so deep rooted that unless families consent to meeting interventionist over a period to deal with these fears, it is impossible to overcome the same.
4. We also noted that when it came to developing follow up plans with child survivors, often parents would discuss that the child had resumed her routine such as school, playing, etc and that if there was a need they would bring her for follow up. One of the reasons was that it is difficult to see tangible gains from counselling. The family may also not have the economic wherewithal to reach the counselling centre, several such issues thwart the follow up process.
5. These issues highlight the fact that several kinds of provisions need to be made for the survivor and her family if a concrete follow up plan for healing and dealing with trauma has to be operationalized. Families have to be provided economic support for relocation, travel to the counselling centre to avail of services and travel for court calls and compensation for the emotional and physical trauma suffered. Comprehensive care and counselling services also need to be developed at multiple sites so that survivors can access these services from different places.

V. Medico legal evidence in cases of sexual assault

The purpose of medico legal analysis is to examine the sexual assault survivor for any signs of harm, collect evidence from her/his body and document the findings in a medico legal report. However in the Indian context, this medico-legal role is fraught with several problems. There is no standard protocol for examination and evidence collection in most hospitals. Furthermore, procedures such as the two-finger test, over emphasis on injuries and status of hymen continue to be the focus of medico legal examinations. While we set out to operationalize a comprehensive health care response, our objective was dual - (1) to ensure that survivors have a right to complete medical treatment and (2) to develop a gender sensitive protocol for sexual assault examinations that upholds women's dignity.

This section attempts to highlight ways in which we operationalized good quality medico legal examination, evidence collection and its interpretation.

Informed consent

Unlike the current medico legal practice in the country where consent seeking from the survivor is mere formality and is not sought for specific procedures, we introduced the concept of informed consent for (1) treatment (2) examination and evidence collection (3) providing the information to law enforcement agencies.

Specific consent enabled survivors to get complete information on the nature of examination, advantages of undergoing an examination, the steps involved in examination and evidence to be collected. Informed consent also meant allowing the survivor to make an informed decision about the extent to which she was comfortable with the invasive examination and the scope to decline at any point when she felt uncomfortable.

In the initial stages, health professionals found it difficult to seek informed consent in an elaborate manner as their past medical education as well as experience did not equip them with the requisite skills. It was through consistent dialogue and demonstration that we were able to operationalize informed consent. Further, while implementing this initiative, we recognised 12 years as the age for consent pertaining to examination and treatment (Sec 89 IPC). This meant that doctors had to develop ways of communicating with survivors of 12 years of age and seek their consent for the above mentioned clauses. They were also expected to learn communication skills, explain procedures to children under 12 years,

besides speaking to their parents and guardians. An illustrative example of communication undertaken by an examining doctor is stated below -

> In one instance, a 14 year survivor's mother refused to allow the health provider to seek history from her daughter. She stated that the daughter was traumatised and that she would provide the required information; and that there was no need to conduct a genital examination. The examining doctor had to communicate with the mother about the importance of undergoing a complete examination and also ensure that she doesn't get put off and leave the hospital. Given the challenging situation, the health provider explained the rationale for a medical examination and evidence collection to the mother and the survivor jointly so that the survivor received information about purpose and rationale for examination. In the process of dialogue, the mother was also explained that consent had to be sought from the survivor herself as she was above 12 years and had the right to consent as per law. Efforts were made by the doctor to explain that the extent of health consequences cannot be determined till a general and genital examination was done as appropriate treatment needed examination. Such communication made the survivor more comfortable and enabled her to decide that she wanted to undergo a complete examination. The survivor was made comfortable by allowing mother to be present during the examination. This also put the mother's concerns to rest that her daughter would experience pain while genital examination.

Evidence from the project highlights the fact that health professionals if provided with the perspective and skills for seeking informed consent are able to do so appropriately. It is seen that in 83/88 survivors, informed consent has been sought and also respected. Of these 5 survivors provided consent for treatment and examination but did not want to file a police complaint **(Table 24)**. Though in law there is no obligation to mandatorily report the case to the police, in practice health systems across the country have developed a procedure of mandatory reporting. It took several efforts to convince the hospital administration that mandatory reporting (against the wishes of the survivor) was illegal. In one case, the survivor refused police intimation as she wanted time to contact her family and decide whether to file a police complaint or not. She requested the health providers to undertake examination and collect evidence but not communicate to the police about the matter. Because the health providers were aware of Sec 39 CrPC, they provided the survivor with complete examination, collected body evidence and stored it in safe custody till such time that she had made her decision. At the same time her informed refusal was documented by the hospital for their records. The health professionals had adopted a legal and ethical path in responding to this survivor. But when the survivor reported the crime to the police, the police almost penalized the hospital for not informing them about the crime. Efforts had to be made to discuss with the police machinery that the approach of the hospital was legal and correct. Examining doctors were also equipped to respond to these allegations by citing the law and sending letters to higher police authorities about misconduct of the police at the hospital.

It is appalling to see that even when there is a law that supports survivors' right to decide when she could activate police machinery, archaic procedures of the law enforcement agencies continue to compel them to file a police complaint. Such penalties from the police machinery drives home the message that

health professionals must mandatorily report a case of sexual assault to the police, even if it means violating the survivors consent. This also leads to defensive practice amongst health professionals. The issue of seeking informed consent is a complex issue, in spite of trainings, demonstrations and discussions, health providers occasionally slip in to old ways of examination without consent. Therefore as partners in the project, a consistent dialogue by CEHAT was useful in constantly ensuring informed consent as an important aspect of Comprehenisve health care response to sexual assault.

Sexual assault history and documentation

Section 164 A CRPC, vests all regiserted medical practioners with the responsibiity of documenting particulars of survivor, history of assault, marks of injuries, and collection of medico legal evidence. But in reality, sexual assault documentation doesn't occur in this manner. Interactions with health care providers across hospitals before initiating a comprehenisve health care response, brought to light lack of training related to seeking history of the assault as well as documenting it in a detailed manner. Providers also discussed that they were trained to document injuries only and many stated that injuries to the hymen was one of the conclusive evidences to determined sexual assault. There was also a sense amongst health providers that if there is no injury to the survivor, it could also be consensual sex.

Given this context, we found it critical to develop a gender sensitive sexual assault proforma that laid emphasis on eliciting a detailed sexual assault history not restricted to peno vaginal assault but included peno anal, peno oral assault, masturbation of the survivor ,use of objects etc. The proforma also included documenting activities undertaken post-assault such as urinating, douching, bathing that lead to the loss of evidence and also enabled them in formulating a medical opinion based on findings. Examining doctors in the initial phase of the project found eliciting such history challenging because of the awkwardness related to eliciting details about the sexual act. Steps were taken by us to increase their comfort level and also bring in other aids such as body charts to communicate with adult survivors and dolls to communicate with child survivors.

It was seen that the details of the assault was recorded thoroughly in most cases; in 95% cases nature of penetration was recorded, in 97% cases number of assailants was recorded and in 97% cases threats used by the assailant were recorded by the doctor. **(Table 25)** This was particularly noteworthy as half the cases that we have seen are of children, and finding common language to elicit history was a challenge. Despite this, doctors have been able to do so successfully.

History of activities such as bathing, douching, urinating and defecating after the assault was recorded in 97% of the cases **(Table 25)**. The documentation of such information was crucial as these activities lead to rapid loss of evidence, which would explain why evidence was not found on the body of the survivor. Lapse of time between the assault and the medical examination was another reason why evidence may have been lost. 65% of survivors reported within 24 hours **(Table 26)**. However, it is pertinent to note that 47% of survivors had changed clothes immediately after assault, 38% had bathed, 28% had douched, 67% had urinated and 40% defecated. **(Table 27)** In these cases, even if the survivor had reached the hospital within 24 hours, the chances of finding evidence reduced drastically. It is also

important to understand that when a survivor has been forced in to a sexual act, the immediate reaction is to clean and scrub oneself after it. Thus it is important to factor in the loss of evidence and the reasons behind it.

Capacity building worskhops, discussions with experts and developing pointers within the sexual assault examination proforma were useful in impressing upon health providers the need for such detailed documentation.

Medico-legal Examination

Physical and Genital Examination

In order to ensure meticulous and scientific medicolegal examination, all efforts were made to orient health providers through regular capacity buidling workshops. Through these workshops doctors were equipped to identify not just injuries but also health consequences which may even be in the form of pain, discharge or other signs of infection. They were also trained to identify and record only those findings relevant to the sexual assault. It was found that in 97% cases the documentation of injuries was complete; injuries were not only described meticulously but also marked on body charts for better illustration. Similarly in 85% cases, doctors refrained from examining and documenting irrelevant aspects such as old tears of the hymen and the size of the introitus. Such an approach amongst doctors was extremely progressive considering that evidence from the rest of the country suggests that such irrelevant details related to hymen, vaginal elasticity, position of tears are recorded by doctors across the country, which then get used by the lawyer of the accused used against the survivor in the court. (HRW, 2010, Contractor et. al. 2012)

But in 12 cases some doctors slipped in to the old methods where in they recorded old tears of the hymen and findings of the 'two-finger test' **(Table 28)**. Comments were noted as 'old tear to the hymen' or 'hymen absent'. Such comments were made in the context where survivors were sexually active as they were married or sexually active and in some instances had even borne children. In case of two adolescents aged 14 and 16, the "two-finger test" was done and findings such as 'admits two fingers' or 'admits only one finger' were recorded to ascertain whether intercourse had taken place. Documentation of hymen in all these cases was absolutely irrelevant, as only fresh bleeding to hymen is relevant to sexual assault but the bias is so ingrained in medical education of doctors at both under- and post-graduate levels that even after explicitly stating the unscientific nature of such an examination, these biases creep in occasionally. Among children too irrelevant documentation of hymenal status was noted. In one instance of repeated sexual abuse of a child, the doctor noted that there was an old tear to the hymen, but the documentation stated "she is habituated to intercourse as there is an old tear to hymen". While in another child survivor's case, the sexual assault was a first time occurrence, there too an old tear to the hymen was noted and documented. Mere recording of old tear to the hymen is problematic. While in the first case the old tear could be associated with repeated sexual abuse reported by the child, it was interpreted as "habituated to sexual intercourse" which then raises doubts about the character of the survivor. In the second case, where there was no past sexual abuse, the documentation

of old tears was totally redundant as such tears could occur due to vigorous physical activities such as cycling, swimming, and so on.

Yet another myth related to medical examination of sexual assault is that all survivors have to present with genital and physical injuries as evidence of forced sex. However this is far from true. Out of the 94 survivors, as many as 74 did not have bodily injuries, even though most have reported to the hospital within 2 days of the assault **(Table 29)**. Narrations of survivors have brought to light reasons for not being able to resist the assault, these are - fear of being killed, feeling completely numbed / shocked when assaulted , being rendered unconscious during the assault and the nature of assault itself such as fondling, masturbation of the survivor which don't leave any physical injury. Similarly 57 out of 94 sustained no genital injury **(Table 30)**, the reasons as stated above clearly bring out that intimidation of the survivor can occur using several tactics and there need not be any physical force what so ever. It is therefore critical to disseminate widely that absence of physical and/or genital injuries doesn't mean that the assault has not occurred and in fact detailed recording related to threats, intimidation of the survivor etc can help in interpretation of lack of injuries.

General Mental Condition

It is largely seen that health professionals do not record the general mental status of the survivor as a part of the sexual assault documentation proforma, though this is expected by law. When they do record it, the language used does further damage. Some examples of such problematic documentation are "appears unaffected", "does not show signs of distress". Just like the general society, health professionals expect that a survivor of sexual assault must appear distraught and crying uncontrollably. They fail to understand that when a survivor has decided to seek health care or report the crime, she must have dealt with the trauma in some way and will not be weeping uncontrollably. Alternatively, she may be too shocked to display emotions. In order to understand her emotional state accurately doctors would have to make efforts to dialogue with her. Through the implementation of this model, doctors were trained to record the emotional status accurately. Terms such as "doesn't provide eye contact", "looks sad, distracted" were some of the terms used by doctors in the documentation. In some cases when doctors did slip back in to recording it in a damaging way, our interventions were appreciated by the doctors and the necessary corrections were carried out. **(Table 31)**

Collection of Medical Evidence

While implementing the model, we emphasized the need for evidence collection to be based on the history of sexual assault provided by the survivor. This is because the presence/absence of evidence depends on several factors such as delay in reporting, nature of assault and activities undertaken by the survivor such as bathing, urinating, etc after the assault. Based on history elicited on these accounts, the doctor is expected to make a judgment of what nature of evidence needs to be collected.

Our data show that in almost all cases, relevant body and genital samples were collected when indicated. In 2 instances, where a survivor had come for seeking medical termination of pregnancy resulting out

of the assault, doctors were trained to discuss the importance of collection and dispatch of products of conception as medico legal evidence to be tested in the FSL.

But some times even well trained and well oriented examining doctors collected unnecessary evidence. Doctors would collect evidence from orifices where there was no penetration (oral/anal) or would collect evidence even though more than one week had passed since the assault. In two of the cases, evidence has been collected even after one month had passed and in another 8 cases, oral and anal swabs had been collected even though the nature of penetration did not indicate the need for their collection. Although these problems were seen only in 10 of the 88 cases, it is important to note that this stems from doctors' tendency to collect 'everything' for fear of omitting something. While both the instruction manual and training imparted to providers stresses on only collecting relevant samples, this is not always adhered to. **(Table 32)**

The table below presents analysis of FSL reports for 17 cases out of 94 that were received in the project duration:

FSL results received for testing semen (17 cases)		
Semen Found (3 cases)	**Number of cases**	**Reasons for positive evidence**
	2 cases where semen was found on clothes but not vaginal swabs	1) Assault involved penile penetration 2) Survivor preserved clothes, had not washed 3) Came within one day
	1 case where semen was found on both clothes and vaginal swab	1) Assault involved penile penetration and reported history of emission of semen 2) Survivor reported soon after assault 3) Had not washed, bathed, douched 4) Preserved clothes, had not washed them
Semen not found (14 cases)	**Number of cases**	**Reasons for negative evidence**
	1	Nature of assault was masturbation and hence semen could not be detected but because child was unable to articulate whether ejaculation occurred.
	5	In one case, survivor was intoxicated and could not recall the episode , while in the other 4 cases, children were under 5 years and were unable to provide details related to emission of semen
	7	In these cases, even though the assault was penetrative in nature, survivor informed that she had bathed, washed, urinated, even though she reached the hospital the same day after assault. Therefore positive evidence could not be found. Out of the 7 cases, in one survivor came the same day as assault and reported that she was menstruating during the assault. Evidence gets washed out with menstrual blood and therefore evidence could not be found.
	1	Evidence was lost due to bleeding from a genital injury that was sustained by the survivor so no positive evidence found.

Provision of Medical Opinion

The most crucial aspect related to medical evidence is the interpretation of the examination and evidence collection findings. These are prepared on two occasions; one called provisional opinion, which indicates the interpretation of the findings related to the collected evidence immediately, while the other called the final opinion is formulated after the receipt of the test results from the forensic science laboratory. Both opinions hold significant value in the courts. Though this is the case, evidence from all over India suggests that doctors are reluctant to provide a provisional (clinical) opinion in cases of sexual assault. One of the reasons is that the judiciary itself has extremely limited understanding as far as the medical evidence in sexual assault cases is concerned. Police are also known to ask doctors irrelevant questions such as "whether rape occurred or not", or whether a particular injury exhibited by a survivor occurred due to a fall or a physical assault and not sexual assault. Health providers themselves are ignorant about their role. This has led to defensive practice amongst health providers. Most state in the medical certificates "opinion pending for want of FSL reports". In instances where medical opinion is formulated, it often ends up making judgments such as "habituated to sexual intercourse", or "no signs of struggle" without a rationale for the absence of signs of struggle and the like.

Within this context we felt that there was an urgent need to educate and equip health providers on aspects such as examination, documentation, and medical opinion; therefore the instructional manual developed by us specifically provided examples of 'medical opinions' that could be formulated based on findings. An attempt was made to factor in different case scenarios related to sexual assault and provide template opinions to aid the doctors to formulate opinions. Special trainings with case studies were also undertaken to equip doctors to provide opinions. This engagement resulted in doctors formulating appropriate medical opinion in 81% cases. **(Table 33)** Even in situations where medical examination did not show use of signs of force, doctors provided rationale for the absence of physical injuries by stating possibilities such as use of condom, lubricants, threats, which may result in non-injury out of assault. However some health professionals continued to slip in to the old and defensive ways of stating opinion. Inspite of dialoguing with them, they would refuse to discuss the medical opinion. This conduct is rooted in providers' reluctance to provide any opinion, for fear of having to take a stand. Suggestions from the CEHAT interventionists were regarded as a challenge to their medical expertise and knowledge. In situations of such conflict the medical superintendent and honoraries had to be involved in dialoguing with the examining doctor.

VI. Inter-agency coordination

A comprehensive response to sexual assault requires a multi-pronged approach. Several entities such as the police, public prosecutors, community based organisations, shelter homes and legal aid institutions play an important role in sexual assault redressal. Since the inception of this model in 2008, we have made efforts to build partnerships with such agencies and institutions, with the aim of working together to reach out to the survivors.

Liaisoning with the Forensic Science Laboratory

The FSL plays an important role as they carry out chemical analysis of the evidence collected by the health professionals. The reports generated from the FSL are crucial for doctors to formulate a final opinion that is to be presented before the court. Since the inception of the project, we engaged with key officers of the FSL to ensure smooth processing of the evidence. In the initial stages , support was needed from the FSL to understand best ways of preserving evidence, steps in air drying evidence so that it doesn't get fungus etc. In order to get further clarity we invited the FSL officers to conduct a training for health care providers of all the 3 hospitals and present appropriate ways of preserving, packing and sealing the evidence. The interface enabled several health providers to clarify their doubts related to the collected evidence. The second issue was related to the delay in receiving the chemical analysis reports. Often the FSL reports did not reach the hospital and would be lying in the police stations, whereas in some cases the FSL reports were not dispatched at all. These reports would be invariably given to the doctor when she reached the court room, but this was problematic as the doctor would have no time to prepare the final medical opinion. It was only after constant engagement with the FSL that we were able to receive reports in 14 cases of sexual assault. It is important to note that there is only one FSL in Mumbai which has to carry out the analysis of all forensic evidence collected and due to the over burden of different kinds of work, their reports often get delayed. Thus there is an urgent need for the government of Maharashtra to establish additional FSLs.

Coordination with police

The police play an important role in the investigation of sexual assault. In situations where a survivor and / or her family reaches the police station, the police ought to appreciate their courage for reporting the incident. Instead, we have often seen that the police themselves become judgmental, show disbelief and abuse their power. In at least 3 separate instances, survivors and their families shared that they were detained for 24 hours in the police station itself and some were made to clean the police station. We have also seen contradictions within the police procedures. In situations where the survivors want to file a police complaint and state that they were raped, they try to put lesser charges such as Section 354, which is outraging the modesty of the survivor and refrain from putting Sections 375 /376. In

instances where the survivors are not willing to file a police complaint, they threaten the survivor and pressurise her in to making a complaint. In one case, 4 male police officers attempted to barge in to the examining room of the hospital and warned the survivor and her family that they would face dire consequences if they didn't file a police complaint. In each of these situations the interventionists ensured that the survivor's agency was respected. When a lesser charge was applied against the perpetrators, the interventionist dialogued with the higher authorities at the police stations and ensured that the charge was changed as per the history narrated by the survivor. In situations where the police took the survivors to the Police Hospital inspite of availability of a qualified public hospital close to the survivors residence, efforts were made to speak to the regional DCPs that forcing survivors to travel the distance to Police Hospital for an examination was against the law when health institutions were available. Further the Police Hospital offered no treatment to the survivor and neither did the police bother to ensure that the treatment needs of the survivor were responded to. This consistent dialogue with the police helped to some extent where in the police stations near the 3 hospitals started bringing sexual assault survivors to these hospitals. This dialogue also prompted us to conduct trainings of the police personnel on the role of health facilities in responding to sexual assault and what they can and cannot do, as often police would ask the doctor to opine on whether rape occurred or did not. The fact that rape is a legal term and the doctor cannot determine the same has to be constantly reiterated in the mind of the police machinery.

Coordination with community based organisations

CBO's play a crucial role in responding to survivors of sexual assault. They can be instrumental in creating a responsive community culture which caters to the needs of the survivor. But in practice, CBOs hardly operate with this understanding. In one instance a 15 year old survivor was taken away by the police to an observation home forcibly. When the survivor's mother reported about the episode to the CBO, they reiterated that because she was so poor , it was best for her to institutionalise her daughter and they also told her that she should be thankful that she would be taken care of in the institution . such a response is problematic as it does not take in to account the wishes of survivor and her mother at all. After a traumatic episode such as rape, the survivor may find the separation from her mother who is also her care giver more traumatic, and third, it is a known fact that institutions themselves are not sensitive to the needs of survivor. In fact these institutions are known to further stigmatize survivors and label girls. At one level, we made efforts to release the survivor from the institution and also worked towards a safety net for the survivor and her family. Simultaneously, we sought a dialogue with the CBO about problems related to forced institutionalisation and the responsibility that we have in the service sector to build resources so that the survivor and her family are able to tide over the assault and heal from it. We realised that many CBOs were not aware of the laws related to sexual assault as well as the role of medical institutions in responding to sexual assault. If CBOs are to be the first contact in the community, it is crucial that they are aware of the roles of allied agencies. Therefore we undertook trainings of CBOs to create awareness on their potential role in being the first contact for survivors of sexual assault.

Interface with Courts

As the evidence collection and documentation that is carried out at the hospital is eventually presented to the court of law, interface with the judiciary is crucial. We have provide support in this regard to both the doctor and the survivor and also liaised with the public prosecutor. In case of one survivor who followed up with us consistently and sought our assistance for the legal case, we were able to dialogue with the public prosecutor and explain the absence of medical evidence in her case, to him. We also prepared the survivor and her family for deposing in court. The doctor too was prepared prior to appearing in court and as an expert witness, so that he was able to explain to the court the fact that injuries and evidence of semen were both not expected to be seen in this case, as the girl had been intoxicated and was menstruating at the time. It is observed often that 'negative medical evidence' is often regarded as evidence of 'no rape' both among lay persons as well as lawyers and judges. The doctors who appear in court as expert witnesses, therefore, need to be able to interpret results from medical examination reports appropriately. There is also clearly a need to work with judges and public prosecutors in this regard for proper understanding/ interpreting medical evidence.

VII. Conclusions and Recommendations

The experience of implementing a comprehensive health care response has reinforced the need to seek informed consent of the survivor at all stages of the provider - survivor interface. Complete medical treatment and psycho-social care are important cornerstones of a holistic health care model. Therefore it is pertinent that the public health department and the health ministry make efforts to upscale this model. This would necessitate training of health providers not only on the issue of medico legal care and examination related to sexual assault but also an in-depth analysis related to the prevalent myths and stereotypes related to "rape" and sexual assault.

Recommendations for the Health System

1. *Need for Standard Operating Protocols in the Health System:* A model cannot work in the absence of a policy document that mandates the role of examining doctors, nurses, administrators, records officers and social workers at the health system, mechanisms to deal with the police and guidelines for interface with the Forensic Science Laboratory. CEHAT has drafted a standard operating procedure (SOP) which was especially crucial in a public health system, where there is a constant turn-over of doctors and change in resident medical officers every six months. Such protocols are also required for private medical facilities as people do seek health care from the private sector in India.

2. *Implementation of Gender Sensitive Proformas:* The implemented model has demonstrated the utility of having a gender sensitive proforma for sexual assault related examination and treatment. Documenting history related to past episodes of sexual abuse, use of threats, time lapse between the assault and reporting to the hospital have found to be useful to explain loss of medical evidence. Important and relevant documentation is crucial in situations of sexual assault and therefore the two finger test and overemphasis on the hymen and genital injuries doesn't find any place in a gender sensitive proforma. There is an urgent need to implement such a proforma which upholds the dignity of the survivor and records relevant issues related to the assault and doesn't comment on the survivors genitalia out of context.

3. *Changes in the content of Medical Education:* This intervention project has brought to light several biases, stereotypes and prejudices that health providers carry about sexual assault survivors. In part this can be attributed to the gender biased medical textbooks that doctors read as students. Forensic medicine textbooks perpetuate biases among health care providers that act against fair assessement of sexual assault and related crimes. These and the teaching curricula need to be revised. It is crucial that the Directorate of Medical Education and Research takes steps to remedy this situation. This could be done by the formation of an advisory board that could recommend

reform of medical education curricula and content so that gender stereo types and biases that negatively impact medical examination and treatment of sexual assault are revised and changes made in the way sexual assault medical management is taught in medical colleges.

Recommendations to Investigating Agencies/ Police:

4. *Expedite processing of evidence at Forensic Science Laboratory:* The home department needs to take cognizance of the indiscriminate delays in receiving reports related to chemical analysis of samples related to sexual assault, to the extent that often the samples sent disintegrate and develop fungus. Ways to reduce the burden on the FSL labs are required, that could lead to swift analysis and reports. One way could be to conduct testing of as many samples as possible at the hospital itself, so that these do not have to be examined by the FSL. It is also important to develop additional infrastructure where only DNA analysis of the samples can be carried out, which would lead to reducing the burden of examining multiple samples as well increase accuracy related to the chemical analysis.

5. *Standard Operating Procedures for the Police:* Implementation of the health care model on sexual assault brought to light several problems in the police-health system interface as well as police-survivor interface. In the hospital context, these have been seen in the form of interfering in the health providers' duty, not allowing for privacy during examination and compelling the doctor to provide a medical opinion on "whether rape occurred or not" . Further refusal by the police to take the survivor to the nearest public hospital created a lot of inconvenience to the survivor and family. Inspite of being examined in a public hospitals , police would force the survivor in to a repeat examination at the Nagpada police hospital. In terms of problems faced by the survivor – these have ranged from detaining survivors in the police stations, forcing them to file an FIR immediately, harassment and humiliation. This calls for development of standard operating procedures for police along with accountability when police officers violate such protocol.

6. *Capacity building for Police to understand role of the health system:* Just as health providers, it is mandatory for the police to get educated about the role of health professionals in examination of sexual assault so as to minimize their interference with hospital procedures. It is also important to educate police about the fact that it is not mandatory for a survivor to report to the police before going to a health facility and it is also not mandatory as per the law for the health facility to report every case of sexual assault to the police. The police must also understand the limitations of medical evidence and not ask health care providers to 'rule out rape' in requisitions for medical examination. A directive must be issued to prevent the police from taking survivors to Nagpada police hospital as any public hospital can conduct a sexual assault examination and stop repeat examinations as per Sec 164A CRPC.

7. *Reconsidering Mandatory Reporting:* The recently passed Protection of Children from Sexual Offences Act has been critiqued by civil society organizations and the aspect which we find most problematic is mandatory reporting of sexual offences to the police. Section 19 of the law mandates

that any person who has knowledge that a sexual offence has been committed against a child shall report it to the local police or to the Special Juvenile Police Unit. If the local police or special juvenile police unit feel that the child is in need or protection, then it would make arrangement for admitting the child into a shelter home or the nearest hospital. This would directly impinge on the autonomy of the survivor who may reach a hospital for treatment but would have no choice but to be put in a juvenile home as per the law. Due to the fear of mandatory reporting survivors may not access hospitals jeopardizing treatment. Our intervention in 94 cases has shown that often in case of child survivors, the survivor herself or the parent may not be willing to report the case to the police, or may not want institutionalization. It is important to ensure that the survivor is not forced to separate from the parent who may be her strongest source of support – this is crucial for her recovery. The aspect of mandatory reporting to the police needs to be reconsidered – survivors may not be in a position to report the crime to the police due to concerns regarding safety, confidentiality, compulsory institutionalization and other social implications of reporting the crime. If reporting is made mandatory, it will close doors for accessing medical facilities as well, which is likely to be detrimental to the child's health. In addition to this, it would also be pertinent to consider that the social services available for children in our country are rudimentary, insensitive and ill equipped to respond to survivors of sexual assault.

Recommendations to the Women and Child Department:

8. *Making shelter homes responsive to the needs of survivors of sexual assault:* Though there are several programs and shelter homes set up by the state towards ensuring care for survivors of sexual assault, it is seen that most of them are not geared towards upholding the survivors' rights and dignity. The perspective of the officials is strictly related to institutionalising child and adolescent survivors, whether it is relevant or not and whether the survivor consents to it or not. No efforts are made to dialogue with the survivors family and to develop safety plans to enable the parents and guardians to take charge of the situation. Even when survivors are institutionalised, no efforts are made to enable them to heal from the abuse as there are no programs run such as support group meetings, art therapies and counselling. There is a need for officials to be trained to understand the several implications of sexual assault and be more empathetic to them.

9. *Compensation for Survivors of Sexual Assault:* Our intervention has shown that survivors have various needs and financial help to address these would help tremendously, both in their recovery and quest for justice. Although the Rape Victims Compensation Board has been established (under the scheme of WCD), till date there are no funds being disbursed to survivors. This needs to be remedied immediately. There are other problems in the scheme itself, such as the fact that it only provides compensation to cases filed under the section of 'rape', thus excluding an entire range of survivors who suffer sexual assaults and face the same consequences as rape survivors, but are excluded only because the assault did not involve peno-vaginal penetration. Further, the scheme offers compensation only to those survivors who file FIR, not recognizing the fact that several survivors may not report to the police but still require support in order to overcome the trauma.

Recommendations to CBOs:

10. *Developing Capacity to Respond effectively to survivors of sexual assault:* Community based organizations and non-governmental organisations play an important role in developing a coordinated response for the survivor. However there are several gaps in their own knowledge and practice related to therapy, laws, role of medical evidence and that of the police. There is an urgent need to build a perspective on the role of interventionists and develop a sound practice in responding to the multiple needs of survivors of sexual assault.

11. *Raising awareness within communities:* CBOs need to be involved in building a perspective on the issue of rape and sexual assault within the community. In several situations they may be the first contact for survivors of sexual assault and must be equipped with understanding health consequences and implications of the delay in seeking health care. Sexual assault also has tremendous social implications for survivors and CBOs can play a crucial role in garnering support for them, ensuring their safety within the community and reducing stigma related to such violence. CBOs can also play a critical role in creating awareness on the issue of sexual violence itself as there is taboo around the issue of sex per se and that such an assault is also perceived to be a loss of honour.

Recommendations for the Judiciary

12. *Building capacity of judges and lawyers to understand medical evidence:* The findings, particularly those related to medical evidence throw up some important recommendations for training of judicial officers. There is a gross misconception among both prosecutors and judicial officers as to what medical evidence can ascertain in cases of rape. There is a need to educate the judiciary about the fact that the doctor as an expert witness cannot, on the basis of medical examination, conclude as to whether the crime of sexual assault occurred. The courts must also be aware that when evidence in the form of physical and genital injuries, are not found as part of medical examination it does not mean that the incident was consensual. An understanding of the fact that injuries are rarely seen in sexual assault survivors and factors that lead to loss of evidence is crucial for judges, if they are to interpret medical evidence accurately and this must be made a part of the training of judges.

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Annexure 1: Tables

Source: MIS of Sexual Assault Cases

Note: Being an intervention project, CEHAT was committed to speaking to every survivor of sexual assault that reached the intervention hospital sites. However 18 out of the 94 survivors arrived at odd hours and left immediately after examination, therefore we were able to speak with 76 out of the 94 survivors. For tables 19 through 23, therefore, the 'N' is 76.

Medico legal examination and complete medical care along with treatment was offered to 88 out of 94 survivors. 6 additional survivors were referred to us by community based organisations for crisis intervention support. These were examined elsewhere but came to us only for counselling. Therefore details of the nature of treatment provided and appropriateness of medico-legal documentation and evidence collection at the respective hospitals where they were attended to was not relevant for this analysis. For table 18 in Chapter IV and all tables in Chapter V (barring genital and physical injuries), therefore, the 'N' is 88.

Chapter III: Profile of survivors facing sexual assault

Table 1: Year of Contact and referred from

Year of registration	**Frequency (n=94)**	**Percent**
2008 (from April)	9	10
2009	15	16
2010	30	32
2011	38	40
2012 (up to April)	2	2
Total	94	100
Name of hospital		
H1	55	59
H2	24	25
H3	9	10
Other hospital/organizations	6	6
Total	94	100

Table 2: Place of Residence

Place of residence	Frequency	Percentage (n=94)
Eastern suburbs	53	57
Western suburbs	34	36
Out of Mumbai	1	1
No information	6	6
Total	94	100

Table 3: Year of registration by hospital

		name of the hospital				Total (n=94)
		H1	H2	H3	Other hospital/ organizations	
Year of registration	2008	2	5	0	2	9
	2009	8	6	0	1	15
	2010	21	5	4	0	30
	2011	23	8	4	3	38
	2012	1	0	1	0	2
Total		55	24	9	6	94

Table 4: Socio-demographic profile of survivors

Age	**Frequency**	**Percent (N=94)**
0-6	30	32
12-Jul	21	22
13-18	27	29
19 & above	16	17
Total	94	100
Gender		
Male	2	2
Female	92	98
Total	94	100
Marital status		
Married	9	10
Single/never married	82	87
Separated/widowed	2	2
No information	1	1
Total	94	100
Religion		
Hindu	67	71
Muslim	25	27
Christian	2	2
Total	94	100

Table 5: Nature of assault

Nature of assault	Frequency	Percentage (n=94)
Attempted Peno vaginal penetration	18	19
Completed Peno vaginal penetration	34	36
Attempted Peno anal penetration	2	2
Completed Peno anal penetration	7	7
other types of penetration (fingering, oral penetration)	21	22
Non penetrative assault	30	32
Survivor unable to give history because she was mentally disabled	3	3
Survivor unable to give history because she was too small	8	9
Survivor unable to give history because was intoxicated or unconscious	6	6
No information	2	2

*Percentages exceed 100 due to multiple responses

Table 6: Relationship with Assailant

Relationship with the assailant category	Age			Total (n=94)
	0-12	13-18	19 & above	
Unknown	8	9	3	20
Neighbor	22	7	5	34
Family	2	6	3	11
Friend	0	1	2	3
Acquaintance	12	2	1	15
Any other	3	1	0	4
Don't know	4	1	2	7
Total	51	27	16	94

Table 7: Details pertaining to luring * Age

Luring	Age			Total (n=94)
	0-12	13-18	19 & above	
Lured with cash/food/toys	15	1	0	16
Misled	2	2	1	5
Job	0	2	0	2
Not lured	23	21	13	57
Pretext of playing with her	2	0	0	2
No information	9	1	2	12
Total	51	27	16	94

Table 8: Whether resistance was offered by the survivor

Resistance	Age			Total (n=94)
	0-12	13-18	19 & above	
Resisted by screaming	7	8	2	17
Unable to resist because physically restrained	5	4	2	11
Unable to resist because drugged/unconscious	5	3	3	11
Unable to resist due to threats/fear	3	5	1	9
Too small to understand/resist	27	0	0	27
Other	1	3	3	7
Can't say	0	4	2	6
No information	3	0	3	6
Total	51	27	16	94

Table 9: Location of assault * Age

Location of assault	Age			Total (n=94)
	0-12	13-18	19 & above	
Survivor's house	6	7	7	20
Assailant's house	15	6	2	23
Relatives house	1	0	0	1
Neighborhood area	13	5	2	20
Unknown isolated area	1	3	2	6
Other places	3	2	2	7
in the school	2	2	0	4
In the assailant's shop	4	0	0	4
Don't know	6	2	1	9
Total	51	27	16	94

Table 10: Physical assault * Age of survivor

Physical assault	Age			Total (n=94)
	0-12	13-18	19 & above	
Yes	5	8	8	21
No	36	14	5	55
No information	1	0	0	1
Don't know	9	5	3	17
Total	51	27	16	94

Table 11: Disclosure * Age

Disclosure	Age			Total (n=94)
	0-12	13-18	19 & above	
Caught the accused in the act	9	2	2	13
Informed immediately after assault.	13	8	3	24
Health compliant led to disclosure	14	7	6	27
future abuse/ threats led to disclosure	0	2	1	3
Any other	1	1	0	2
Police found her/ rescued her & brought to hospital	3	3	1	7
caregiver asked her then she revealed	3	2	0	5
No information	8	2	3	13
Total	51	27	16	94

Chapter IV: Sexual Assault and Health Consequences

Table 12: Contact with the Hospital

	Frequency	Percent (n=94)
Self	41	44
Police	47	50
NA	6	6
Total	94	100

Table 13: Request for medical examination received from * Age

Request received from	Age			Total (n=94)
	0-12	13-18	19 & above	
Self	16	13	12	41
Police	32	12	3	47
NA	3	2	1	6
Total	51	27	16	94

Table 14: Pathway to hospital

		Frequency	Percent (n=94)
These are the cases which are self reported cases to hospital.	survivor – hospital	27	29
	survivor - police – hospital	1	1
	survivor - organization – hospital	3	3
	survivor - private hospital – hospital	5	6
	survivor - police – Police Hospital – hospital	3	3
	survivor - other public hospital – hospital	2	2
	Cases reported with police requisition	47	50
	NA*	6	6

*Cases which were referred to only for counseling, not to the hospital.

Table 15: Physical health consequences

	Frequency	Percentage
Genital Injury	37	39
Physical Injury	20	21
Burning micturation	11	11
Pain in genital area	6	6
Pain in Rectum/Defecation	2	2
Pain in other body parts	3	3
Nausea vomiting weakness	6	6
Unwanted pregnancy	5	5
Other health consequences	15	16
No physical health consequence	32	34

N=94

Total frequency exceeds 94 due to multiple responses.

Table 16: Physical health consequences*age

	Age			Total
	0-12 (n=51)	13-18 (n=27)	19 & above (n=16)	
Genital Injury	31	4	2	37
Physical Injury	8	4	8	20
Burning micturation	10	0	1	11
Pain in genital area	6	0	0	6
Pain in Rectum/Defecation	2	0	0	2
Pain in other body parts	1	0	2	3
Nausea vomiting weakness	0	5	1	6
Unwanted pregnancy	0	5	0	5
Other health consequences	6	6	3	15
No physical health consequence	14	12	6	32

N=94

Total frequency exceeds 94 due to multiple responses.

Table 17: Physical health consequences*time lapsed since the assault

	Time lapsed since the assault						Total
	less than 1 day (n=57)	2-3 days (n=5)	4-7 days (n=7)	8 days to a month (n=2)	More than a month (n=10)	No information (n=13)	
Genital Injury	27	0	2	1	1	5	37
Physical Injury	13	1	2	0	0	4	20
Burning micturation	5	0	1	2	0	3	11
Pain in genital area	3	0	1	0	0	2	6
Pain in Rectum/Defecation	1	0	1	0	0	0	2
Pain in other body parts	1	1	0	0	0	1	3
Nausea vomiting weakness	3	0	0	0	3	0	6
Unwanted pregnancy	0	0	0	0	5	0	5
Other health consequences	8	1	1	1	2	2	15
No apparent physical health consequence at the time of reporting	18	3	3	0	4	4	32

N=94

Total frequency exceeds 94 due to multiple responses

Table 18: Treatment Provided

Nature of Treatment	Whether Indicated	Whether Provided	Frequency
Analgesics – to be provided when there is an injury, tenderness or when the survivor complains of pain.	Indicated	**Provided**	**58**
		Not provided	**4**
	Not Indicated		22
	No information		4
	Total		88
Antibiotics to prevent infection – to be provided when there is an injury	Indicated	**Provided**	**55**
		Not provided	**0**
	Not Indicated		29
	No information		4
	Total		88
Tetanus Toxoid – to be provided when there is an injury and when the survivor has not received TT already	Indicated	**Provided**	**51**
		Not provided	**4**
	Not Indicated		29
	No information		4
	Total		88
HBSAg test advised – to be provided when there is peno-vaginal penetration and injury	Indicated	**Provided**	**63**
		Not provided	**0**
	Not Indicated		21
	No information		4
	Total		88
EC – to be provided if the survivor reports within 5 days, and when there is a history of completed penovaginal penetration and/or ejaculation	Indicated	**Provided**	**13**
		Not provided	**3**
	Not Indicated		74
	No information		4
	Total		88
UPT – to be provided at least one week after the assault AND when there is a history of completed penovaginal penetration and/or ejaculation AND if the survivor is not already pregnant	Indicated	**Provided**	**8**
		Not provided	**1**
	Not Indicated		81
	No information		4
	Total		88
HIV test advised – to be provided when there is a history of penetration and injury.	Indicated	**Provided**	**75**
		Not provided	**0**
	Not Indicated		9
	No information		4
	Total		88

N=88 as 6 cases have not been examined in the intervention hospitals.

N= 76 for tables 19 through 23, as the interventionists were able unable to make contact with 18 survivors.

Table 19: Difficulties in establishing rapport * Age for Crosstab

Difficulties in establishing rapport	Age			Total
	0-12	13-18	19 & above	
Yes	7	7	3	17
No	31	17	11	58
Total	38	24	14	76

Table 20: Emotions expressed by survivors

	Frequency (n=76)	Percentage
Anxious	19	25
Angry	3	4
Crying/ sad	10	13
Flashbacks nightmares	2	3
Fear	19	25
Suicidal ideation	2	3
Guilt	2	3
Shame	2	3
Determined	3	4
Feeling dirty	2	3
Loss of trust	2	3
Other emotions	3	4
Children - cooperative and able to communicate	18	24
Unable to get the client to open up	2	3
NA	14	18

Total exceeds 76 due to multiple responses.

Table 21: Survivor wanting to pursue case * Age

Wanted to pursue case	Age			Total
	0-12	13-18	19 & above	
Yes	15	7	8	30
No	8	10	4	22
No information	15	7	2	24
Total	38	24	14	76

Table 22: Follow up

	Frequency	Percentage
Yes	26	34
No	50	66
Total	76	100

Table 23: Reasons for not following up

	Frequency	Percentage
Alternate support available	9	12
Has relocated	5	7
Long distance	1	1
priority is to get back on daily routine	1	1
did not want to be contacted	7	9
preoccupied with other things	7	9
Did not follow up	11	15
No information	9	12
NA (as they followed up)	26	34
Total	76	100

V. Medico legal evidence in cases of sexual assault:

N=88 for the tables in this chapter, as 6 cases have not been examined in the intervention hospitals.

Table 24: Informed consent respected

	Frequency	Percentage
Yes	83	94
No	5	6
Total	88	100

Table 25: Appropriate Documentation of Details of Sexual Assault

Indicator		Frequency	Percentage (n=88)
No damaging and irrelevant details in history (like she did not scream/resist)	Yes	83	95
	No	3	3
	No information	2	2
Nature of penetration is recorded correctly wherever possible	Yes	84	96
	No	2	2
	No information	2	2
Details of condom use, ejaculation have been recorded	Yes	85	97
	No	1	1
	No information	2	2
Details of activities leading to loss of evidence has been recorded	Yes	85	97
	No	1	1
	No information	2	2
History of drugging/intoxication is recorded	Yes	85	97
	No	1	1
	No information	2	2
History of physical assault, threats, weapons used is documented	Yes	85	97
	No	1	1
	No information	2	2
Relationship to assailant mentioned where known	Yes	85	97
	No	1	1
	No information	2	2
Number of assailants mentioned	Yes	85	97
	No	1	1
	No information	2	2
Place of assault mentioned	Yes	85	97
	No	1	1
	No information	2	2

Table 26: Time lapsed since assault

	Frequency	Percentage
less than 1 day	57	65
2-3 days	5	6
4-7 days	7	8
8 days to a month	2	2
More than a month	10	11
No information	7	8
Total	88	100

Table 27: Activities leading to loss of evidence

	Frequency	Percentage (n=88)
Changed clothes	41	47
Bathe	33	38
Douche	25	28
Void urine	59	67
Defecate	35	40
no activity done after assault	15	17

Total exceeds 88 due to multiple responses.

Table 28: Appropriate Documentation of Examination Findings

Indicator		Frequency	Percentage (n=88)
Complete documentation of injuries (including age and detailed description)	Yes	85	97
	No	1	1
	No Information	2	2
Irrelevant, observations not mentioned (like old hymen tear, two finger, position of tears)*	Yes	75	85
	No	11	13
	No Information	2	2
Injuries marked on body charts	Yes	75	85
	No	11	13
	No Information	2	2

Table 29: Physical Injury

	Frequency	Percent
Yes	20	21
No	74	79
Total	94	100

Table 30: Genital Injury

	Frequency	Percent
Yes	37	39
No	57	61
Total	94	100

Table 31: Appropriate Recording of mental status

	Frequency	Percent (n=88)
Yes	75	85
No	11	13
No information	2	2
Total	88	100

Table 32: Appropriate Medicolegal Evidence Collection

Indicator		Frequency	Percentage (n=88)
Relevant body samples collected	Yes	82	93
	No	4	5
	No information	2	2
Relevant genital samples collected	Yes	82	93
	No	4	5
	No Information	2	2
Irrelevant samples not collected (as per nature of assault)	Yes	78	89
	No	8	9
	No Information	2	2
Irrelevant samples not collected (as per time lapsed)	Yes	84	96
	No	2	2
	No Information	2	2

Table 33: Provision of medical opinion

	Frequency	Percent
Yes	71	81
No	7	8
Not relevant	8	9
No information	2	2
Total	88	100

Annexure 2: MIS Intake for Intervention in Cases of Sexual Assault

PERSONAL INFORMATION

Name:

Religion:

Age:

Marital Status:

Address:

Occupation:

Telephone:

Date of first contact:

DETAILS OF CASE REGISTERED

FIR filed: Yes/No

Case filed under section:

Police Station:

Date of FIR:

HISTORY:

INTERVENTION WITH SURVIVOR

- Disposition

- Activities undertaken to establish rapport [games, play, keeping parents away or with the survivor, talking about school etc.], Response of survivor to these activities

- Emotions identified

  - o Fear
  - o Anxiety
  - o Feeling Sad
  - o Crying
  - o Guilt/self-blame
  - o loss of trust
  - o Flashbacks
  - o withdrawn
  - o Confused
  - o Thoughts of ending life
  - o Denial
  - o Others

Describe:

- How were these emotions dealt with

- Physical Health Consequences (listing)- explaining the cause, prevention, follow up etc

  - o Genital Injuries
  - o Body Injuries
  - o burning or pain while urinating
  - o Pain while passing stools
  - o Tenderness
  - o Inflammation
  - o Bleeding
  - o abdominal pain
  - o back pain
  - o difficulty walking
  - o pregnancy
  - o constipation
  - o loss of appetite
  - o nausea
  - o unconsciousness
  - o white discharge
  - o sleep disturbances
  - o headaches
  - o choking sensations
  - o difficulty in breathing
  - o bed-wetting
  - o excessive sweating
  - o menstrual irregularities
  - o others

- Coping mechanisms identified (for instance, using distraction methods, resuming daily life, sharing with friends and close family members)

- Nature of support available - formal and informal and describe in detail (friends, family, employer, CBO, political party, mahila mandal)

- Safety - both physical safety as well as suicidal ideation (assessing threat from perpetrator, abuse from family or neighbours, suicide risk assessment. Making a safety plan)

- Providing information about treatment as well as medico-legal formalities
- Reintegration into community and school - preparing her for community reactions, providing ways of dealing with stigma

Family/caretaker concerns dealt with:

- Emotions identified in the caregiver - disbelief, victim-blaming, self-blame, fear, shame
- Strategies for protecting survivor in the future
- Preparing the care giver for coping with community reactions
- Impressing upon care giver need for counseling and follow up

Interventions with police: (helped her negotiate to file/not file a complaint, helped her get an FIR copy, accompanied her to witness identification parade)

Legal interventions: (Provided legal information to survivor/carer including court procedures, following up stages for litigation FIR, charge sheet, magistrate, dialoguing with PP, preparing the client for evidence, preparing the doctor for evidence)

Referrals to other organizations:

Intervention with the doctor/hospital

Consent:

History:

Examination:

Evidence Collection and preservation:

Provisional opinion:

Treatment

Interface with Police, FSL, CWC or other agencies

Any insensitive/biased remarks passed by HCPs

Future plan:

Indicators to assess appropriateness of response

Indicator		
No damaging and irrelevant details in history (like she did not scream/resist)	Yes No	
Nature of penetration is recorded correctly wherever possible	Yes No	
Details of condom use, ejaculation have been recorded	Yes No	
Details of activities leading to loss of evidence has been recorded	Yes No	
History of drugging/intoxication is recorded	Yes No	
History of physical assault, threats, weapons used is documented	Yes No	
Relationship to assailant mentioned where known	Yes No	
Number of assailant mentioned	Yes No	
Place of assault mentioned	Yes No	
General Mental Condition recorded appropriately	Yes No	
Complete documentation of injuries (including age and detailed description)	Yes No	
Irrelevant, observations not mentioned (like old hymen tear, two finger, position of tears)	Yes No	
Injuries marked on body charts	Yes No	
Relevant body samples collected	Yes No	
Relevant genital samples collected	Yes No	
Irrelevant samples not collected (as per nature of assault)	Yes No	
Irrelevant samples not collected (as per time lapsed)	Yes No	
Provisional Opinion recorded	Yes No	

Treatment Provided

Analgesics – to be provided when there is an injury, tenderness or when the survivor complains of pain.	Yes No Not Indicated	
Antibiotics to prevent infection – to be provided when there is an injury	Yes No Not Indicated	
Tetanus Toxoid – to be provided when there is an injury and when the survivor has not received TT already	Yes No Not Indicated	
HBSAg test advised – to be provided when there is peno-vaginal penetration and injury	Yes No Not Indicated	
EC – to be provided if the survivor reports within 5 days, and when there is a history of completed penovaginal penetration and/or ejaculation	Yes No Not Indicated	
UPT – to be provided at least one week after the assault AND when there is a history of completed penovaginal penetration and/or ejaculation AND if the survivor is not already pregnant	Yes No Not Indicated	
HIV test advised – to be provided when there is a history of penetration and injury.	Yes No Not Indicated	

FOLLOW-UP

Date of follow up:

Follow up by:

Nature of follow up (in person, over the phone, at home, at Dilaasa)

Reason for follow up (treatment, counseling, help with police, etc)

Any new health consequences identified:

Intervention in follow up:

- Emotional

- Medical (Assistance in getting treatment, follow up at the hospital)

- Safety (strategies for ensuring physical safety and addressing suicide ideation if any)

- Police (helped her negotiate to file/not file a complaint, helped her get an FIR copy, accompanied her to witness identification parade)

- Legal (Provided legal information to survivor/carer including court procedures, following up stages for litigation FIR, charge sheet, magistrate, dialoguing with PP, preparing the client for evidence, preparing the doctor for evidence)

Annexure 3: Proforma for Medical Examination of Sexual Assault

SEXUAL ASSAULT SURVIVOR EXAMINATION PROFORMA

I) Information:

Hospital Name & Place ....

Out Patient Dept./In Patient Dept No...

MLC Reference Number/Outward Number...

Survivor's name ....M/F/Transgender.................................

Address ....

Telephone number/Contact number if available ....

Age .... Date of birth .... Married / Single / Divorced ....

Name of accompanying female nurse /attendant/relative..

Identification marks (1) .... (2) ....

Date and Time of survivor's arrival at the hospital...

Received Request From *(tick or write if any other)* Self/ Police/ Magistrate/..

Letter number .... Dated ....

Crime Registration No. .... Under section ....

Brought by .... (Name and signature)

Relation: .... on .... (Date) at ....

PC/ HC/ PN/ WPC Number .... Police Station: ....

Date, Time and Place of examination ....

Examined in presence of .... (Name & Signature of Witness)

II) MEDICAL HISTORY

Relevant medical/surgical history ....

Past History of Abuse ....

History of allergies .... Current medication ....

Was the survivor pregnant at the time of assault? .... If Yes, Length of Gestation ....

III)SEXUAL ASSAULT HISTORY

Narration of incident in survivor's own words *(In case this space is insufficient, please use notes page attached at the end)* :

....

....

....

....

....

....

....

....

....

This proforma contains 4 copies of each sheet. Sheets are to be distributed as follows:
Pink - For the patient, Yellow - For the police, Blue - for the FSL, White - for the hospital

Location of assault .... Date and time of assault ....
Number of assailants and name/s ....
Whether known to survivor Yes/ No .... if yes- Relationship to survivor ....
Is there any history of drug or alcohol being given to the survivor before or during the assault? ....
Since assault has the survivor changed clothes?- Yes/ No ....
If yes, are they available?.. Were they washed / repaired? ....
Since assault has the survivor, *(tick)* 1. Eaten food 2. Ingested fluids 3. Smoked 4. Brushed 5. Gargled
Has the survivor left any marks of injury on the body of the assailant during the assault? If yes, enter details ....
....

Describe pertinent data of the assault with regard to :
Verbal threats ....
Body areas touched ....
Physical violence ....
Weapons or objects used (or threatened with) ....

Details regarding penetration: Was penetration attempted by penis, fingers or other object? (Write (Y), No (N), or Don't know (DK))									
	Attempted Penetration			Completed Penetration			Emission of Semen		
Orifice	By Penis	By Finger	By Object	By Penis	By Finger	By Object	Yes	No	Don't know
Vagina									
Anus									
Mouth									

Was oral sex performed by assailant on survivor?	Y	N	DK
Masturbation of survivor by assailant	Y	N	DK
Masturbation of assailant by survivor	Y	N	DK
Did ejaculation occur outside body orifice?	Y	N	DK
Describe Location			
Kissing, licking or sucking of breasts or parts of survivor's body?	Y	N	If Yes, describe-

Was condom used? .... Y / N / DK ....
If yes - Status of the condom .... Untorn / Torn / DK ....
Was lubricant used? .... Yes / No / DK ....
If penetration was attempted by object, describe object: ....
Was last previous intercourse within one week prior to the assault? .... Yes / No / Do not remember ....
Was survivor menstruating at the time of the assault? ....
Was survivor menstruating at the time of the examination? ....

Between the assault and the time of the examination did the survivor:			
	Yes	No	Don't know
Bathe			
Douche			
Void Urine			
Defecate			
Use Spermicide			
Since the assault has there been any vaginal/anal/oral bleeding/discharge?			
Prior to the assault has there been any vaginal/anal/oral bleeding/discharge?			

IV) FORENSIC EVIDENCE

- Debris Collection Paper (on which survivor is undressed) to be placed in envelope ....
- Is the clothing worn now the same as worn during the assault? .... Yes / No ....
  (If not, request clothes worn during the assault to be submitted)
- Clothing evidence to be air dried and placed in the bag provided...

Clothing Evidence	Description

Body evidence samples duly labeled to be placed in the bag provided. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination. (Use Distilled water provided for moistening swab sticks)

BODY EVIDENCE	List sites where applicable. If not collected, give reason.
Oral Swab	
Blood Stains on body	
Foreign material on body	
Seminal Stains on body	
Other stains (specify site and suspected nature of material)	
Head Hair Combing	
Scalp Hairs (5-10 strands)	
Take nail scrapings of both hands separately	
Nail clippings of both hands separately (Write if deeply cut already)	
Blood for grouping (Plain Vaccutainer)	
Blood for drug estimation (Plain Vaccutainer)	
Blood for alcohol levels (Sodium Fluoride Vaccutainer)	
Blood for DNA analysis (EDTA Vaccutainer)	
Any other sample (collect in sterile container)	

Genital and Anal evidence samples to be placed in the bag provided. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination (Use Distilled water provided for moistening swab sticks)

GENITAL AND ANAL EVIDENCE	List sites where applicable. If not collected, give reason.
Matted Pubic Hair	
Combing of Pubic Hair (mention if shaved)	
Cutting of Pubic Hair of survivor (5-10, mention if shaved)	
Vulval Swabs (2)	
Vaginal Swabs (2)	
Anal Swab (2)	
Vaginal Smear (1 for detecting spermatozoa)	
Vaginal Smear(for evidence of STD - to be sent to hospital laboratory)	
Any other sample	

V) GENERAL EXAMINATION

General mental condition ....

Physical Examination: Examine the following areas for assault related findings:

- Scalp examination for areas of tenderness (if hair pulled out/dragged by hair) ....
- Facial bone injury: orbital blackening, tenderness ....

- Petechial haemorrage in eyes and other places ....
- Lips and Buccal Mucosa / Gums ....
- Behind the ears ....
- Ear drum ....
- Neck, Shoulders and Breast ....
- Wrists and forearms ....
- Medial aspect of upper arms ....
- Inner aspect of thighs ....
- Buttocks ....
- Other, please specify ....

VI) Genital examination - Examine the following aras for assault related findings

(Note- PV & PS examination not to be performed in children unless required to detect injuries)

State of the sphincters : ....

Labia Majora : ....

Labia Minora : ....

Fourchette and introitus : ....

External urethral meatus: ....

Hymen (only if relevant): ....

Anus and Rectum: ....

Per Speculum examination: YES / NO ....

If yes, findings: ....

....

Per Vaginum Examination : YES / NO ....

If yes, findings: ....

....

Any other findings to be noted: ....

....

VII) Opinion

After examining .... bearing identification marks as described above, ... day/s after the incident.

I am of the opinion that ....

....

....

....

....

Date

Time | Signature of Examining Doctor

Place

Name of Examining Doctor with Seal

This report contains ____________ (number of) Sheets.

NOTES

(Please use this space to record any extra information other than what has already been mentioned in the proforma)

SURVIVOR CONSENT FORM

I, ………………………………………………........................…… *(Name of the person giving consent)* hereby give voluntary consent to:

1. Examine and treat ……………………………………..........................………………………........…………*(Survivor's name)* (myself / my …………................….......…/ specify other relationship ………….........................……) for the effects of sexual assault.
2. Conduct a medico-legal examination for the purpose of assisting the police in apprehending and/or prosecuting the persons who committed the assault. This investigation will include a physical examination which may involve an examination of the mouth, breasts, vagina, anus and rectum; in addition it may include the removal and isolation of articles of clothing, scalp hair, foreign substances from the body surface, saliva, pubic hair, samples taken from the vagina, anus, rectum, and the collection of a blood specimen.
3. Inform the police the history as recorded and the findings of the examination, and provide them with any substances collected during the course of the medical investigation and/or any information and observations that might assist them in apprehending and/or prosecuting the person(s) who committed the assault.

I give my consent to the above fully and freely. I also understand that I have the right to refuse either a medicolegal investigation or information to be given to the police or both, but that my refusal will in no way result in denial of treatment for the effects of the assault.

I also understand that I am free to revoke all or any part of this consent at any time during the examination.
The content of above is explained to me in .... language which I understand and hence I sign.

....

....

(Name & Signature of Witness)
....

(Date, Place and Time)

....

....

(Name & Signature of Doctor)

....

(Date, Place and Time)

....

....

(Name & Signature of Survivor)
....

....

(Name & Signature of Guardian or Relative of the Survivor when s/he is unable give her consent due to mental disability, or if s/he is under the age of 12 years.)

ESTIMATION OF AGE IN CASE OF MINORS

Kindly fill in a request for X-rays and attach a copy to this form.

Height Weight

Breast Staging (Please refer manual)

Axillary Hair

Pubic hair (Please refer manual)

Dentition:

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Teeth: Permanent / Deciduous / Mixed

Whether space formed behind second molar Yes ☐ No ☐

Ossification test -

1. X-rays advised ....

....

2. Observations ....

....

....

Opinion on Age ....

Date Signature of Examining Doctor

Time

Place Name of Examining Doctor with Seal

REQUISITION FOR LABORATORY EXAMINATION BY FORENSIC SCIENCE LABORATORY

From :
Name and Address of Hospital

____

____

To,
The Director Forensic Science Laboratory

____

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from..

age..................... sex.................... .

Concerning OPD/IPD No.. MLC No ....

Cr. No. .... U/S .... of Police Station ....

Please examine the following sealed packets and opine on

1. .... For Evidence of ....
2. .... For Evidence of ....
3. .... For Evidence of ....
4. .... For Evidence of ....
5. .... For Evidence of ....
6. .... For Evidence of ....
7. .... For Evidence of ....
8. .... For Evidence of ....

Yours sincerely

Dr.. Hospital name ....

Signature Seal

Received intact, sealed, labelled samples by

.... (Signature)

PC No: .... Police Station: ....

Date:

REQUISITION FOR LABORATORY EXAMINATION BY PATHOLOGY/ MICROBIOLOGY DEPT

(To be used if a pathology/microbiology laboratory is not available in the hospital)

From

To,

The HOD

Dept of ____________________________

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from...

age............. sex.................... .

Concerning OPD/IPD No... MLC No ....

Cr. No. .... U/S .... of Police Station ....

Please examine the following sealed packets and opine on

1. .... For Evidence of ....
2. .... For Evidence of ....
3. .... For Evidence of ....
4. .... For Evidence of ....
5. .... For Evidence of ....

Yours sincerely

Dr.. Hospital name ....

Signature Seal

Received intact, sealed, labelled samples by

....(Signature)

PC No: .... Police Station: ....

Date:

DISCHARGE / SUMMARY SLIP

Survivor's name : ....

Date of examination : ....

Doctor's name : ....

Sexully transmitted diseases	Test done	Treatment given /	Follow up on .....
Gonorrhea			
Chlamydia			
Syphilis			
HIV testing (after counselling and if consent given)			At 3 mths & 6 mths
Routine prophylaxis for HIV			
Hepatitis B			At 1 mth & 6 mths

	Tests done	Post-coital contraception given	Follow up on .....
Pregnancy			

Injuries	Surgery	Follow up on .....
1.		
2.		
3.		
4.		
5.		

Injection Tetanus Toxoid (T.T.) Yes ☐ No ☐

Psychological assessment and counselling ....

Immediate referral to ....

Advise on discharge (including follow up dates) ....

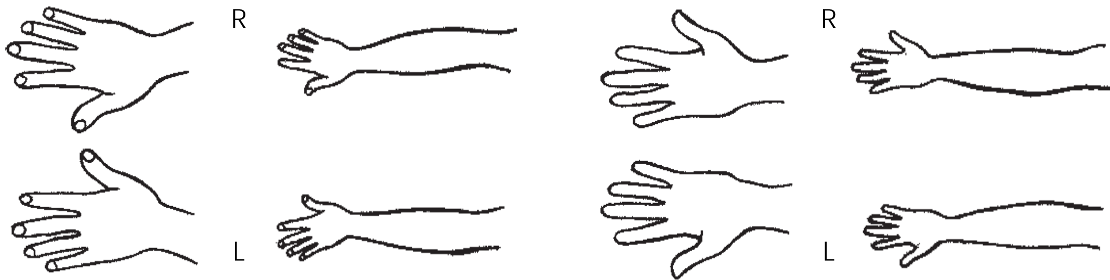
Date :

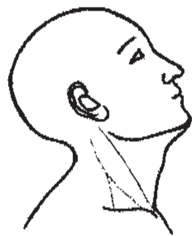
Time :

Signature of Examining Doctor

Name of Examining Doctor with Seal

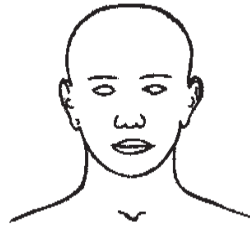
Mark all injuries on the diagram provided on next page, indicating type of injury, size (length, breadth and depth as relevant), shape, colour, borders, age and content. Opinion regarding cause of injury for each injury - - - e.g; sharp object, cloth, rope, cigarette butt, metal/wood, nails/fingers to be recorded. Nature of force used - - - very aggressive, violent, restraint, etc. to be recorded.

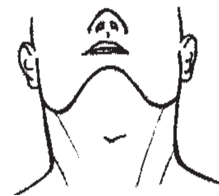


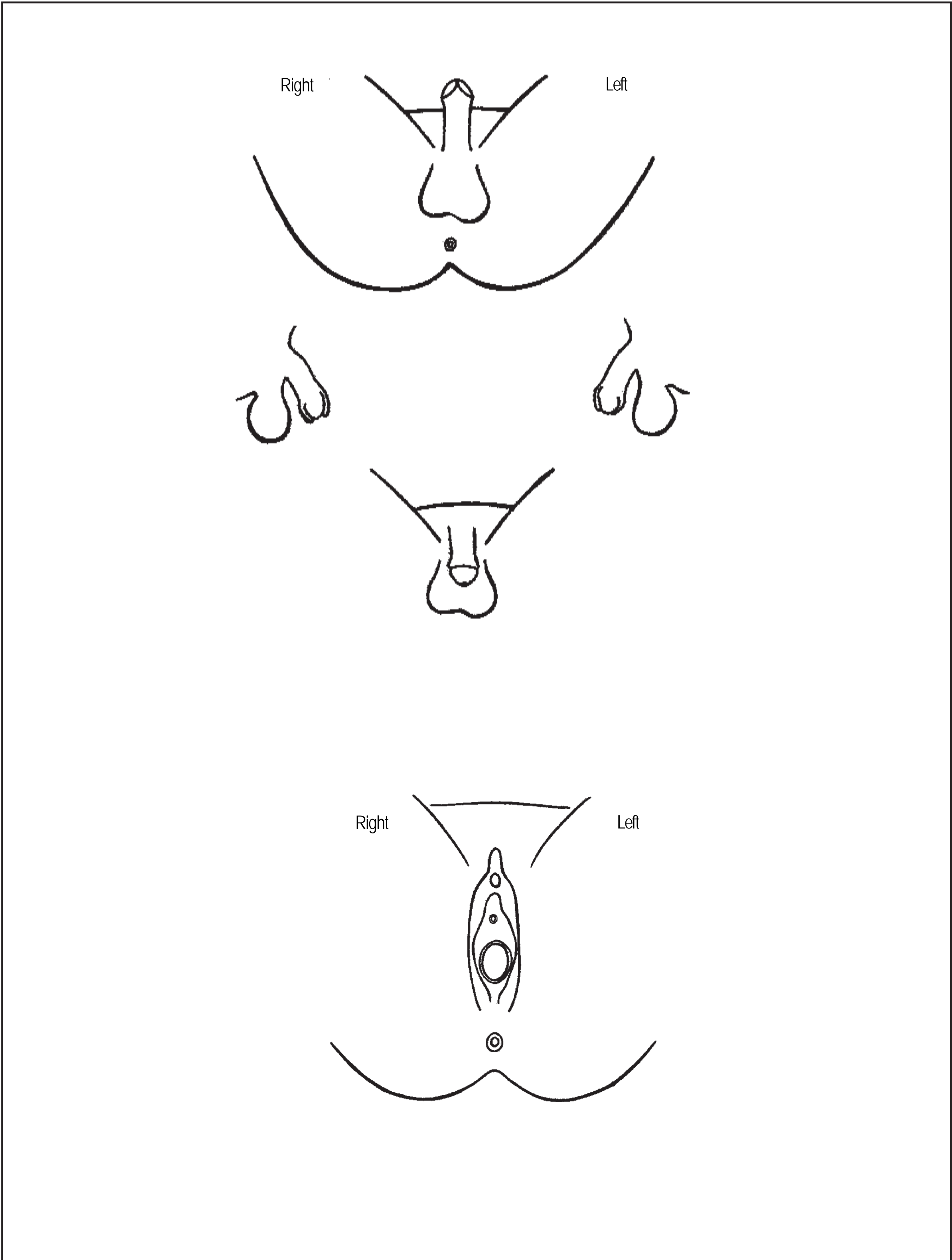


Right

Left



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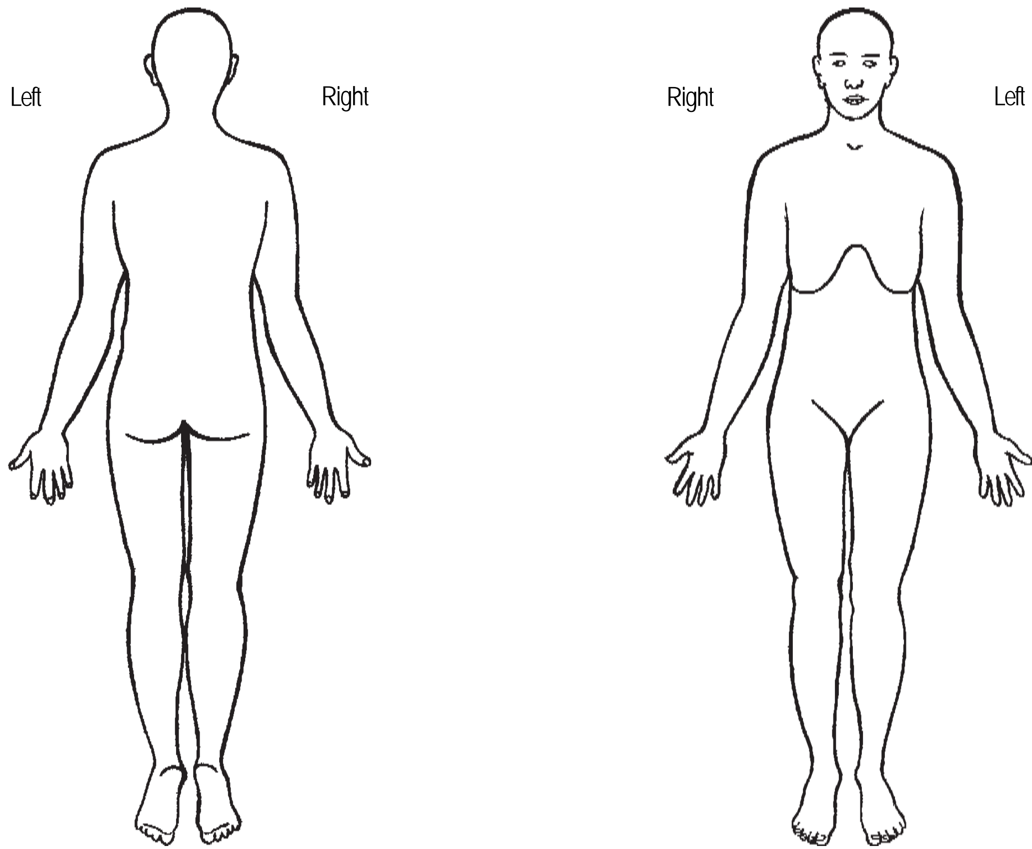

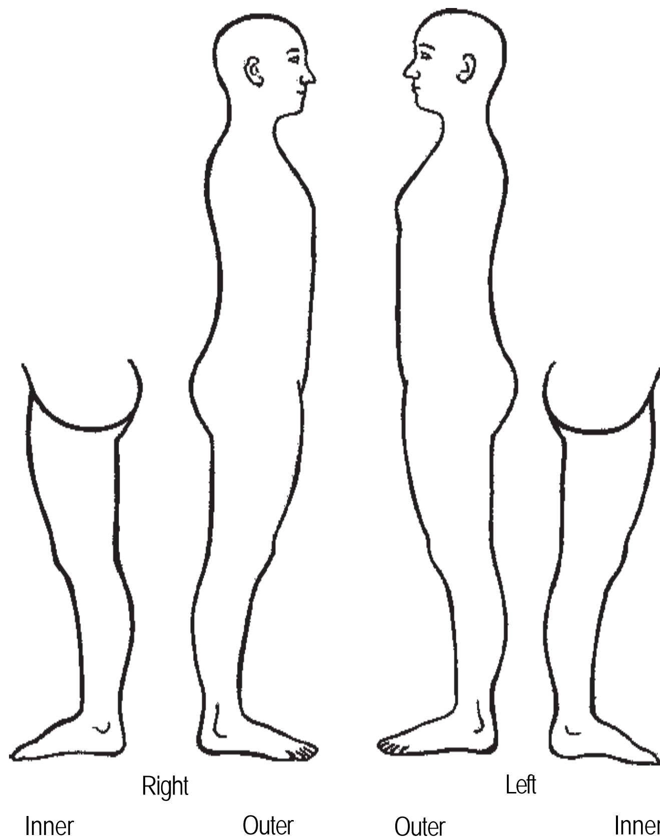

Figures courtesy WHO document 'Guidelines for Medico-Legal Care for Victims of Sexual Assault'

Annexure 4: Standard Operating Procedures for Medical Examination and Treatment of Sexual Assault Survivors

All concerned persons are expected to follow the guidelines outlined below for management of cases of sexual assault. These have been drafted with the objective of providing comprehensive, patient-centered care services at our hospitals.

1. Examination of a survivor of sexual assault is a medico-legal emergency. Prompt attention and care is to be provided for the same.

2. Survivors of sexual assault must be examined on an outpatient basis. A survivor may be admitted **ONLY IF** determined absolutely essential for medical/surgical treatment by the examining doctor [lecturer on-call]. Examination, evidence collection, investigations and treatment are all to be ensured on an outpatient basis.

3. **Informed Consent:**

a. Age of consent for medical examination is 12 years. A parent/ guardian is required to consent only if the survivor is less than 12 years of age or mentally unsound. If a parent/ guardian is not present, a designated group of senior hospital officials must decide in the best interests of the survivor.
b. The survivor has a right to consent for examination, evidence collection, treatment and police complaint independent of each other. This option of partial consent is to be provided to all survivors. The survivor may refuse certain parts of the examination. The doctor must explain to the survivor the benefits and consequences of such refusal, to allay any fears. If the survivor still refuses, their word needs to be respected and refusal must be documented.
c. Providing treatment and necessary medical investigations is the prime responsibility of the examining doctor. Admission, evidence collection or filing a police complaint is not mandatory for providing treatment.
d. The examining doctor must counsel the survivor that a MLC [police intimation] will need to be registered in the casualty, as per hospital protocol. It should be clarified that MLC does not amount to filing a police complaint [FIR], and that the survivor has the option of declaring to the police that s/he does not want a FIR filed.

4. Management on an outpatient basis:

a. The doctor should inform the survivor that the entire process of management on an OPD basis may take between 3-5 hours and includes:
   i. History taking, examination, evidence collection and documentation
   ii. Investigations for HIV, VDRL, HBsAg, UPT, urine [routine, microscopy] and other lab investigations as necessary
   iii. X-Rays for age estimation, as required
   iv. Dental, radiology, counselor/social worker consultations
   v. Treatment for presenting symptoms and prophylaxis

b. When a sexual assault survivor is examined on an OPD basis, a copy of the OPD paper must be attached to the medical examination proforma and preserved in the Medical Records Department. A copy of the same must be provided to the survivor.

c. The survivor must be examined in a private space. Designating a separate room for this purpose is desirable. A spare pair of clothes must be made available, as the clothes of the survivor are usually required to be handed over for forensic analysis.

d. Police personnel must not be allowed in the examination room during the consultation with the survivor. If the survivor requests, her relative may be present.

e. Police statement in the hospital too must be taken in a private place.

f. Investigations:

   i. HIV and VDRL samples are to be collected by the ICTC [Integrated Counseling and Testing Center]. If the ICTC has closed for the day, HIV kits from the ANC ward may be used. If still not feasible, the survivor is to be asked to come to the OPD the following day and get the tests done. Reports may be collected on the next day, and will be the responsibility of the survivor/guardian.
   ii. X-Rays for age estimation are to be done in radiology OPD as a priority, and reports given promptly. If the survivor reports out of the OPD hours, X-Rays may be done on an emergency basis. If provisions are not available, the survivor should be asked to get the X-rays done the following day in the OPD.
   iii. Urine pregnancy test is to be done where there is likelihood of a pregnancy, for e.g. peno-vaginal penetration, adolescents or adults, missed periods and so forth. USG may be done as necessary.

g. Treatment:

   i. Survivors of sexual assault are to receive all in-house services completely free of cost. This includes OPD/inpatient registration, lab and radiology investigations, UPT and medicines. The casualty medical officer must label the case papers for any sexual assault case as "free". Medicines should

be prescribed from those available in-house. If certain investigations or medicines are not available in-house, the CDO is to ensure that the survivor is compensated for investigations/ medicines from outside, using the Poor Box Charity Funds [PBCF].

ii. Broad spectrum antibiotics are to be provided as prophylaxis in case of penetrative sexual assault. Other medicines are to be provided as necessary for the presenting symptoms of the survivor.
iii. Inj. TT [2 doses] is to be given if the survivor is not previously immunized.
iv. Emergency contraception is to be provided for survivors with h/o peno-vaginal intercourse reporting within 72-96 hours.
v. HIV prophylaxis is to be provided to the survivor based on the WHO guidelines.
vi. **All medicines are to be provided to the survivor free of cost.** Doctors must prescribe medicines from those available in the pharmacy.

h. Follow-up: The survivor is to be asked to follow-up for evaluation of injuries/ symptoms, repeat investigations [HIV/others], missed periods etc.

5. The survivor must be referred to a psychologist/social worker for counseling and psychosocial support. Survivors may be referred to the Dilaasa department at Bhabha Hospital, Bandra for such services. (Tel no: 26400229)

6. Routine referral of sexual assault cases to Psychiatry is not required. Psychiatric referral may be made only for obvious symptoms requiring psychiatric opinion or treatment, as per guidelines used for any other patient.

7. Maintaining chain of custody: All samples must be kept in the custody of a designated person in the department. Once dry, the evidence must be stored under lock and key. A log of handing over of evidence from one 'custodian' to the other must be maintained.

8. The medical officer must ensure that the respective police station is contacted to collect forensic samples from the hospital promptly. If sending the products of conception for DNA testing, the police is to be requested to procure the DNA Kit from the Forensic Lab and bring it to the hospital. The chemical analysis requisition form, as prescribed by the government, is to be sent with the samples.

9. A copy of all documentation (including that pertaining to medicolegal examination and treatment) must be provided to the survivor free of cost. Such documentation would help the survivor in the legal case as well as to claim compensation from the government.

10. The Government of Maharashtra, through a scheme implemented by its Women and Child Welfare Department, provides compensation for survivors of rape. Information regarding this scheme must be provided to all survivors as the monetary compensation thus obtained would help them to access long-term rehabilitation services.

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.

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